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

OCTOBER 6, 2022
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

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

Supervisor Katrina Foley, Alternate

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

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

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

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

To ensure public safety and compliance with emergency declarations and orders related to the COVID-19 pandemic, individuals are encouraged not to attend the meeting in person. As an alternative, members of the public may:
Participate via Zoom Webinar at:
https://us06web.zoom.us/webinar/register/WN_7oxm8UM4Qeyd04JzRHx-9g
and Join the Meeting.
Webinar ID: 876 3719 1893
Passcode: 678251-- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. Chief Executive Officer Report

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

CONSENT CALENDAR
2. Minutes
   a. Approve Minutes of the September 1, 2022 Regular Meeting of the CalOptima Health Board of Directors

3. Adopt Board Resolution No. 22-1006-01, Authorizing Remote Teleconference Meetings for the CalOptima Health Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

4. Approve Modifications to CalOptima Health Policies AA.1207a and AA.1207b

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

6. Approve Actions Related to the Procurement of an Encounter Data Management System

7. Authorize Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2023

8. Ratify an Amendment to Agreement 16-93274 ("Care Coordination Agreement") with the California Department of Health Care Services in Order to Continue Operation of the Dual Eligible Special Needs Plan OneCare Program

9. Approve New CalOptima Health Policy MA.2101p: Non-Monetary Member Incentive for OneCare and OneCare Connect

10. Approve Changes to the Whole-Child Model Family Advisory Committee Chair and Vice Chair Requirements and Extend Term of Current Chair and Vice Chair

11. Authorize Amendment to Contract with NR Medical Associates for On-Call Services for CalOptima Health's Program of All-Inclusive Care for the Elderly

12. Authorize Expenditures in Support of CalOptima Health's Participation in a Community Event

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

REPORTS/DISCUSSION ITEMS

14. Authorize a General Awareness and Brand Development Campaign to Increase Visibility and Understanding of CalOptima Health in Orange County

15. Accept and Receive and File Fiscal Year 2021-22 CalOptima Health Audited Financial Statements

16. Approve Amendments to Mental Health Provider Contracts to Increase Rates for Medi-Cal Outpatient Counseling Services

17. Approve Actions Related to the Procurement of a Cybersecurity Asset Management Software Solution

18. Approve Actions Related to the Procurement of a Data Protection and Recovery Operations Software Solution

19. Authorize the Chief Executive Officer to Implement Changes to Executive Level Job Titles

20. Consider Approval of Amendments to the Employment Agreement and Agreement Terms for the Chief Executive Officer (*to follow Closed Session*)

CLOSED SESSION

CS-1. Pursuant to Government Code section 54956.9(d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION

CS-2. Pursuant to Government Code section 54957(b)(1) PUBLIC EMPLOYEE PERFORMANCE EVALUATION Title: [Chief Executive Officer]

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on October 6, 2022 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_7oxm8UM4Qeyd04JzRHx-9g

Join from a PC, Mac, iPad, iPhone or Android device:

To **Join** please click this url:
https://us06web.zoom.us/s/87637191893?pwd=T2M3QmlSVnpkb0FSMUQrdzVNSlpldz09

Or One tap mobile:
+16694449171,,87637191893#,,,,*678251# US
+17207072699,,87637191893#,,,,*678251# US (Denver)

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

Webinar ID: 876 3719 1893
Passcode: 678251

International numbers available: **https://us06web.zoom.us/u/kfceR555K**

MEMORANDUM

DATE: September 30, 2022

TO: CalOptima Health Board of Directors

FROM: Michael Hunn, Chief Executive Officer

SUBJECT: CEO Report — October 6, 2022, Board of Directors Meeting

COPY: Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

a. CalOptima Health Rated a Top Health Plan by NCQA

CalOptima Health has received a rating of 4 out of 5 in the National Committee for Quality Assurance (NCQA) Medicaid Health Plan Ratings 2022. Released on September 15, the NCQA rating means that CalOptima Health has the distinction of being a top Medi-Cal plan in California for eight years in a row. No other Medi-Cal plan in California earned higher than 4 out of 5 in the ratings this year. NCQA assesses health plan quality based on 43 clinical measures related to both preventive care and treatments. Preventive measures report whether members receive services intended to keep them healthy and treatment measures gauge whether members receive appropriate care in response to illnesses and chronic diseases. NCQA also evaluates health plans based on five customer satisfaction dimensions.

b. DHCS Shares Draft Medical Audit Report

The Department of Health Care Services (DHCS) conducted a full scope review of CalOptima Health's Medi-Cal plan from January 24–February 4, 2022. The audit covered a longer review period — from February 1, 2020, through December 31, 2021 — than in previous years due to the Public Health Emergency. DHCS staff held an exit conference with CalOptima Health on September 27 and released a draft report identifying nine findings. CalOptima Health has until October 12 to provide feedback. Then, DHCS is expected to finalize its report and formally request a Corrective Action Plan by October 27, 2022.

c. CalFresh Plans for Expanded Outreach

CalOptima Health is extending CalFresh outreach efforts with new tactics, including sharing collateral material (flyers, posters, etc.) with several additional community locations and partners including but not limited to federally qualified health centers, city offices, libraries, community/recreation and senior centers, homeless shelters and school districts serving the highest CalFresh-eligible populations. From January to July 2022, 26,059 CalOptima members are newly enrolled in CalFresh.

d. New Call Back Feature Added to Customer Service

As of September 8, members who call our Customer Service department can opt for a call back instead of waiting on the phone in a queue. Early data shows that the service is appreciated, as 714 members selected this option during the first few weeks of the implementation. There's been a 97% success rate of members accepting the return call.

e. Updated Compliance Program Coming in 2023

Chief Compliance Officer John Tanner will present CalOptima Health's 2023 Compliance Program for Board approval in December. The compliance plan will ensure regulatory standards are met and will emphasize operating our health plan in an ethical manner that's compliant with applicable regulations.

f. CalOptima Health Nominated for OCBC Award

CalOptima Health has been nominated for Orange County Business Council's (OCBC) 12th Annual "Turning Red Tape Into Red Carpet Awards." These awards honor outstanding local agencies, leaders, programs and public-private partnerships that cut through red tape and encourage jobs and economic growth in Orange County. CalOptima Health was nominated for two awards in the public-private partnership category for partnering with Housing for Health Orange County and with the Be Well OC Orange Campus. Winners will be named on Thursday, November 17.

g. PAC Representative Nominated for Award

Congratulations to Dr. Alpesh Amin, chair of the Department of Medicine in the UCI School of Medicine, for being nominated for Modern Healthcare's 100 Most Influential People in Healthcare. Dr. Amin is one of our Provider Advisory Committee physician representatives.

h. PACE Holds Senior Health and Wellness Event

CalOptima Health PACE is hosting an event on Saturday, October 1, from 10:30 a.m. to 1 p.m. for prospective participants and their families.

i. Community COVID-19 Vaccine Clinics Deliver Shots to Hundreds

CalOptima Health hosted a series of COVID-19 vaccine clinics in September focused on children. A total of 709 vaccines were administered. Staff was on-site to give $25 Member Health Rewards to eligible members and host a resource table. Medi-Cal and CalFresh enrollment was also available. An additional clinic will be held on Saturday, October 8, 9 a.m.–1 p.m. at Villa Fundamental Intermediate School in Santa Ana.

j. Tustin Facility Planning Continues

CalOptima Health is making progress on the Tustin facility that will combine two adjacent buildings into a Community Living and Program of All-Inclusive Care for the Elderly (PACE) Center. Staff is continuing to work with our architect team on the program and design elements for the facility. We are tracking toward an October 15 conditional use permit application submittal.

k. OneCare Marketing and Outreach Efforts Begin

CalOptima Health is preparing to launch a marketing campaign to promote OneCare, considering the upcoming sunset of the OneCare Connect program on December 31, 2022. The theme of the OneCare campaign will be "Zero Hassles. One Solution." Further, CalOptima Health is, for the first time, engaging a field marketing organization to support sales efforts. The new outside team will be

trained and equipped with collateral material to engage potential members during open enrollment, which starts in October.

l. Governor Signs Assembly Bill (AB) 498 and AB 2449 Into Law

Gov. Gavin Newsom has signed into law two key pieces of legislation affecting the CalOptima Health Board. Please see below for summaries and potential impacts:

AB 498 Quirk-Silva	**CalOptima Health Board of Directors:** Makes permanent the current structure of the CalOptima Health Board of Directors (Board), including all designated seats. ***Potential Impact:*** Permanent continuation of the current Board structure; new employment restrictions for one year following a Director's Board term.	**9/19/2022** Signed into law
AB 2449 Rubio, B.	**Brown Act Flexibilities:** Extends and modifies certain Brown Act flexibilities ***after*** the termination of the COVID-19 public health emergency (PHE) until January 1, 2026. Specifically, teleconferencing locations for any members of a legislative body will still ***not*** need to be publicly accessible or identified on the meeting agenda. ***Potential Impact:*** Continued ability for Board and advisory committee members to participate in meetings by teleconference after the COVID-19 PHE; modified Board streaming capabilities by ITS; and modified recordkeeping by the Clerk of the Board.	**9/13/2022** Signed into law

m. California State Auditor (CSA) Visits CalOptima Health Building

As part of the ongoing state audit, CSA had an on-site visit to CalOptima Health's 505 building from Monday, September 26, through Thursday, September 29. During the visit, CSA staff requested documents, conducted in-person interviews with staff and continued the ongoing operations analysis.

n. CalOptima Health Featured in Media Coverage

- On September 16, Local OC News, OC Breeze, Newsbreak and New Santa Ana ran the news about CalOptima Health's NCQA rating.
- On September 9, KFI radio ran an interview with Carmen Katsarov on the School Behavioral Health Incentive Program (SBHIP).

CalOptima Health

Finance Fast Facts
October 2022

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

Membership Data from August 31, 2022

Total CalOptima Health Membership
925,756

Program	Members
Medi-Cal*	907,677
OneCare Connect	14,771
OneCare (HMO SNP)	2,874
Program of All-Inclusive Care for the Elderly (PACE)	434

Note: Membership data is for Fiscal Year 2022–23, which began July 1, 2022.
*Based on unaudited financial report and includes prior year adjustment

Operating Budget

	YTD Actual	YTD Budget	Difference
Revenues	$669,824,867	$664,882,836	**$4,942,031**
Medical Expenses	$636,851,097	$623,750,770	**($13,100,327)**
Administrative Expenses	$27,802,626	$34,400,917	**$6,598,291**
Operating Margin	$5,171,143	$6,731,149	**($1,560,006)**
Medical Loss Ratio (MLR)	95.1%	93.8%	**1.3%**
Administrative Loss Ratio (ALR)	4.2%	5.2%	**1.0%**

Note: Fiscal Year 2022–23 Operating Budget began on July 1, 2022.

Reserve Summary (in millions)

	Amount
Board Designated Reserves	$569.6*
Capital Assets (Net of depreciation)	$66.4
Resources Committed by the Board	$364.7
Resources Unallocated/Unassigned	$428.2*
Total Net Assets	$1,428.9

*Total of Board Designated reserve and unallocated reserve amount can support approximately 90 days of CalOptima Health's current operations

Personnel Summary

	Filled	Open	Vacancy %
FTE Count	1,461.9	218.5	13.0%

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

CalOptima Health, A Public Agency

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MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

September 1, 2022

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on September 1, 2022, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Zoom) in light of the COVID-19 public health emergency and Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings. Chairman Andrew Do called the meeting to order at 2:02 p.m., and Director Trieu Tran led the Pledge of Allegiance.

ROLL CALL

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

The Clerk noted for the record that Consent Calendar, Agenda Item 9, was continued.

PRESENTATIONS/INTRODUCTIONS

None

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Michael Hunn, Chief Executive Officer, began his report with a thank you to CalOptima Health staff and all of the tremendous work being done each and every day to live up to the agency's mission, put the member at the heart of all CalOptima Health does, and treat each person with kindness, dignity and respect. Mr. Hunn highlighted the new name, CalOptima Health, and its new logo, which depicts the following attributes: community connection, diversity, innovation, excellence, inspiration, growth, wellness, and joy. Mr. Hunn noted that the new name and logo have been received incredibly well and thanked the Board for its approval at the August 4 Board meeting.

Vice Chair Corwin commented that the Board appreciates the comments and the sincerity with which those comments come through. He noted that the change in attitude, energy, and in the culture that has transpired over the last eight or nine months, has truly made it worthwhile personally to be part of the CalOptima Health Board. Vice Chair Corwin added that the impact on membership and the community in Orange County as a whole is commendable, and he thanked Mr. Hunn and staff.

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Mr. Hunn provided an update on the CalFresh Program, formerly known as the Food Stamp Program, noting that with the State of California's additional funding, a family of four could be eligible to receive up to $912.00 a month. Formerly, the CalFresh funding for an eligible family of four was up to $825.00 a month. Of CalOptima Health's approximately 925,000 members, Mr. Hunn reported that another 344,000 members may still be eligible to receive CalFresh benefits. He also reported that since January 2022, 24,082 individuals have been enrolled in CalFresh. CalOptima Health's awareness campaign is working, and CalOptima Health continues to collaborate with the Social Services Agency (SSA) to reach the initial goal of enrolling 100,000 individuals in the CalFresh program.

Mr. Hunn provided a brief update on his request to the Orange County Board of Supervisors to withdraw the second reading of the ordinance change to allow CalOptima Health to join Covered California, California's health care exchange (Exchange). The second reading was scheduled for August 23, 2022, and Mr. Hunn noted that he did not feel CalOptima Health had sufficient depth of support in order to be successful in joining the Exchange. As such, CalOptima Health will focus its efforts on how it can best help navigate its members to an insurance product on the Exchange when redetermination occurs. Mr. Hunn also noted that the public health emergency (PHE) has been extended at least through October, and CalOptima Health will start working with its community partners, including the SSA, Health Care Agency, community clinics, and other community providers and stakeholders, on defining a clear plan to assist members in navigating the Exchange to ensure continuity of care and avoid duplication of efforts.

CEO Hunn updated the Board on the Kaiser direct contract with the Department of Health Care Services (DHCS) for Medi-Cal services. The Kaiser contract is now moving to the federal level, and DHCS will submit the 1915b Waiver amendment to the Centers for Medicare & Medicaid Services for review and approval. Mr. Hunn noted that CalOptima Health submitted a joint letter to the U.S. Department of Health and Human Services (HHS) Secretary Xavier Becerra, expressing its concerns regarding the proposed Waiver amendment. CalOptima Health has requested a meeting with HHS Secretary Becerra to ensure that the county organized health system (COHS) model is preserved and protected and will keep the Board updated.

Mr. Hunn also reported that CalOptima Health is audited by regulators on a consistent basis, and currently, Nancy Huang, CalOptima Health's chief financial officer (CFO), is in the middle of the Moss Adams financial audit. In addition, as mentioned at the August 4 Board meeting, CalOptima Health is also going through a Joint Legislative Audit to examine CalOptima Health's budget, reserves, homeless services to ensure timely access standards are met, executive-level changes, salaries, and hiring practices. Mr. Hunn reminded the Board that this audit process is confidential until the audit findings are published and will keep the Board apprised accordingly.

CEO Hunn reported that President Biden signed H.R. 5376 into law on August 16, 2022, which is the Inflation Reduction Act of 2022, and will require Medicare to negotiate lower prices for certain high-cost drugs as part of Medicare Part B and D. This will hopefully reduce out of pocket prescription costs and eliminate vaccine costs for CalOptima Health OneCare members.

Lastly, Mr. Hunn shared that CalOptima Health's chief information officer (CIO), Wael Younan, was named a finalist in the 2022 SoCal CIO of the Year ORBIE Awards in the Enterprise category. The awards are sponsored by the SoCal Leadership Association, and more than 155 nominations were received this year. Mr. Younan is one of 22 finalists, and CalOptima Health is very proud of his efforts.

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Mr. Hunn asked Mr. Younan to provide any additional comments.

Wael Younan thanked Mr. Hunn and the Board, noting that being nominated was an honor. Mr. Younan added that the leadership at CalOptima Health and the work CalOptima Health is doing, inspires him daily to try to help leverage the best outcomes for CalOptima Health's members through technology.

Chairman Do thanked Mr. Younan and noted that he really appreciated his comments and the comments from Vice Chair Corwin, and their observations of the agency and its leadership. Chairman Do noted that the agency is facing closer scrutiny, and he appreciates the positive feedback and feels it is important for CalOptima Health staff to hear observations from the Board and leadership.

Director Contratto added that when she received her electronic Board materials, opened the link, and saw the new name and logo, it truly gave her joy. She thanked Deanne Thompson, Executive Director, Marketing and Communications, for all of her work on the rebrand. Director Contratto commented that the agency has an amazing opportunity to build brand awareness and noted that even though CalOptima Health is not joining the Exchange, it is still important to build the CalOptima Health brand. She offered her assistance to help in building brand awareness.

2. ITS Digital Transformation Update

Mr. Younan provided an update on CalOptima Health's Digital Transformation to date. Mr. Younan reviewed the identification of core business needs and opportunities to improve those core business needs. This involved understanding what CalOptima Health's members, providers, leadership, and employees are experiencing related to technology to be able to deliver outcomes that make sense and are meaningful for the organization. After conducting a technology assessment, several projects were identified that will assist CalOptima Health in its digital transformation. During the first and second quarters, the following transformations were implemented: 505 building wi-fi; mobile device and security enhancements; remote work enhancements for access to Teams, SharePoint, OneDrive and Office365; provider portal enhancements; video conferencing upgrade for the 9th floor; and endpoint security implementation. Mr. Younan provided details on each of the accomplishments and also reviewed the future planned milestones for the third and fourth quarters. Mr. Younan also provided an overview of the digital transformation year-one budget, noting for FY 2022-23, the total budget allocation is $45.2 million, and of that total, approximately $9.6 million are initiatives that are in progress. He added that actual expenses will be reported as part of the monthly financial statements presented to the Board.

Mr. Younan responded to the Board's comments and questions, including questions on the provider portal and whether there is a plan to provide training to physicians and provider offices on how to use the technology. He noted that much of the technology being implemented will not require training, but some will and outreach and education will go along with the implementation of certain technologies as needed.

PUBLIC COMMENTS

There was no request for public comment.

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CONSENT CALENDAR

3. Minutes

a. Approve Minutes of the August 4, 2022 Regular Meeting of the CalOptima Health Board of Directors

4. Adopt Board Resolution No. 22-0901-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

5. Approve New CalOptima Health Policy GG.1666p: CalOptima Health Mobile Texting Program

6. Approve CalOptima Health PACE Policy: PA.2022 Service Determination Request

7. Adopt Resolution to Replace and Rename Seats on the CalOptima Health Board of Directors' Member Advisory Committee

8. Appoint the Chairs and Vice Chairs of the CalOptima Health Board of Directors' Member Advisory Committee and Provider Advisory Committee

9. Appoint Physician Representative to the CalOptima Health Board of Directors' Provider Advisory Committee

This item was continued.

10. Receive and File:

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

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors approved Consent Calendar Agenda Items 3.a. through 10.d., minus Agenda Item 9., as presented. (Motion carried 7-0-0; Directors Schoeffel and Shivers absent)***

REPORTS/DISCUSSION ITEMS

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

Action: ***On motion of Director Tran, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer (CEO) to submit the Housing and Homelessness Incentive Program (HHIP) investment plan to the Department of Health Care Services (DHCS); and 2.) Authorized reallocation of up to $40.1 million from the following Board of Directors (Board)-approved categories within the restricted Homeless Health Initiatives Reserve to provide investment funding related to homeless initiatives included in the HHIP: a.) $5.1 million***

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from "Clinic health care services in all homeless shelters."; b.) $2.0 million from "Authorize mobile health team to respond to all homeless providers."; c.) $13.0 million from "Residential support services and housing navigation."; and d.) $20.0 million from "Extend recuperative care for homeless individuals with chronic physical health issue." (Motion carried 7-0-0; Directors Schoeffel and Shivers absent)

12. Approve Modifications to CalOptima Health's Purchasing Policy

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors approved modifications to CalOptima Health Policy GA.5002: Purchasing Policy. (Motion carried 7-0-0; Directors Schoeffel and Shivers absent)***

13. Authorize Amendment to the Medi-Cal, OneCare, and OneCare Connect Ancillary Services Contract for Community Supports Providers to Reflect Updated Insurance Requirements

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

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors amended the Medi-Cal, OneCare, and OneCare Connect Ancillary Services Contract for Community Supports providers with updated insurance liability limits. (Motion carried 7-0-0; Directors Schoeffel and Shivers absent)***

14. Approve Actions Related to the Procurement of a Fraud, Waste, and Abuse Data Analytics/Detection Solution

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors: 1.) Authorized reallocation of budgeted but unused funds in the amount of $950,000 from the "Clinical Evidence Based Criteria/Guidelines" capital project to a new project, "FWA Data Analytics/Detection Solution" under the "Applications Management" category in the CalOptima Fiscal Year (FY) 2022-23 Digital Transformation Year One Capital Budget.; 2.) Approved the scope of work (SOW) for the fraud, waste, and abuse (FWA) detection solution.; and 3.) Authorized the Chief Executive Officer to release the FWA detection solution request for proposal (RFP) with the approved SOW and to negotiate and contract with the selected vendor. (Motion carried 7-0-0; Directors Schoeffel and Shivers absent)***

15. Approve Authorization to Extend the Contract Related to the Fraud Data Analytics/Detection Solution

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors authorized the Chief Executive Officer to extend the current contract with LexisNexis Risk Solutions (LexisNexis) for the following***

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services through December 31, 2023, while a request for proposal for a new vendor is issued: Intelligent Investigator and Virtual Special Investigative Unit (VSIU) Services. (Motion carried 7-0-0; Directors Schoeffel and Shivers absent)

16. Authorize Contract Amendment Related to CalOptima Health's Key Operational System Vendor for Claims Editing and Clinical Coding Validation

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors authorized the Chief Executive Officer to amend the current contract with Cotiviti, Inc (Cotiviti). To extend the contract term for two years, beginning October 7, 2023, with the option of two additional one-year extensions, each exercisable at CalOptima Health's sole discretion. (Motion carried 7-0-0; Directors Schoeffel and Shivers absent)***

17. Adopt Resolution Approving and Adopting Updated CalOptima Health Human Resources Policies

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Adopted resolution approving updated CalOptima Health policies: a.) GA. 8012: Conflicts of Interest and Attachments A-C; b.) GA. 8022: Performance and Behavior Standards; c.) GA. 8025: Equal Employment Opportunity; and d.) GA. 8052: Drug-Free and Alcohol-Free Workplace and Attachment A. (Motion carried 7-0-0; Directors Schoeffel and Shivers absent)***

ADVISORY COMMITTEE UPDATES

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

Jena Jensen, Provider Advisory Committee Chair, provided an update on the August 11, 2022, meeting of the Joint Member Advisory Committee (MAC) and Provider Advisory Committee (PAC).

CLOSED SESSION

The Board adjourned to Closed Session at 3:16 p.m. pursuant to Government Code section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION, Chapman Global Medical Center/KPC ("Claimant"), and CalOptima, Claim number 2110311200900.

The Board reconvened to Open Session at 3:45 p.m., and the Clerk re-established a quorum.

ROLL CALL

Members Present: Supervisor Andrew Do, Chairman; Clayton Corwin, Vice Chair; Isabel Becerra; Supervisor Doug Chaffee; Blair Contratto; José Mayorga M.D.; Trieu Tran, M.D.
(All Board Members participated remotely except Chairman Do, Vice Chair Corwin, Director Contratto and Director Tran who participated in person)

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Members Absent: Clayton Chau, M.D. (non-voting); Scott Schoeffel; Nancy Shivers

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

The Clerk read the following action taken in Closed Session:

Action: ***On motion of the Board of Directors, seconded and carried, the Board Approves the Settlement of a Government Claim payment dispute between Chapman Global Medical Center/KPC ("Claimant"), and CalOptima, Claim number 2110311200900 in the amount of $1,010,567.88. (Motion carried 7-0-0; Directors Schoeffel and Shivers absent)***

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

There were no Board member comments.

ADJOURNMENT

Hearing no further business, Chairman Do adjourned the meeting at 3:47 p.m.

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Sharon Dwiers
Clerk of the Board

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

3. Adopt Board Resolution No. 22-1006-01, Authorizing Remote Teleconference Meetings for the CalOptima Health Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

Contact

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

Recommended Action

Adopt Board Resolution No. 22-1006-01, authorizing remote teleconference meetings for the CalOptima Health Board of Directors and its advisory committees in accordance with Government Code section 54953, subdivision (e).

Background

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

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

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

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

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

Discussion

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

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

Given the continued active declaration of emergency arising from the COVID-19 pandemic, there is an ongoing need for holding teleconference meetings for the CalOptima Health Board of Directors and its advisory committees. In addition, the County of Orange Health Officer issued "Orders and Strong Recommendations," updated as of August 19, 2022, to strongly recommend preventative measures such as wearing masks in all public spaces and businesses, and engaging in social distancing for vulnerable populations. For CalOptima Health to continue the teleconference meetings, the required findings are set forth in the attached Resolution No. 22-1006-01.

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Board Resolution No. 22-1006-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with Government Code section 54953, subdivision (e)
2. March 4, 2020, Proclamation of a State of Emergency
3. August 19, 2022, Orange County Health Officer's Orders and Strong Recommendations
4. Government Code section 54953, as amended by AB 361

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-1006-01

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

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

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

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

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

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

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

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

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

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

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

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

WHEREAS, on August 19, 2022, the County of Orange Health Officer issued a revised "Orders and Strong Recommendations," which includes strong recommendations for preventative measures, such as wearing masks in all public spaces and businesses, and engaging in social distancing for vulnerable populations;

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

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

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

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

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

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 6th day of October 2022.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

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

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

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

PROCLAMATION OF A STATE OF EMERGENCY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IT IS HEREBY ORDERED THAT:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

REGINA CHINSIO-KWONG, DO
COUNTY HEALTH OFFICER

MATTHEW ZAHN, MD
DEPUTY COUNTY HEALTH OFFICER/MEDICAL DIRECTOR CDCD

405 W. 5TH STREET, 7TH FLOOR
SANTA ANA, CA 92701
www.ochealthinfo.com

COUNTY OF ORANGE HEALTH OFFICER'S ORDERS AND STRONG RECOMMENDATIONS (Revised August 19, 2022)

In light of recent Face Mask Guidance issued by the California Department of Public Health (CDPH) and certain recent orders issued by the State Public Health Officer regarding COVID-19 vaccine requirements, the following Orders and Strong Recommendations shall revise and replace the prior Orders and Strong Recommendations of the County Health Officer that were issued on June 15, 2022. The Orders and Strong Recommendations issued on June 15, 2022, are no longer in effect as of August 19, 2022.

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

ORDERS

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

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

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

1. Persons who are symptom-free but test positive for COVID-19.
   If you do not have any COVID-19 symptoms (as defined below in this Order) but test positive for COVID-19, you shall immediately isolate yourself in your home or another suitable place for at least 5 days from the date you test positive and may end your self-isolation after day 5:

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

Exceptions.

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

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

2. Persons who have COVID-19 symptoms.

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

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

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

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

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

Exception:

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

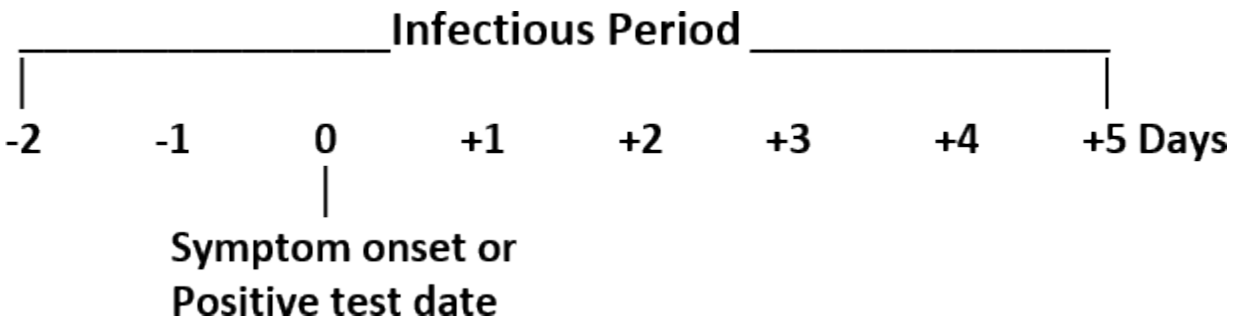
You are not required to self-isolate for more than 10 days from the date of your COVID-19 symptom(s) onset regardless of whether your symptoms are present on Day 11.

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

3. Additional Considerations for Self-Isolation.

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

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



NOTE: In workplaces, employers and employees are subject to the Isolation and quarantine requirements as stated in the CalOSHA COVID-19 Emergency Temporary Standards (ETS) as modified by the Governor's Executive Order N-5-22 or in some workplaces the Cal/OSHA Aerosol transmissible Diseases (ATD) Standard. Information about CalOSHA COVID-19 Emergency Temporary Standards (ETS) can be found at https://www.dir.ca.gov/dosh/coronavirus.

Definition.

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

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache

- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea
- The list above does not include all possible symptoms.

IV. Face-Coverings/Masks:

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

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

Masks are required for all individuals in the following indoor settings, regardless of vaccination status:

- Emergency shelters and cooling and heating centers.
- Healthcare settings (applies to all healthcare settings, including those that are not covered by State Health Officer Order issued on July 26, 2021).
- Local correctional facilities and detention centers.
- Long Term Care Settings & Adult and Senior Care Facilities.

NOTE:

1) When using public transit, individuals shall follow the guidance and requirements set by the Federal government. More information about the guidance on public transportation can be found at https://www.cdc.gov/quarantine/masks/face-masks-public-transportation.html.

2) In workplaces, employers are subject to the Cal/OSHA COVID-19 Prevention Emergency Temporary Standards (ETS) or in some workplaces the Cal/OSHA Aerosol

Transmissible Diseases (ATD) Standard (PDF) and should consult those regulations for additional applicable requirements, as modified by the Governor's Executive Order N-5-22. Additional information about how CDPH isolation and quarantine guidance affects ETS-covered workplaces may be found in Cal/OSHA FAQs.

3) In accordance with State Health Officer Order, issued on July 26, 2021, and found at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx, in certain healthcare situations or settings, surgical masks are required.
No person shall be prevented from wearing a mask as a condition of participation in an activity or entry into a business.

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

Exemptions to masks requirements.

The following individuals are exempt from this mask order:

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

V. Health Care Workers COVID-19 Vaccine Requirement Order:To help prevent transmission of COVID-19, all workers who provide services or work in facilities described below shall comply with the COVID-19 vaccination and booster dose requirements as set forth in the February 22, 2022, State Health Officer Order. A copy of the State Health Officer Order is attached herein as Attachment "**B**" and can be found at the following link:

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

Facilities covered by this order include:

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

The word, "worker," as used in this Order shall have the same meaning as defined in the State Health Officer's Order, dated December 22, 2021.

VI. Requirements and Guidance for Specific Facilities

Requirements for COVID-19 Vaccination Status Verification, COVID-19 Testing, and Masking for Certain Facilities.

To help prevent transmission of COVID-19, all facilities described below shall comply with the State Health Officer Order, issued on July 26, 2021 and effective August 9,

2021. A copy of the State Health Officer Order is attached herein as Attachment "**C**" and can be found at the following link:

C: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx

Facilities covered by this order include:

- Acute Health Care and Long-Term Care Settings:
  - General Acute Care Hospitals
  - Skilled Nursing Facilities (including Subacute Facilities)
  - Intermediate Care Facilities
- High-Risk Congregate Settings:
  - Adult and Senior Care Facilities
  - Homeless Shelters
  - State and Local Correctional Facilities and Detention Centers
- Other Health Care Settings:
  - Acute Psychiatric Hospitals
  - Adult Day Health Care Centers
  - Adult Day Programs Licensed by the California Department of Social Services
  - Program of All-Inclusive Care for the Elderly (PACE) and PACE Centers
  - Ambulatory Surgery Centers
  - Chemical Dependency Recovery Hospitals
  - Clinics & Doctor Offices (including behavioral health, surgical)
  - Congregate Living Health Facilities
  - Dental Offices
  - Dialysis Centers
  - Hospice Facilities

- Pediatric Day Health and Respite Care Facilities
- Residential Substance Use Treatment and Mental Health Treatment Facilities

- **Requirements for COVID-19 Vaccine Status Verification and COVID-19 Testing for School Workers in Transitional Kindergarten through Grade 12**.

  To prevent the further spread of COVID-19 in K-12 school settings, all public and private schools serving students in transitional kindergarten through grade 12 shall comply with the State Health Officer Order, effective August 12, 2021, regarding verification of COVID-19 vaccination status and COVID-19 testing of all workers. A copy of the State Health Officer Order is attached herein as Attachment "**D**" and can be found at the following link:

  D: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Vaccine-Verification-for-Workers-in-Schools.aspx

  This Order does not apply to (i) home schools, (ii) child care settings, or (iii) higher education.

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

  To prevent the further spread of COVID-19 in local correctional facilities and detention centers, all individuals identified in the State Health Officer Order, effective December 22, 2021, shall comply with the State Health Officer's Order with regards to obtaining COVID-19 vaccination and booster doses. A copy of the State Health Officer Order is attached herein as Attachment "**E**" and can be found at the following link:

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

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

  To help prevent transmission of COVID-19, all individuals specified below shall comply with the COVID-19 vaccination and booster dose requirements as set forth in the February 22, 2022, State Health Officer Order. A copy of the State

Health Officer Order is attached herein as Attachment "**F**" and can be found at the following link:

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

Individuals covered by this order include:

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

7. **Requirements for Visiting Acute Health Care and Long-Term Care Settings**.

To help prevent transmission of COVID-19, all acute health care and long-term care settings shall comply with the indoor visitation requirements set forth in the State Health Officer issued February 7, 2022. A copy of the State Health Officer Order is attached herein as Attachment "**G**" and can be found at the following link:

G. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Requirements-for-Visitors-in-Acute-Health-Care-and-Long-Term-Care-Settings.aspx

VII. Seasonal Flu Vaccination Order:

Seasonal Flu Vaccination for Certain County Residents.

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

- *Emergency responder* shall mean military or national guard; law enforcement officers; correctional institution personnel; fire fighters; emergency medical services personnel; physicians; nurses; public health personnel; emergency medical technicians; paramedics; emergency management personnel; 911 operators; child welfare workers and service providers; public works personnel; and persons with skills or training in operating specialized equipment or other skills needed to provide aid in a declared emergency; as well as individuals who work for such facilities employing these individuals and whose work is necessary to maintain the operation of the facility.

- *Health care provider* shall mean physicians; psychiatrists; nurses; nurse practitioners; nurse assistants; medical technicians; any other person who is employed to provide diagnostic services, preventive services, treatment services or other services that are integrated with and necessary to the provision of patient care and, if not provided, would adversely impact patient care; and employees who directly assist or are supervised by a direct provider of diagnostic, preventive, treatment, or other patient care services; and employees who do not provide direct heath care services to a patient but are otherwise integrated into and necessary to the provision those services – for example, a laboratory technician who processes medical test results to aid in the diagnosis and treatment of a health condition. A person is not a health care provider merely because his or her employer provides health care services or because he or she provides a service that affects the provision of health care services. For example, IT professionals, building maintenance staff, human resources personnel, cooks, food services workers, records managers, consultants, and billers are not health care providers, even if they work at a hospital of a similar health care facility.

STRONG RECOMMENDATIONS

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

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

- If you are known to be exposed to COVID-19 (regardless of vaccination status, prior disease, or occupation), it is strongly recommended to follow CDPH Quarantine guidance found at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Guidance-on-Isolation-and-Quarantine-for-COVID-19-Contact-Tracing.aspx.

- **K-12 Schools and Child Care**

    - Schools/school districts are advised to follow CDPH COVID-19 Public Health Guidance for K-12 Schools in California, 2022-2023 School Year found at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/K-12-Guidance-2022-23-School-Year.aspx

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

- **Workplaces**

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

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

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

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

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

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

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

6. Furthermore, it is strongly recommended that all unvaccinated Emergency Medical Technicians, Paramedics, and Home Healthcare Providers (including In Home Supportive Services Program workers) undergo at least twice weekly testing for COVID-19 until such time they are fully vaccinated.

GENERAL PROVISIONS

1. The Orders and Strong Recommendations, above, shall not supersede any conflicting or more restrictive orders issued by the State of California or federal government. If any portion of this document or the application thereof to any person or circumstance is held to be invalid, the remainder of the document, including the application of such part or provision to other persons or circumstances, shall not be affected and shall continue in full force and effect. To this end, the provisions of the orders and strong recommendations are severable.

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

REASONS FOR THE ORDERS AND STRONG RECOMMENDATIONS

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

2. On February 26, 2020, the Chairwoman of the Board of Supervisors, acting as the Chair of Emergency Management Council, proclaimed a Local Emergency in that the imminent and proximate threat to public health from the introduction of COVID-19 created

conditions of extreme peril to the safety of persons and property within the territorial limits of Orange County.

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

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

5. As of August 19, 2022, the County has reported a total of 652,703 recorded confirmed COVID-19 cases and 7,280 of COVID-19 related deaths.

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

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

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

9. The Orders and the Strong Recommendations contained in this document are based on the following facts, in addition to the facts stated under the foregoing paragraphs: (i) Safe and effective FDA authorized COVID-19 vaccines have become widely available, but many Orange County residents have not yet had the opportunity to be vaccinated, or have not completed their vaccination series to be fully vaccinated or boosted; (ii) the current consensus among public health officials for slowing down the transmission of and avoiding contracting COVID-19 is for at-risk persons to complete a COVID-19 vaccination series and receive a booster if eligible, wear well-fitted mask in indoor settings when around others outside of their household, practice distancing, frequently wash hands with soap (iii) some individuals who contract COVID-19 have no symptoms or have only mild symptoms and so are unaware that they carry the virus and are transmitting it to others; (iv) current evidence shows that the novel coronavirus can survive on surfaces and can be indirectly transmitted between individuals; (v) older adults and individuals with medical conditions are at higher risk of severe illness; (vi) sustained COVID-19 community transmission continues to occur; (vii) the age, condition, and health of a portion of Orange County's residents place them at risk for serious health

complications, including hospitalization and death, from COVID-19; (viii) younger and otherwise healthy people are also at risk for serious negative health outcomes and for transmitting the novel coronavirus to others.

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

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

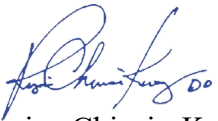
12. The California Health and Safety Code sections 101030 and 101470 require the county health officer to enforce and observe in the unincorporated territory of the county and within the city boundaries located with a county all of the following: (a) Orders and ordinances of the board of supervisors,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

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

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

IT IS SO ORDERED:

Date: August 19, 2022



Regina Chinsio-Kwong, DO
County Health Officer
County of Orange

GOVERNMENT CODE - GOV

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Any of the following circumstances exist:

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

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

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

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

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

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
4. Approve Modifications to CalOptima Health Policies AA.1207a and AA.1207b

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

Recommended Actions
Approve recommended modifications to the following existing policies and procedures, in accordance with CalOptima Health's regular review process and regulatory requirements:

1. Policy AA.1207a: CalOptima Auto-Assignment.
2. Policy AA.1207b: Performance based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology.

Background/Discussion
CalOptima Health staff regularly review agency policies and procedures to ensure that they are up-to-date and aligned with federal and state health care program requirements, contractual obligations, and laws, as well as CalOptima operations.

1. **Policy AA.1207a: CalOptima Auto-Assignment** establishes a process by which CalOptima shall assign a Member who has not voluntarily selected a Health Network, or CalOptima Community Network (CCN), to a Health Network, or CCN. Policy AA.1207a was updated to clarify that CCN is included in the auto-assignment process and add guidance for allocation of auto-assignment for Whole Child Model (WCM) members.

2. **Policy AA.1207b: Performance based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology** establishes CalOptima's methodology for determining a Health Network and CCN's assignment allocations according to performance-based indicators. Policy AA.1207b was modified to update the quality metrics and scoring methodology used in auto-assignment allocation.

   The updated quality metrics and scoring methodology have been shared and discussed with the Health Networks at Health Network forums, quality forums, and the Quality Improvement Committee.

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

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Additionally, glossaries for both policies have been updated to add definitions for California Children Services (CCS) Program, Member, Primary Care Provider, Shared Risk Group, and WCM, as applicable.

1. **Policy AA.1207a: CalOptima Auto-Assignment**

Policy Section	Changes
Page 1. Section: II. C. b.	Added "Member Experience" as a second category of quality metrics for auto assignment.
Page 1 Section: II. D.	Added language to preserve existing member to provider relationship within the Auto Assignment process.
Page 3. Section III. C. 1.	Added language to clarify assignment of family linked members, eligible with WCM to Health Networks participating in WCM.
Page 4. Section III. E-H	Added process to ensure CCS-eligible members are not assigned to a Health Network excluded from the WCM program.

2. **Policy AA.1207b: Performance based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology**

Policy Section	Changes
Page 1. Section: II. C. b.	Added "Member Experience" as a second category of quality metrics for auto assignment.
Page 2. Section II. C. a-c.	Added language that describes the new quality ratings and scoring methodology. Quality metrics scoring were changed to align with industry standards to establish minimum performance levels and to drive higher health plan quality performance scores.
Page 3. Section II. G.	Added language defining requirements for auto-assignment for new Health Networks.

Fiscal Impact

The recommended action to approve changes to AA.1207a and AA.1207b is operational in nature and has no additional fiscal impact beyond what was included in the CalOptima Fiscal Year 2022-23 Operating Budget.

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Rationale for Recommendation

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

Concurrence

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

Attachments

1. Policy AA.1207a CalOptima Auto-Assignment
2. Policy AA,1207b Performance based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology
3. September 14, 2022 Presentation to the Quality Assurance Committee: Changes to Auto-Assignment Quality Metrics and Scoring

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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Policy:	AA.1207a
Title:	~~CalOptima~~CalOptima Health **Auto-Assignment**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy ~~outlines the~~establishes a process by which ~~CalOptima~~CalOptima Health ~~assigns~~shall assign a Member who has not voluntarily selected a Health Network, or ~~CalOptima~~CalOptima Health Community Network (CCN), to a Health Network, or CCN.

II. POLICY

A. A Health Network ~~Eligible~~ eligible Member shall select a Health Network~~,~~ or CCN~~,~~ in accordance with ~~CalOptima~~CalOptima Health Policy DD.2008: Health Network and ~~CalOptima~~CalOptima Health Community Network Selection Process. If a Member does not select a Health Network~~,~~ or CCN, in accordance with ~~CalOptima~~CalOptima Health Policy DD.2008: Health Network and ~~CalOptima~~CalOptima Health Community Network Selection Process, ~~CalOptima~~CalOptima Health shall assign such Member to a Health Network~~,~~ or CCN~~,~~ in accordance with the terms and conditions of this policy.

B. ~~CalOptima~~CalOptima Health shall ~~auto-assign~~Auto-Assign Members, in accordance with the provisions of this policy, to ensure the following:

1. Member access to health care services in geographic proximity to his or her residence, as on file with ~~CalOptima~~CalOptima Health from eligibility files received from the Department of Health Care Services (DHCS);

2. Community Health Center ~~Safety Net~~safety net provider participation in the ~~CalOptima~~CalOptima Health program; and

3. Member enrollment in Health Networks~~,~~ or CCN~~,~~ demonstrating quality performance.

C. Members may request to change their Health Network~~,~~ or CCN~~,~~ enrollment once per month, in accordance with ~~CalOptima~~CalOptima Health Policy DD.2008: Health Network and ~~CalOptima~~CalOptima Health Community Network Selection Process.

D. ~~CalOptima~~CalOptima Health shall ~~auto-assign~~Auto-Assign a Member who has not selected a Health Network~~,~~ or CCN~~,~~ to a Health Network~~,~~ or CCN~~,~~ by using available data from

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~~CalOptima~~CalOptima Health or network providers or clinics indicating an existing relationship with a contracted provider or clinic to preserve the relationship where possible. In the absence of this information the Auto-Assign of a Member is based on a Zip Code Match between the Member's residence and a ~~HN~~Health Network/CCN's coverage area, as set forth in Section ~~II.E~~III.A.1.b. of this policy.

III. PROCEDURE

A. ~~CalOptima~~CalOptima Health shall ~~auto-assign~~Auto-Assign eligible Members to a Health Network~~,~~ or CCN~~,~~ as follows, and in the following order:

1. ~~CalOptima~~CalOptima Health shall ~~auto-assign~~Auto-Assign a Member to an existing contracted provider or clinic when provided with the data establishing the relationship by ~~CalOptima~~CalOptima Health or a network provider or clinic.

~~1.~~2. ~~CalOptima~~CalOptima Health shall Auto-Assign no less than thirty-seven percent (37%) of eligible Members to a Health Network~~,~~ or CCN~~,~~ based on the Member's assignment to a ~~Community Health Center~~community health center as a Primary Care Provider (PCP). ~~CalOptima~~CalOptima Health shall ~~auto-assign~~Auto-Assign Members through the Health Network~~,~~ or CCN~~,~~ level to the Community Health Center. If a new Federally Qualified Health Center (FQHC), or FQHC-Look-Alike, enters the ~~CalOptima~~CalOptima Health program, ~~CalOptima~~CalOptima Health shall increase the base Auto-Assignment allocation for Community Health Centers by one percent (1%), not to exceed forty-five percent (45%). If a FQHC, or FQHC-Look-Alike, terminates with the ~~CalOptima~~CalOptima Health program, ~~CalOptima~~CalOptima Health shall decrease the total Auto-Assignment allocation by one percent (1%), not to fall below thirty-seven percent (37%).

a. A Community Health Center shall select CCN~~,~~ or at least one (1) Health Network~~,~~ that shall receive its allocation of ~~auto-assigned~~Auto-Assigned Members. A Community Health Center may select CCN~~,~~ or one (1) Health Network~~,~~ that shall receive its allocation of pediatric ~~auto-assigned~~Auto-Assigned Members, and CCN~~,~~ or one (1) Health Network~~,~~ that shall receive its allocation of adult ~~auto-assigned~~Auto-Assigned Members.

i. If a Community Health Center intends to select~~,~~ or unselect~~,~~ CCN~~,~~ or change the Health Network which shall receive its allocation of ~~auto-assigned~~Auto-Assigned Members, it shall notify ~~CalOptima~~CalOptima Health's Provider Relations Department, in writing.

ii. If a Community Health Center fails to select CCN~~,~~ or at least one (1) Health Network~~,~~ that shall receive its allocation of ~~auto-assigned~~Auto-Assigned Members, ~~CalOptima~~CalOptima Health shall exclude that Community Health Center from receiving any allocation of ~~auto-assigned~~Auto-Assigned Members until a Health Network, or CCN, has been selected.

iii. If the Community Health Center previously selected CCN~~,~~ or a Health Network~~,~~ that has been suspended for Auto-Assignment, the Community Health Center shall select an alternate Health Network~~,~~ or CCN~~,~~ to receive its allocation of ~~auto-assigned~~Auto-Assigned Members.

b. If a Member has a Zip Code Match with a Community Health Center's coverage area, ~~CalOptima~~CalOptima Health shall assign the Member to the Community Health Center as

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the Member's Primary Care ~~Physician~~Provider, in accordance with ~~CalOptima~~CalOptima Health Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider.

c. ~~CalOptima~~CalOptima Health shall ~~auto-assign~~Auto-Assign Members to Community Health Centers based on performance metrics established in ~~CalOptima~~CalOptima Health Policy AA.1207c: Performance-based Community Health Center Auto-Assignment Allocation Methodology.

d. A Health Network~~,~~ or CCN's~~,~~ receipt of ~~auto-assigned~~Auto-Assigned Members from a Community Health Center shall not affect the Health Network~~,~~ or CCN's~~,~~ receipt of any other ~~auto-assigned~~Auto-Assigned Members.

e. If ~~CalOptima~~CalOptima Health ~~auto-assigns~~Auto-Assigns a Member to a Community Health Center as the Member's PCP, the Member's Health Network~~,~~ or CCN~~,~~ shall not reassign such Member to a PCP that is not a Community Health Center unless the Member requests such reassignment.

~~2.~~3. ~~CalOptima~~CalOptima Health shall ~~auto-assign~~Auto-Assign eligible Members, not ~~auto-assigned under Section II.E of this policy~~Auto-Assigned to a Health Network~~,~~ or CCN. The Health Network~~,~~ or CCN~~,~~ shall assign a PCP to the Member.

a. ~~CalOptima~~CalOptima Health shall assign Members to a Health Network~~,~~ or CCN~~,~~ once it fills a Community Health Center's assignment allocation, or if there is no Zip Code Match between an eligible Member and a ~~Community Health Center's~~community health center's coverage area.

b. ~~CalOptima~~CalOptima Health shall ~~auto-assign~~Auto-Assign eligible Members to a Health Network~~,~~ or CCN~~,~~ based on the Health Network~~,~~ or CCN's~~,~~ score on the indicators listed in the Health Network~~,~~ or CCN~~,~~ Performance-based Auto Assignment Allocation Table, which shall be calculated pursuant to ~~CalOptima~~CalOptima Health Policy AA.1207b: Performance-based Health Network and ~~CalOptima~~CalOptima Health Community Network Auto Assignment Allocation Methodology.

c. ~~CalOptima~~CalOptima Health shall assign any remaining Members to a Health Network with a Zip Code Match, regardless of whether or not that Health Network's Auto-Assignment allocation has been satisfied.

B. The number of ~~auto-assigned~~Auto-Assigned Members a Health Network~~,~~ or CCN~~,~~ receives may vary monthly, depending upon the number of Members eligible for Auto-Assignment and the Zip Code Match between a Member and a Health Network~~,~~ or CCN's~~,~~ coverage area.

C. In an effort to keep Members of the same family covered under one (1) Health Network~~,~~ or CCN, ~~CalOptima~~CalOptima Health shall ~~auto-assign~~Auto-Assign Members by family unit in accordance with ~~CalOptima~~CalOptima Health Policy DD.2006b: ~~CalOptima~~CalOptima Health Community Network Member Primary Care Provider Selection/Assignment. If a Family Linked Member who is less than twenty-one (21) years of age has family members in more than one (1) Health Network~~,~~ or CCN, ~~CalOptima~~CalOptima Health shall ~~auto-assign~~Auto-Assign such Family Linked Member to the same Health Network~~,~~ or CCN~~,~~ as his or her sibling.

1. If the Family Linked Member is known to be eligible with the Whole-Child Model (WCM) program/California Children Services Program (CCS) and the Family Linked Member's sibling is assigned to a Health Network that does not participate in the WCM program whether

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excluded from doing so or otherwise, the Family Linked Member shall be assigned to a Health Network participating in the WCM program.

D. Notwithstanding any other provisions of this policy~~,~~ and if applicable, subject to Section III.I., ~~CalOptima~~CalOptima Health shall assign a new Health Network ~~Eligible~~-eligible Member to CHOC Health Alliance if:

1. The Member's parent, or guardian, fails to select a Health Network, or CCN, upon enrollment with ~~CalOptima~~CalOptima Health;

2. The Member will be less than seven (7) months of age at the time of enrollment with a Health Network~~,~~ or CCN;

3. The Member does not have another Family Linked Member enrolled in a ~~HN~~Health Network/CCN at the time of assignment; and

4. CHOC Health Alliance is not suspended from Auto-Assignment pursuant to this policy.

~~III.I. PROCEDURE~~

E. ~~CalOptima~~ Notwithstanding any other provisions of this policy, ~~CalOptima~~CalOptima Health shall ensure, effective July 1, 2019, that CCS-eligible Members are not assigned, whether by Auto-Assignment or otherwise, to a Health Network that is excluded from participating in the WCM program.

F. An existing Member assigned to a Health Network who becomes CCS/WCM-eligible, or new CCS/WCM Members who do not select a Health Network, will be assigned to participating Health Networks after consideration of factors, unique to each Member, such as current PCP and specialist relationships to the Member, Members preference, provider and service utilization, diagnosis, severity of condition, Health Needs Assessment, geography, and language.

G. Effective July 1, 2019, if a new Member who is known to be CCS-eligible or an existing Member who becomes CCS-eligible (while enrolled in a Health network that does not participate in the WCM program) ~~CalOptima~~CalOptima Health's Auto-Assignment process will only allow a new ~~CalOptima~~CalOptima Health Member who is known to be CCS-eligible, to be assigned to a participating Health Network. All other existing Auto-Assignment rules will apply, including accounting for allotted percentages for the Health Networks.

H. Health Networks that do not meet the WCM network certification requirements can become eligible for the affected category of Auto-Assignment if they meet such requirements at a later date and are added to the WCM network with the approval of DHCS.

~~A.~~ Quality metrics and a minimum performance level on the established quality metrics shall be utilized to qualify for Auto Assignment. ~~CalOptima~~CalOptima Health may ~~impose penalties~~suspend Auto-Assignment against a Health Network~~,~~ or CCN~~,~~ if a Health Network~~,~~ or CCN~~,~~ fails to score at, or above, a specified performance ~~rate on a publicly reported~~level based on overall performance on established HEDIS ~~indicator.~~

~~E.~~I. ~~For publicly reported HEDIS performance~~ indicators ~~reported for the current measurement year, Health Networks are expected to score at the 50th percentile, or higher, based on the National Committee for Quality Assurance (NCQA) National Quality Compass benchmarks on at least two (2) of the clinical measures used to establish the Health Networks' Annual Quality performance.~~ .

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~~1. For publicly reported HEDIS performance indicators reported for measurement year 2015, or later, CalOptima~~CalOptima Health ~~shall:~~

1. ~~Report~~ Achievement of minimum performance levels on quality metrics is assessed annually. A Health Network that has been suspended from Auto-Assignment due to failure to meet minimum performance levels will be reassessed annually. Auto-Assignment will be reinstated when a Health Network has demonstrated that they meet the minimum performance levels established by ~~CalOptima~~CalOptima Health.

~~1.~~2. ~~CalOptima~~CalOptima Health shall report to the Audit & Oversight Committee (AOC) any Health Network that fails to ~~score a fifty percent (50%), or higher, performance rate on at least two (2) of the clinical measures used to establish the Health Network's Annual Quality performance.~~meet established minimum performance levels. ~~CalOptima~~CalOptima Health shall provide a written notice to any Health Network that fails to meet this threshold.

~~2.~~3. Pursuant to ~~CalOptima~~CalOptima Health Policy HH.~~2002A:~~2002A: Sanctions, ~~CalOptima~~CalOptima Health's ~~AOC~~Compliance Committee may impose penalties against a Health Network that fails to meet the minimum performance requirements.

~~3.~~4. Minimum Health Network performance ~~rates~~levels may be modified for future measurement years, pursuant to this policy. Any change in ~~rate~~performance level expectations shall be approved by the Quality Assurance Committee (QAC) of the Board of Directors prior to implementation. ~~CalOptima~~CalOptima Health shall notify Health Networks of the change prior to the ~~commencement of the measurement year.~~Implementation of changes to metrics or scoring of quality metrics. Notification to the networks includes discussion at Health Network Forum, Quality Forum, or other stakeholder forums that permit the Health Networks to be informed of planned changes to the quality metrics or scoring, and also permit them to provide feedback on the proposed changes.

IV. ATTACHMENT(S)

~~V.~~ **Not Applicable**

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V. REFERENCE(S)

A. ~~CalOptima~~CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. ~~CalOptima~~CalOptima Health Policy AA.1207b: Performance-based Health Network and ~~CalOptima~~CalOptima Health Community Network Auto-Assignment Allocation Methodology
C. ~~CalOptima~~CalOptima Health Policy AA.1207c: Performance-based Community Health Center Auto- Assignment Allocation Methodology
D. ~~CalOptima~~CalOptima Health Policy DD.2006: Enrollment In/Eligibility with ~~CalOptima~~CalOptima Health Direct
E. ~~CalOptima~~CalOptima Health Policy DD.2006b: ~~CalOptima~~CalOptima Health Community Network Member Primary Care Provider Selection/Assignment
F. ~~CalOptima~~CalOptima Health Policy DD.2008: Health Network and ~~CalOptima~~CalOptima Health Community Network Selection Process
G. ~~CalOptima~~CalOptima Health Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider
H. ~~CalOptima~~CalOptima Health Policy HH.~~2002A:~~2002Δ: Sanctions
I. Department of Health Care Services All Plan Letter (APL) 21-005: California Children's Services Whole Child Model Program
J. Department of Health Care Services All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2006	Regular Meeting of the CalOptima Board of Directors
12/04/2007	Regular Meeting of the CalOptima Board of Directors
02/05/2008	Regular Meeting of the CalOptima Board of Directors
10/07/2010	Regular Meeting of the CalOptima Board of Directors
03/03/2011	Regular Meeting of the CalOptima Board of Directors
11/01/2012	Regular Meeting of the CalOptima Board of Directors
12/06/2012	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the ~~CalOptima~~CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	12/04/2007	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	02/05/2008	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	01/01/2011	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	03/01/2011	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	11/01/2012	AA.1207a	CalOptima Auto Assignment	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	07/01/2013	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	02/01/2016	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	02/01/2017	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	11/01/2017	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	TBD	AA.1207a	~~CalOptima~~CalOptima Health Auto-Assignment	Medi-Cal

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IX. GLOSSARY

Term	Definition
Auto-Assignment	The process by which a ~~CalOptima~~CalOptima Health Member who does not select a PCP and/or Health Network is assigned to a participating ~~CalOptima~~CalOptima Health Provider and/or ~~to a~~ Health Network ~~or CalOptima~~CalOptima Health ~~Community Network~~.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
~~CalOptima~~CalOptima Health Community Network (CCN)	A managed care network operated by ~~CalOptima~~CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. ~~1.~~ Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. ~~2.~~ Affiliated with a Health Network or ~~CalOptima~~CalOptima Health Direct; and 3. ~~3.~~ Ability to function as a Primary Care Provider (PCP).
Corrective Action Plan	A plan delineating specific and identifiable activities or undertaking that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by ~~CalOptima~~CalOptima Health, the State, or designated representatives. Health Networks and Providers may be required to complete CAPs to ensure that they are in compliance with statutory, regulatory, contractual, ~~CalOptima~~CalOptima Health policy, and other requirements identified by ~~CalOptima~~CalOptima Health and its regulators.
Family Linked Member	A Member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another Member who is in his or her family and who resides in the same household.
Healthcare Effectiveness Data and Information Set (HEDIS)	The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with ~~CalOptima~~CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Health Network Eligible Member	A member who is eligible to choose a ~~CalOptima~~CalOptima Health Health Network or ~~CalOptima~~CalOptima Health Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the ~~CalOptima~~CalOptima Health program.

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Term	Definition
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
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~~CalOptima Health as the responsible partner for facility services.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.
Zip Code Match	The DHCS reported member's home address zip code must match to a zip code within the zip code range table in order for that clinic or health network to be eligible for the Member assignment.

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Policy:	AA.1207a
Title:	**CalOptima Health Auto-Assignment**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process by which CalOptima Health shall assign a Member who has not voluntarily selected a Health Network, or CalOptima Health Community Network (CCN), to a Health Network, or CCN.

II. POLICY

A. A Health Network-eligible Member shall select a Health Network or CCN in accordance with CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process. If a Member does not select a Health Network or CCN, in accordance with CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process, CalOptima Health shall assign such Member to a Health Network or CCN in accordance with the terms and conditions of this policy.

B. CalOptima Health shall Auto-Assign Members, in accordance with the provisions of this policy, to ensure the following:

1. Member access to health care services in geographic proximity to his or her residence, as on file with CalOptima Health from eligibility files received from the Department of Health Care Services (DHCS);

2. Community Health Center safety net provider participation in the CalOptima Health program; and

3. Member enrollment in Health Networks or CCN demonstrating quality performance.

C. Members may request to change their Health Network or CCN enrollment once per month, in accordance with CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process.

D. CalOptima Health shall Auto-Assign a Member who has not selected a Health Network or CCN to a Health Network or CCN by using available data from CalOptima Health or network providers or clinics indicating an existing relationship with a contracted provider or clinic to preserve the

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relationship where possible. In the absence of this information the Auto-Assign of a Member is based on a Zip Code Match between the Member's residence and a Health Network/CCN's coverage area, as set forth in Section III.A.1.b. of this policy.

III. PROCEDURE

A. CalOptima Health shall Auto-Assign eligible Members to a Health Network or CCN as follows, and in the following order:

1. CalOptima Health shall Auto-Assign a Member to an existing contracted provider or clinic when provided with the data establishing the relationship by CalOptima Health or a network provider or clinic.

2. CalOptima Health shall Auto-Assign no less than thirty-seven percent (37%) of eligible Members to a Health Network or CCN based on the Member's assignment to a community health center as a Primary Care Provider (PCP). CalOptima Health shall Auto-Assign Members through the Health Network or CCN level to the Community Health Center. If a new Federally Qualified Health Center (FQHC), or FQHC-Look-Alike, enters the CalOptima Health program, CalOptima Health shall increase the base Auto-Assignment allocation for Community Health Centers by one percent (1%), not to exceed forty-five percent (45%). If a FQHC, or FQHC-Look-Alike, terminates with the CalOptima Health program, CalOptima Health shall decrease the total Auto-Assignment allocation by one percent (1%), not to fall below thirty-seven percent (37%).

   a. A Community Health Center shall select CCN or at least one (1) Health Network that shall receive its allocation of Auto-Assigned Members. A Community Health Center may select CCN or one (1) Health Network that shall receive its allocation of pediatric Auto-Assigned Members, and CCN or one (1) Health Network that shall receive its allocation of adult Auto-Assigned Members.

      i. If a Community Health Center intends to select or unselect CCN or change the Health Network which shall receive its allocation of Auto-Assigned Members, it shall notify CalOptima Health's Provider Relations Department, in writing.

      ii. If a Community Health Center fails to select CCN or at least one (1) Health Network that shall receive its allocation of Auto-Assigned Members, CalOptima Health shall exclude that Community Health Center from receiving any allocation of Auto-Assigned Members until a Health Network, or CCN, has been selected.

      iii. If the Community Health Center previously selected CCN or a Health Network that has been suspended for Auto-Assignment, the Community Health Center shall select an alternate Health Network or CCN to receive its allocation of Auto-Assigned Members.

   b. If a Member has a Zip Code Match with a Community Health Center's coverage area, CalOptima Health shall assign the Member to the Community Health Center as the Member's Primary Care Provider, in accordance with CalOptima Health Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider.

   c. CalOptima Health shall Auto-Assign Members to Community Health Centers based on performance metrics established in CalOptima Health Policy AA.1207c: Performance-based Community Health Center Auto-Assignment Allocation Methodology.

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d. A Health Network or CCN's receipt of Auto-Assigned Members from a Community Health Center shall not affect the Health Network or CCN's receipt of any other Auto-Assigned Members.

e. If CalOptima Health Auto-Assigns a Member to a Community Health Center as the Member's PCP, the Member's Health Network or CCN shall not reassign such Member to a PCP that is not a Community Health Center unless the Member requests such reassignment.

3. CalOptima Health shall Auto-Assign eligible Members, not Auto-Assigned to a Health Network or CCN. The Health Network or CCN shall assign a PCP to the Member.

a. CalOptima Health shall assign Members to a Health Network or CCN once it fills a Community Health Center's assignment allocation, or if there is no Zip Code Match between an eligible Member and a community health center's coverage area.

b. CalOptima Health shall Auto-Assign eligible Members to a Health Network or CCN based on the Health Network or CCN's score on the indicators listed in the Health Network or CCN Performance-based Auto Assignment Allocation Table, which shall be calculated pursuant to CalOptima Health Policy AA.1207b: Performance-based Health Network and CalOptima Health Community Network Auto Assignment Allocation Methodology.

c. CalOptima Health shall assign any remaining Members to a Health Network with a Zip Code Match, regardless of whether or not that Health Network's Auto-Assignment allocation has been satisfied.

B. The number of Auto-Assigned Members a Health Network or CCN receives may vary monthly, depending upon the number of Members eligible for Auto-Assignment and the Zip Code Match between a Member and a Health Network or CCN's coverage area.

C. In an effort to keep Members of the same family covered under one (1) Health Network or CCN, CalOptima Health shall Auto-Assign Members by family unit in accordance with CalOptima Health Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment. If a Family Linked Member who is less than twenty-one (21) years of age has family members in more than one (1) Health Network or CCN, CalOptima Health shall Auto-Assign such Family Linked Member to the same Health Network or CCN as his or her sibling.

1. If the Family Linked Member is known to be eligible with the Whole-Child Model (WCM) program/California Children Services Program (CCS) and the Family Linked Member's sibling is assigned to a Health Network that does not participate in the WCM program whether excluded from doing so or otherwise, the Family Linked Member shall be assigned to a Health Network participating in the WCM program.

D. Notwithstanding any other provisions of this policy and if applicable, subject to Section III.I., CalOptima Health shall assign a new Health Network-eligible Member to CHOC Health Alliance if:

1. The Member's parent, or guardian, fails to select a Health Network, or CCN, upon enrollment with CalOptima Health;

2. The Member will be less than seven (7) months of age at the time of enrollment with a Health Network or CCN;

3. The Member does not have another Family Linked Member enrolled in a Health Network/CCN at the time of assignment; and

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4. CHOC Health Alliance is not suspended from Auto-Assignment pursuant to this policy.

E. Notwithstanding any other provisions of this policy, CalOptima Health shall ensure, effective July 1, 2019, that CCS-eligible Members are not assigned, whether by Auto-Assignment or otherwise, to a Health Network that is excluded from participating in the WCM program.

F. An existing Member assigned to a Health Network who becomes CCS/WCM-eligible, or new CCS/WCM Members who do not select a Health Network, will be assigned to participating Health Networks after consideration of factors, unique to each Member, such as current PCP and specialist relationships to the Member, Members preference, provider and service utilization, diagnosis, severity of condition, Health Needs Assessment, geography, and language.

G. Effective July 1, 2019, if a new Member who is known to be CCS-eligible or an existing Member who becomes CCS-eligible (while enrolled in a Health network that does not participate in the WCM program) CalOptima Health's Auto-Assignment process will only allow a new CalOptima Health Member who is known to be CCS-eligible, to be assigned to a participating Health Network. All other existing Auto-Assignment rules will apply, including accounting for allotted percentages for the Health Networks.

H. Health Networks that do not meet the WCM network certification requirements can become eligible for the affected category of Auto-Assignment if they meet such requirements at a later date and are added to the WCM network with the approval of DHCS.

I. Quality metrics and a minimum performance level on the established quality metrics shall be utilized to qualify for Auto Assignment. CalOptima Health may suspend Auto-Assignment against a Health Network or CCN if a Health Network or CCN fails to score at, or above, a specified performance level based on overall performance on established HEDIS indicators.

1. CalOptima Health Achievement of minimum performance levels on quality metrics is assessed annually. A Health Network that has been suspended from Auto-Assignment due to failure to meet minimum performance levels will be reassessed annually. Auto-Assignment will be reinstated when a Health Network has demonstrated that they meet the minimum performance levels established by CalOptima Health.

2. CalOptima Health shall report to the Audit & Oversight Committee (AOC) any Health Network that fails to meet established minimum performance levels. CalOptima Health shall provide a written notice to any Health Network that fails to meet this threshold.

3. Pursuant to CalOptima Health Policy HH.2002Δ: Sanctions, CalOptima Health's Compliance Committee may impose penalties against a Health Network that fails to meet the minimum performance requirements.

4. Minimum Health Network performance levels may be modified for future measurement years, pursuant to this policy. Any change in performance level expectations shall be approved by the Quality Assurance Committee (QAC) of the Board of Directors prior to implementation. CalOptima Health shall notify Health Networks of the change prior to the Implementation of changes to metrics or scoring of quality metrics. Notification to the networks includes discussion at Health Network Forum, Quality Forum, or other stakeholder forums that permit the Health Networks to be informed of planned changes to the quality metrics or scoring, and also permit them to provide feedback on the proposed changes.

IV. ATTACHMENT(S)

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Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1207b: Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology
C. CalOptima Health Policy AA.1207c: Performance-based Community Health Center Auto Assignment Allocation Methodology
D. CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct
E. CalOptima Health Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment
F. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process
G. CalOptima Health Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider
H. CalOptima Health Policy HH.2002Δ: Sanctions
I. Department of Health Care Services All Plan Letter (APL) 21-005: California Children's Services Whole Child Model Program
J. Department of Health Care Services All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2006	Regular Meeting of the CalOptima Board of Directors
12/04/2007	Regular Meeting of the CalOptima Board of Directors
02/05/2008	Regular Meeting of the CalOptima Board of Directors
10/07/2010	Regular Meeting of the CalOptima Board of Directors
03/03/2011	Regular Meeting of the CalOptima Board of Directors
11/01/2012	Regular Meeting of the CalOptima Board of Directors
12/06/2012	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	12/04/2007	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	02/05/2008	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	01/01/2011	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	03/01/2011	AA.1207a	CalOptima Auto Assignment	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2012	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	07/01/2013	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	02/01/2016	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	02/01/2017	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	11/01/2017	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	TBD	AA.1207a	CalOptima Health Auto-Assignment	Medi-Cal

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IX. GLOSSARY

Term	Definition
Auto-Assignment	The process by which a CalOptima Health Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Health Provider and/or Health NetworkCalOptima Health.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
CalOptima Health Community Network (CCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network or CalOptima Health Direct; and 3. Ability to function as a Primary Care Provider (PCP).
Corrective Action Plan	A plan delineating specific and identifiable activities or undertaking that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the State, or designated representatives. Health Networks and Providers may be required to complete CAPs to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements identified by CalOptima Health and its regulators.
Family Linked Member	A Member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another Member who is in his or her family and who resides in the same household.
Healthcare Effectiveness Data and Information Set (HEDIS)	The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima Health Health Network or CalOptima Health Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.

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Term	Definition
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 Health as the responsible partner for facility services.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.
Zip Code Match	The DHCS reported member's home address zip code must match to a zip code within the zip code range table in order for that clinic or health network to be eligible for the Member assignment.

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Policy:	AA.1207b
Title:	**Performance-~~Based~~based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes ~~CalOptima~~CalOptima Health's methodology for determining a Health Network and ~~CalOptima~~CalOptima Health's Community Network's (CCN) Assignment allocations according to performance-based indicators.

II. POLICY

A. ~~CalOptima~~CalOptima Health shall ~~auto-assign~~Auto-Assign a Health Network Eligible Member who has not selected a Health Network, or CCN, to a Health Network, or CCN, in accordance with ~~CalOptima~~CalOptima Health Policy AA.1207a: ~~CalOptima~~CalOptima Health Auto~~-~~-Assignment.

B. ~~CalOptima~~CalOptima Health shall assign eligible Members not ~~auto-assigned~~Auto-Assigned under ~~CalOptima~~CalOptima Health Policy AA.1207a: ~~CalOptima~~CalOptima Health Auto~~-~~-Assignment based on a Health Network's, or CCN's, performance-based Auto-Assignment allocation.

C. ~~CalOptima~~CalOptima Health shall determine a Health Network's, or CCN's, performance-based Auto-Assignment allocation according to indicators listed in the Health Network/CCN Performance-based Auto-Assignment Allocation Table.

1. Indicators listed in the Health Network/CCN Performance-based Auto-Assignment Allocation Table shall measure the following:

    a. Quality of clinical service; and

    ~~a. Administrative excellence.~~
    b. Member Experience

2. ~~CalOptima~~CalOptima Health shall assign each indicator a weight percent and score based on performance.

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3. ~~CalOptima~~CalOptima Health shall calculate a Health Network's, ~~or~~(including CCN's~~,~~), performance-based Auto-Assignment allocation as follows:

~~b. CalOptima shall consider a Health Network's, or CCN's, score on an indicator as a "raw score."~~

~~c. CalOptima shall divide the Health Network's, or CCN's, "raw score" by the total number of points scored by all Health Networks and CCN for that indicator, yielding the Health Network's, or CCN's, "relative score:"~~

~~*Relative score = (indicator raw score) / (total indicator raw score for all Health Network and CCN)*~~

~~d. CalOptima shall multiply a Health Network's, or CCN's, "relative score" by the weight percent assigned to the indicator to yield the "weighted score:"~~

~~*Weighted score = (relative score) x (weight percent for the indicator)*~~

~~e. A Health Network's, or CCN's, performance-based auto assignment allocation is equal to the sum of the Health Network's, or CCN's, "weighted score" for all indicators.~~

~~*Performance-based auto assignment allocation = Sum of weighted scores for all indicators*~~

~~CCN, or~~

a. ~~CalOptima~~CalOptima Health shall calculate a Health Network Quality Rating (HNQR) (scored between 1-5) for each Health Network. A higher score indicates better performance. The HNQR utilizes industry standard scoring developed by the National Committee for Quality Assurance to derive health plan quality performance scores. This methodology also aligns with ~~CalOptima~~CalOptima Health's Board of Directors approved Pay for Value program scoring methodology.

b. Health networks that do not achieve a HNQR of at least 2.5 will be suspended from Auto-Assignment until the next measurement period. Health Networks that do not achieve a HNQR of at least 2.5 will be notified and required to complete an improvement plan that details their plans to raise their performance to expected minimum performance levels.

c. Annually, each Health Network will be provided with documentation of how their HNQR score was derived which includes their performance on each quality metric, comparison to national benchmarks which are used in the scoring, as well as assigned measure weights and calculations used to derive the HNQR.

D. CCN, and each individual Health Network, shall be given a ~~rank. The Health Network, or CCN, rank is determined by the Health Network's, or CCN's, achieved "weighted score" in comparison to the achieved "weighted scores" of the other Health Networks, or CCN.~~ health network quality rating ~~(~~HNQR~~)~~ score from 1.0 to 5.0 based on their performance during the measurement period.~~CalOptima~~ CalOptima Health shall utilize the Health Network, or CCN, ~~rank~~HNQR, in numerical sequence, (highest to lowest) as the processing order for Auto-Assignments.

E. In the event that CCN's, or a Health Network's, Auto-Assignment is suspended for any reason, ~~CalOptima~~CalOptima Health shall distribute that Health Network's, or CCN's, allocation of ~~auto-assigned~~Auto-Assigned Members amongst the remaining eligible Health Networks, or CCN, in a

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manner that is proportional to each individual Health Network's, or CCN's, Performance-based Auto-Assignment allocation.

F. ~~CalOptima~~CalOptima Health shall score a Health Network for an indicator as long as the Health Network maintains a Contract for Health Care Services for the entire measurement year and is contracted with ~~CalOptima~~CalOptima Health at the time of measurement calculation~~.~~. Kaiser Permanente is excluded from Auto-Assignment.

G. Performance-based Auto-Assignment allocation for a new Health Network, or CCN:

~~2. CalOptima shall consider a Health Network, including CCN, as a~~A new Health Network for purposes of Auto-Assignment ~~for~~ is considered a Health Network with less than one (1) full measurement year~~.~~

1. ~~A new Health Network, including CCN, may receive partial points for an indicator if no~~ of data during the measurement period. New health networks will not be eligible for Auto-Assignment until the following year when a full year of data is available ~~for the indicator for the measurement year.~~and a HNQR can be calculated with evidence of minimum performance level achievement calculated by ~~CalOptima~~CalOptima Health staff.

   a. In the event of a declaration of a "extreme and uncontrollable event" declared by DHCS (such as the previous declarations for regional wild-fires and flooding which adversely impacted ability to collect data and calculate quality scores), there will be no penalties to scores and each HN will achieve at least a 2.5 HNQR.

H. ~~CalOptima~~CalOptima Health shall evaluate the performance-based Auto-Assignment allocation methodology for Health Networks and CCN annually, or upon:

1. Addition, or termination, of a Health Network;

2. A material change; or

3. Change in indicators.

I. ~~CalOptima~~CalOptima Health shall notify Health Networks of any changes in the performance-based Auto-Assignment allocation methodology, or indicators.

III. PROCEDURE

A. ~~CalOptima~~CalOptima Health shall measure each indicator annually using the most current data available for the preceding year.

B. The measurement results shall take effect the year following the measurement.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. ~~CalOptima~~CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal

B. ~~CalOptima~~CalOptima Health Policy AA.1207a: ~~CalOptima~~CalOptima Health Auto-Assignment

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
11/14/1995	Regular Meeting of the CalOptima Board of Directors
01/23/1996	Regular Meeting of the CalOptima Board of Directors
12/04/2008	Regular Meeting of the CalOptima Board of Directors
10/07/2010	Regular Meeting of the CalOptima Board of Directors
03/03/2011	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the ~~CalOptima~~CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2009	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2011	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	07/01/2013	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2016	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2017	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	11/01/2017	AA.1207b	Performance-Based Auto Assignment Allocation Methodology	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	TBD	AA.1207b	Performance-based Auto-Assignment Allocation Methodology	Medi-Cal

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IX. GLOSSARY

Term	Definition
Auto-Assignment	The process by which a ~~CalOptima~~CalOptima Health Member who does not select a Primary Care Provider (PCP) and/or Health Network is assigned to a participating ~~CalOptima~~CalOptima Health Provider and/or Health Network.
~~CalOptima~~CalOptima Health Community Network ~~(~~CCN)	A managed care network operated by ~~CalOptima~~CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with ~~CalOptima~~CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Health Network Eligible Member	A member who is eligible to choose a ~~CalOptima~~CalOptima Health, Health Network or ~~CalOptima~~CalOptima Health Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.

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Policy:	AA.1207b
Title:	**Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes CalOptima Health's methodology for determining a Health Network and CalOptima Health's Community Network's (CCN) Assignment allocations according to performance-based indicators.

II. POLICY

A. CalOptima Health shall Auto-Assign a Health Network Eligible Member who has not selected a Health Network, or CCN, to a Health Network, or CCN, in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

B. CalOptima Health shall assign eligible Members not Auto-Assigned under CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment based on a Health Network's, or CCN's, performance-based Auto-Assignment allocation.

C. CalOptima Health shall determine a Health Network's, or CCN's, performance-based Auto-Assignment allocation according to indicators listed in the Health Network/CCN Performance-based Auto-Assignment Allocation Table.

1. Indicators listed in the Health Network/CCN Performance-based Auto-Assignment Allocation Table shall measure the following:

   a. Quality of clinical service; and

   b. Member Experience

2. CalOptima Health shall assign each indicator a weight percent and score based on performance.

3. CalOptima Health shall calculate a Health Network's, (including CCN's), performance-based Auto-Assignment allocation as follows:

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a. CalOptima Health shall calculate a Health Network Quality Rating (HNQR) (scored between 1-5) for each Health Network. A higher score indicates better performance. The HNQR utilizes industry standard scoring developed by the National Committee for Quality Assurance to derive health plan quality performance scores. This methodology also aligns with CalOptima Health's Board of Directors approved Pay for Value program scoring methodology.

b. Health networks that do not achieve a HNQR of at least 2.5 will be suspended from Auto-Assignment until the next measurement period. Health Networks that do not achieve a HNQR of at least 2.5 will be notified and required to complete an improvement plan that details their plans to raise their performance to expected minimum performance levels.

c. Annually, each Health Network will be provided with documentation of how their HNQR score was derived which includes their performance on each quality metric, comparison to national benchmarks which are used in the scoring, as well as assigned measure weights and calculations used to derive the HNQR.

D. CCN, and each individual Health Network, shall be given a HNQR score from 1.0 to 5.0 based on their performance during the measurement period. CalOptima Health shall utilize the Health Network, or CCN, HNQR, in numerical sequence, (highest to lowest) as the processing order for Auto-Assignments.

E. In the event that CCN's, or a Health Network's, Auto-Assignment is suspended for any reason, CalOptima Health shall distribute that Health Network's, or CCN's, allocation of Auto-Assigned Members amongst the remaining eligible Health Networks, or CCN, in a manner that is proportional to each individual Health Network's, or CCN's, Performance-based Auto-Assignment allocation.

F. CalOptima Health shall score a Health Network for an indicator as long as the Health Network maintains a Contract for Health Care Services for the entire measurement year and is contracted with CalOptima Health at the time of measurement calculation. Kaiser Permanente is excluded from Auto-Assignment.

G. Performance-based Auto-Assignment allocation for a new Health Network, or CCN:

1. A new Health Network for purposes of Auto-Assignment is considered a Health Network with less than one (1) full measurement year of data during the measurement period. New health networks will not be eligible for Auto-Assignment until the following year when a full year of data is available and a HNQR can be calculated with evidence of minimum performance level achievement calculated by CalOptima Health staff.

a. In the event of a declaration of a "extreme and uncontrollable event" declared by DHCS (such as the previous declarations for regional wild-fires and flooding which adversely impacted ability to collect data and calculate quality scores), there will be no penalties to scores and each HN will achieve at least a 2.5 HNQR.

H. CalOptima Health shall evaluate the performance-based Auto-Assignment allocation methodology for Health Networks and CCN annually, or upon:

1. Addition, or termination, of a Health Network;

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2. A material change; or

3. Change in indicators.

I. CalOptima Health shall notify Health Networks of any changes in the performance-based Auto-Assignment allocation methodology, or indicators.

III. PROCEDURE

A. CalOptima Health shall measure each indicator annually using the most current data available for the preceding year.

B. The measurement results shall take effect the year following the measurement.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

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TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

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Effective	01/01/2007	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2009	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2011	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	07/01/2013	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2016	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2017	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	11/01/2017	AA.1207b	Performance-Based Auto Assignment Allocation Methodology	Medi-Cal
Revised	TBD	AA.1207b	Performance-based Auto-Assignment Allocation Methodology	Medi-Cal

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IX. GLOSSARY

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Auto-Assignment	The process by which a CalOptima Health Member who does not select a Primary Care Provider (PCP) and/or Health Network is assigned to a participating CalOptima Health Provider and/or Health Network.
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Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima Health, Health Network or CalOptima Health Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.

Changes to Auto-Assignment Quality Metrics and Scoring

Quality Assurance Committee
September 14, 2022

Kelly Rex-Kimmet, Director, Quality Analytics

Our Mission

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

Our Vision

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

Overview

- Auto-Assignment Policy
  - Overview of Policy
  - Performance Criteria
  - Performance Based Rating (current and proposed)
- Minimum Quality Score
- Next Steps

Auto-Assignment Policy Overview (cont.)

- On average ~7,000 Members are AA each month
  - Assignment is based on geographic zip code and performance-based criteria
  - Members can request to change their HN or CCN affiliation once per month
- Of the ~7,000 Members being AA:
  - 45% or ~3,150 are AA to the Community Health Centers
    - Each Community Health Center selects a HN or CCN affiliation in for its allocation of AA members
    - Currently, all Community Health Centers are affiliated with one or two HNs for their AA Members

Historical Quality Performance Criteria

Category	Indicator	Possible Points	Weight
Quality of Clinical Service	Well Child Visits: 3rd, 4th, 5th, 6th Years	0, 2, 5, 10	10%
	Adolescent Well-Care Visits	0, 2, 5, 10	10%
	HbA1c Testing/ Well Child Visit – 15 months	0, 2, 5, 10	10%
	Postpartum Care/ Childhood Immunization Combo 2	0, 2, 5, 10	10%
	Breast Cancer Screening/ Child Immunization MMR	0, 2, 5, 10	10%
	LDL Screening/ Appropriate Treatment Children URI	0, 2, 5, 10	10%
Administrative Excellence	Child Member Satisfaction Survey	0, 4, 10, 20	20%
	Encounters	0, 2, 5, 10	10%
	Auto-Assignment Retention Rate	0, 2, 5, 10	10%
	Total		100%

Proposed Changes to Auto-Assignment Quality Measures and Scoring

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CalOptima Health

Proposed New Performance Criteria

- Policy 1207.b describes quality based indicators for AA allocations
- The current quality-based indicators and scoring methodology is outdated
- Proposal: Adopt DHCS Managed Care Accountability Set minimum performance measures to replace existing quality performance measure set. This aligns with current Pay for Value (P4V) Program
  - Goal: Move away from a “home grown” scoring system and adopt a nationally established and tested quality scoring system.
  - Alignment with P4V program aligns providers to consistently focus their improvement efforts removing confusion about separate measures for different programs

Proposed New Auto-Assignment Quality Metrics and Gate

- Minimum Quality Score (Quality Gate) based on Health Network Quality Rating (HNQR) must be achieved annually to be eligible to receive auto-assignment.
- Proposed Minimum Overall HNQR score=2.5 out of 5
  - Effective 2022, based on Measurement Year (MY) 2021 performance)
  - Corrective action plan issued to HNs below 2.5
  - HNs who do not meet minimum quality score of 2.5 will be suspended from AA for one year until their quality score is above minimum performance level.
  - Higher overall HNQR scores earns higher percentage of AA
- No proposed change to HN vs. Community Health Center distribution. (55% HN, 45% Community Health Center)
- Scoring and auto-assignment allocation remains annual.

Health Network Quality Rating (HNQR)-Overall rating*

Health Network	HNQR 2020	HNQR 2021
AltaMed	3.5	4.5
AMVI Care	3.0	4.0
CCN	3.0	3.5
CHOC	4.0	4.5
Family Choice	2.5	3.0
Heritage-Regal	2.5	3.5
Kaiser	4.5	4.5
Noble	2.5	3.5
OPTUM-Arta	3.0	3.0
OPTUM-Monarch	2.5	3.5
OPTUM-Talbert	2.5	4.0
Prospect	2.5	3.5
UCMG	2.5	3.5

11 of 13 health networks improved compared to prior year

- Overall rating includes points for HEDIS & member experience scores
- Kaiser is excluded from auto-assignment

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 6, 2022
Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contact

Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

Reappoint the following individuals to the Board of Directors' Investment Advisory Committee (IAC) for two (2)-year terms beginning October 6, 2022:

1. Colleen Clark;
2. David Hutchison; and
3. David Young.

Background

At a Special Meeting of the CalOptima Health Board of Directors held on September 10, 1996, the Board authorized the creation of the CalOptima Health IAC, established qualifications for committee members, and directed staff to proceed with the recruitment of the volunteer members of the Committee.

When creating the IAC, the Board stipulated that the Committee would consist of five (5) members; one (1) member would automatically serve by virtue of his or her position as CalOptima Health's Chief Financial Officer. The remaining four (4) members would be Orange County residents who possess experience in one (1) or more of the following areas: investment banking, investment brokerage and sales, investment management, financial management and planning, commercial banking, or financial accounting.

At the September 5, 2000, meeting, the Board approved expanding the composition of the IAC from five (5) members to seven (7) members in order to have more diverse opinions and backgrounds to advise CalOptima Health on its investment activities.

This recommendation was listed on the July 25, 2022, IAC meeting agenda. However, due to lack of quorum at that meeting, Management has brought this item forward to the Finance and Audit Committee directly for review and approval.

Discussion

The candidates recommended for reappointment have proven leadership and expertise in finance and accounting.

Colleen Clark has served as a member of the IAC since October 1, 2020, and has over 27 years of experience and a knowledge of public finance, investments, accounting, and government and legislative processes. Ms. Clark was the Director of Public Finance for the County of Orange and

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worked as the Deputy Chief Executive Officer and Chief Financial Officer for the Orange County Great Park. Ms. Clark has held finance positions at the Transportation Corridor Agency in Irvine and is a former Certified Public Accountant. Her current term expires September 30, 2022.

David Hutchison has served as a member of the IAC since October 1, 2020, and currently works for Triad Investment Management where he is a Partner and Portfolio Manager. Mr. Hutchison has over 15 years of experience and has previously held positions as President and Portfolio Manager for Hutchison Financial, Investment Strategist for the Chamberlin Group, and Senior Equity Analyst for Insight Capital Research & Management. His current term expires September 30, 2022.

David Young has served as a member of the IAC since June 4, 2009. Mr. Young is founder and Chief Executive Officer of Anfield Group, LLC, a financial consulting and investment advisory firm. In addition, Mr. Young is a member of the CFA Society of Orange County Board of Directors and the chair of its Investment Committee. He also is board member of the UCI Paul Merage School of Business Center for Investment & Wealth Management Executive Committee and chairs its Journal editorial board. Mr. Young received his undergraduate degree and M.B.A. from the University of California, Irvine. His current term expires September 30, 2022.

Fiscal Impact
There is no fiscal impact. Individuals appointed to the IAC assist CalOptima Health in suggesting updates to and ensuring compliance with CalOptima Health's Board-approved Annual Investment Policy, and monitor the performance of CalOptima Health's investments, investment advisor, and investment managers.

Rationale for Recommendation
The individuals recommended for CalOptima Health's IAC have extensive experience that meets or exceeds the specified qualifications for membership on the IAC.

Concurrence
Troy R. Szabo, Outside Counsel, Kennaday Leavitt
Board of Directors' Finance and Audit Committee

Attachment
None

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Approve Actions Related to the Procurement of an Encounter Data Management System

Contact

Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), to execute the contract with Edifecs for an Encounter Data Management System for a three (3)-year period, with the option of two (2) additional one-year extensions, each exercisable at CalOptima Health's sole discretion; and
2. Authorize unbudgeted expenditures and appropriate funds in an amount of up to $2.15 million from the Digital Transformation and Workplace Modernization Reserve to fund the contract for Year 1.

Background

As part of CalOptima Health's Workplace Modernization and Digital Transformation Strategy, Information Technology Services will be evaluating and deploying multiple solutions. These solutions coincide with CalOptima Health's Cloud First strategy and take regulatory compliance and security measures into consideration. These initiatives will assist CalOptima Health in achieving its vision statement of removing barriers to achieve real-time claims payments and 24-hour treatment authorizations and doing annual assessments around social determinants of health by 2027. The projects and products that CalOptima Health implements will result in value-based care and improvements for member, provider, and employee experiences. These enhancements will provide CalOptima Health with the ability to be robust and agile, and to scale as a future-focused healthcare organization.

"Encounter" is defined as any unit of covered service provided to a member of CalOptima Health regardless of the reimbursement methodology. For CalOptima Health, encounter data includes services reported by the delegated health networks and those billed directly to CalOptima Health by fee-for-service providers. The submission of encounter data is integral to CalOptima Health's overall program integrity and the primary basis for capitation revenue from the Department of Health Care Services (DHCS) for Medi-Cal and the Centers for Medicare & Medicaid Services (CMS) for OneCare (OC), OneCare Connect (OCC), and Program of All-Inclusive Care for the Elderly (PACE). The regulatory agencies expect complete, accurate, reasonable, and timely encounter data submissions and can sanction health plans if this expectation is not met. In order to maximize revenue and minimize the risk of corrective action plans and/or sanctions, CalOptima Health is contracting with Edifecs to ensure all valid encounter data are submitted accurately for all lines of business on a monthly basis.

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Discussion

CalOptima's current process uses internal operational and technical resources to compile Medi-Cal encounter data, build ANSI X12 5010 837 files, review the results, and submit to DHCS; and a vendor to do the same for Medicare submissions to CMS. On average, over 800,000 unique Medi-Cal encounters and 80,000 unique Medicare encounters are submitted monthly. This volume has increased over the years as CalOptima Health's membership has grown, and the internal resources needed to accurately complete the monthly submission process are strained. In addition, the vendor performing the services for Medicare encounters has failed to meet CalOptima Health's service level expectations for reporting timely to CMS.

Since the vendor contract is expiring in early 2023, staff released a request or proposal (RFP) in March 2022 and received a total of four (4) qualified responses. The responses were reviewed by an evaluation team consisting of Finance, Audit and Oversight, Enterprise Project Management Office, and Information Technology Services departments and were scored based on objective and pre-determined criteria. Two (2) of the respondents provided demonstrations of their products. The results of the RFP were as follows:

Vendor	Score
Edifecs	9.73
Change Healthcare	9.03

Staff awarded the contract to Edifecs based on their strong experience with Medi-Cal and Medicare encounter data submissions for other Medi-Cal Managed Care Plans (MCPs) and the integrated coding module that will provide real-time analysis of the risk acuity of CalOptima Health OC members to maximize revenue. Staff recommends the Board delegate authority to the CEO to enter into a three (3)-year contract with Edifecs, with two (2) additional one-year extension options, each exercisable at CalOptima's sole discretion.

On March 17, 2022, the Board authorized a three-year Digital Transformation and Workplace Modernization Strategy and created a $100 million restricted reserve to fund digital transformation efforts. On June 2, 2022, the Board approved the Fiscal Year (FY) 2022-23 Digital Transformation Year One Capital Budget of $34.196 million. Staff included the best available information at the time of budgeting. As such, based on the current vendor's annual expense, staff included $1.35 million for this capital project in the approved budget. Upon completion of the RFP, the best and final negotiated offer with Edifecs was $3.5 million for Year 1. Staff requests the Board to authorize and appropriate the shortfall amount of $2.15 million from the Digital Transformation and Workplace Modernization Reserve to fund the Edifecs contract for Year 1.

Fiscal Impact

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The estimated cost for Year 1 of the Edifecs contract is $3.5 million. The CalOptima Health FY 2022-23 Digital Transformation Year One Capital Budget included $1.35 million for the "Regulatory Encounter Processing Vendor Replacement" capital project through June 30, 2023.

A previous Board action on March 17, 2022, established a restricted Digital Transformation and Workplace Modernization Reserve in the amount of $100 million. An appropriation of up to $2.15 million from the reserve will fund the remaining shortfall for the Edifecs contract in Year 1. Management will include capital project expenses for subsequent contract years in future capital budgets.

Rationale for Recommendation

DHCS has moved to an encounter-based methodology to set capitation for MCPs. Capitation from CMS has increased the years the vendor has submitted encounter data on behalf of CalOptima Health. Using a vendor to submit encounter data to DHCS and CMS will enhance CalOptima Health's program integrity, maximize revenue, and minimize the risk of non-compliance with complete, accurate, reasonable, and timely encounter data submission requirements at both regulatory agencies.

Concurrence

Troy Szabo, Kennaday Leavitt, Outside General Counsel
Board of Directors' Finance and Audit Committee

Attachments

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Change Healthcare	424 Church St, Suite 1400	Nashville	TN	37219
Edifecs	1756 114th Ave SE	Bellevue	WA	98004

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CalOptima Health Board Action Agenda Referral

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Authorize Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2023

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Brigette Hoey, Chief Human Resources Officer, Human Resources, (714) 246-8405

Recommended Actions

1. Authorize the Chief Executive Officer to enter into contracts and/or amendments to existing contracts, as necessary, to continue to provide group health insurance, including medical, dental, and vision, for CalOptima Health employees and eligible retirees (and their dependents); basic life, accidental death and dismemberment (ADD), short-term disability (STD) and long-term disability (LTD) insurance; an employee assistance program; a wellness program; and flexible spending accounts (FSA) for Calendar Year (CY) 2023 in an amount not to exceed $28.5 million, which includes the following proposed changes:

    a. The replacement of Cigna medical plans with comparable Blue Shield of California (Blue Shield) medical plans.

    b. The replacement of Cigna dental plans with comparable Blue Shield plans, with minimal changes to plan design.

    c. The renewal of the current Kaiser HMO, Kaiser Senior Advantage, VSP vision, New York Life Basic Life/ADD, STD, LTD and Wex FSA plans with no change in plan designs.

    d. The replacement of ACI Employee Assistance Program (EAP) with Aetna Resources for Living, which includes enhanced behavioral health services and on-site counseling options.

    e. An increase in employer contributions as a result of additional full/part-time employees and a 9.30% rise in premium rates increasing costs to CalOptima Health for CY 2023 in an amount of $2,185,777.

    f. A continuation of employer contributions for CY 2023 in an estimated amount of $206,250 to fund the Health Savings Accounts (HSA) monthly for employees anticipated to enroll in the Blue Shield HDHP PPO.

2. Authorize the receipt and expenditures for CalOptima Health staff wellness programs of $75,000 in funding from Blue Shield for CY 2023.

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Background

California Government Code section 53201 provides that local public agencies, including CalOptima Health, have the option of providing health and welfare benefits for the benefit of their officers, employees, and retired employees who elect to accept the benefits and who authorize the local agencies to deduct the premiums, dues, or other charges from their compensation. Government Code section 53200 provides that health and welfare benefits may include hospital, medical, surgical, dental, disability, group life, legal expense, and income protection insurance or benefits. While CalOptima Health previously contracted with the California Public Employees Retirement System (CalPERS) to provide these benefits, on August 5, 2003, the Board approved the cancellation of CalOptima Health's contract with CalPERS for employee health insurance coverage effective January 1, 2004, and opted to contract directly with Aetna and Kaiser for plan year 2004. CalOptima Health has offered such benefits from commercial insurers since that time, purchasing group health insurance through insurance brokers on a year-to-year basis. From April 2020 through March 2023, CalOptima Health will be purchasing insurance through Alliant, an insurance broker. CalOptima Health currently contracts with both Kaiser and Cigna to provide group health insurance coverage for all benefited employees and qualifying retirees. CalOptima Health also contracts with Amwins to provide Medicare supplemental coverage for qualifying Medicare eligible retirees and their dependents.

By statute, the Board may authorize payment of all, or such portion as it may elect, of premiums for these health and welfare benefits. CalOptima Health currently pays a portion of the premiums for health and welfare benefits for employees and eligible retired employees, as well as their eligible dependents. A summary of employer and employee contributions since plan year 2020 is provided below.

- In plan year 2020, there was an 8.00% increase in premium rates in the amount of $1,605,723, and CalOptima Health and employees shared in the costs of premium rate increases.
- In plan year 2021, there was a 7.20% decrease in premium rates in the amount of $1,570,131. With rate caps for 2022 set as high as 12.00%, it was assumed the premium rates for CY2022 would likely increase to such an extent that rates would essentially return to the same premium rates as 2020. As such, the contribution strategy adopted in 2020 was to hold employee contribution rates (no decrease or increase) steady for the two years when CalOptima Health would experience a decrease in premiums (plan year 2021) and then an increase in premiums (plan year 2022).
- As anticipated, in plan year 2022 (last year), there was an increase in premium rates of 7.31% or $1,590,567, and CalOptima Health absorbed this premium increase, with no increase to employee contribution rates.

Discussion

On behalf of CalOptima Health, and in an effort to mitigate renewal increases for plan year 2023, Alliant released a comprehensive request for proposal (RFP), requesting current and prospective medical and dental carriers to submit competitive bids. Upon evaluation of the proposals, staff recommends replacing the Cigna medical and dental plans with Blue Shield plans. In addition to offering medical and dental plans comparable to Cigna, BlueShield offers Trio, which is a partnership with an accountable care organization (ACO). The ACO is a group of doctors, hospitals, and other health care providers that share information about patient care, coordinate care to give better treatment and keep costs down. Trio also offers patient concierge services.

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Alliant also requested competitive bids for CalOptima Health's life and disability plans, as well as its EAP program. For the life and disability plans, the market response was unfavorable, with carriers unable to provide a better quote than CalOptima Health's current carrier, New York Life. As such, staff recommends renewing the New York Life Basic Life, ADD, STD and LTD plans. For the EAP program, several carriers provided quotes; however, only one carrier, Aetna Resources for Living, was able to provide competitive rates for the on-site counseling services requested by CalOptima Health staff. To provide employees with access to additional behavioral health resources, staff recommends replacing the ACI EAP with Aetna Resources for Living for plan year 2023.

With these changes and the renewal of CalOptima Health's other health and welfare benefits, **total benefit renewals** for CY 2023 are approximately 9.30% (or $2,185,777) higher than the previous year. The proposed change in premiums falls in line with the regional average, which is experiencing an increase ranging from 4.35% to 15.76%.

Benefit	**CY 2022**	**CY 2023**	**Difference (CY 2023 – CY 2022)**
Medical Insurance	$20,058,021	$22,677,884	$2,619,863
Medical/Dental Bundling Discount	N/A	($219,126)	($219,126)
Medical Premium Holiday	N/A	($227,157)	($227,157)
Retiree Medicare Supplemental Plan	$256,225	$256,225	$0
Wellness Activities	$25,000	$75,000	$50,000
Wellness Funding	($25,000)	($75,000)	($50,000)
Dental Insurance	$1,525,224	$1,448,944	($76,280)
Vision Insurance	$226,750	$226,750	$0
Basic Life and ADD Insurance	$77,763	$77,763	$0
STD Insurance	$569,175	$569,175	$0
LTD Insurance	$259,466	$357,487	$98,021
Employee Assistance Program	$38,001	$28,457	($9,544)
HSA	$206,250	$206,250	$0
Medical Stipends	$326,400	$326,400	$0
Flexible Spending Account Admin	$26,240	$26,240	$0
COBRA Administration	$7,247	$7,247	$0
Total	**$23,576,762**	**$25,762,539**	**$2,185,777**

Based on the recommendations below, **CalOptima Health's share** of the total group health and welfare benefits package is estimated to result in an annual net increase of approximately 10.20% or $2,185,777 for CY 2023, with CalOptima Health's share of the premiums totaling approximately $23,543,047.

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Contributions to Benefits	CY 2022	CY 2023	Difference
			(CY 2023 – CY 2022)
CalOptima Health's Share	$21,357,270	$23,543,047	$2,185,777
Employees' Share	$2,219,491	$2,219,491	$0
Spousal Surcharge	($9,400)	($9,400)	$0
Total	**$23,567,361**	**$25,753,138**	**$2,185,777**

Additional details are provided by benefit plan for CY 2023 in Attachment A.

Medical

Blue Shield: In the RFP, Alliant requested medical carriers to submit competitive bids for the dual-carrier option, quoting alongside Kaiser. The renewal from the incumbent carrier, Cigna, resulted in an overall 9.00% (or $886,136) premium increase on all medical plans, while the proposal from Blue Shield resulted in a 6.80% premium increase (or $667,039) over the current Cigna plans, with comparable plan designs and minimal provider disruption (Blue Shield matches 99.00% of the current HMO providers on the Full Network HMO and 76.00% of the Narrow Network HMO plan). In addition, Blue Shield's proposal includes a $75,000 wellness subsidy, a premium holiday, and dental bundling discount, providing an additional 2.10% and 2.00% discount off the medical premium respectively. Blue Shield also provides for a second year (2024) blended rate cap of 11.90%. Staff recommends replacing the Cigna medical plans with Blue Shield medical plans in CY 2023. Although rates increased, staff recommends employee contributions remain unchanged to enhance recruitment and retention efforts during a period of high inflation and competition in the labor market.

Kaiser: Kaiser proposed a renewal increase of 14.90% or $1,506,541 for active and early retirees and a decrease of 12.10% or $8,782 for the Senior Advantage HMO Plan. Although rates increased, staff recommends employee contributions remain unchanged to enhance recruitment and retention efforts during a period of high inflation and competition in the labor market.

Amwins PPO**:** Amwins provides PPO supplemental coverage to Medicare-eligible retirees and dependents. While Amwins rates have not yet been released, staff recommends that the employee/retiree contribution rates remain the same level for 2023.

Wellness Funding: As part of their proposal, Blue Shield will provide a $75,000 wellness subsidy to assist in improving the health and wellness of CalOptima Health's employees, focusing on behavior change and health status improvement, and creating a health and wellness program strategy leading toward a culture of well-being. Blue Shield wellness funds may be used to reimburse CalOptima Health for employee health and wellness program expenses, including but not limited to educational workshops and employee wellness activities.

For CY 2023, the proposed wellness activities may include the following, among others:

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2023 Wellness Program/Event/Activity	Estimated Cost
Wellness Month (Wellness activities)	$5,000.00
On-Site Counseling Services	$10,000.00
Health Education/Wellness Incentives	$5,000.00
Early Detection Screenings	$15,000.00
Flu/Biometric Screening Event	$5,000.00
Wellness App and Wellness Challenges	$20,000.00
Health & Wellness Fair	$10,000.00
Mental Health Seminars	$5,000.00
Total	**$75,000.00**

Dental
Blue Shield: In the RFP, Alliant requested dental carriers to submit competitive bids for comparable dental plans. The renewal from the incumbent carrier, Cigna, resulted in an overall 3.30% (or $49,859) premium decrease on both DHMO and DPPO plans, while the proposal from Blue Shield resulted in a 5.00% premium decrease (or $76,281) below the current Cigna plans, with comparable plan designs and minimal provider disruption (Blue Shield matches 95.00% of the most utilized dental providers in network for the DHMO, and 77.00% of the DPPO providers). Staff recommend replacing the Cigna dental plans with Blue Shield dental plans in CY 2023. Staff also recommends no change to employee contributions.

Vision
VSP**:** Renewal came at no rate change due to a rate guarantee through December 31, 2025. Staff recommends no change to employee contributions.

Other Ancillary Plans
New York Life & Disability:

Basic Life/ADD – Renewal came at no rate change due to a rate guarantee through December 31, 2023. Staff recommends no change to employee contribution rates.

Voluntary Life/ADD: Renewal came at no rate change due to a rate guarantee through December 31, 2023. Staff recommends no change to employee contribution rates.

Short-Term Disability and Long-Term Disability: Renewal came at no rate change for STD through December 31, 2023; however, New York Life proposed a renewal increase of 37.80% or $98,021 due to a 150.00% loss ratio for the past twelve (12) months. Staff recommends employee contribution rates remain the same.

Employee Assistance Program: In order to provide employees with access to additional behavioral health resources, Alliant requested proposals for EAP services. Staff recommends changing EAP providers from ACI EAP to Aetna Resources for Living, which in addition to reducing premiums by 25.00% (or $9,544 in savings), includes on-site counseling options.

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Health Savings Account

CalOptima Health offers an HSA for employees enrolled in the HDHP medical plan. CalOptima Health first started offering this medical plan in 2014 and funded the HSA 100.00% that same year as an incentive for employees to transition to the Cigna HDHP. The Cigna HDHP is more cost effective and offers the same or comparable benefits as the PPO plan CalOptima Health previously offered. As part of the benefits renewal in CY 2020, staff eliminated the more expensive PPO plan for employees and retirees who reside in California. To assist with a transition period away from the PPO medical plan to the Cigna HDHP medical plan, staff recommended that CalOptima Health fund the HSAs for CY 2020 on January 1, 2020 for employees who elected the Cigna HDHP medical plan. This strategy was successful as it resulted in 96 employees who enrolled in the HDHP medical plan. For 2021, the PPO plan was limited to only employees residing outside of California; therefore, there was no longer a need to incentivize movement out of the PPO plan by frontloading CalOptima Health's contribution; however, CalOptima Health continued to partially fund the HSAs monthly as a tool for attracting and retaining talent. Staff recommends continuing to partially fund the HSAs for attracting and retaining talent in CY 2023. Assuming all employees currently in the plan continue this coverage, the annual amount will be $206,250.

Medical Stipends

CalOptima Health offers a medical stipend of $100 per pay period (for 24 pay periods) as a cost saving measure to CalOptima Health and an incentive for employees who have medical coverage outside of CalOptima Health. Employees must submit proof of outside coverage in order to be eligible for this benefit.

Spousal Surcharge

Employees who enroll their spouse or domestic partner under a CalOptima medical plan will be subject to a $50 bi-monthly Spousal Surcharge if their spouse or domestic partner is eligible to enroll in other medical coverage elsewhere.

Employer and Employee Contribution Comparison

CalOptima Health's and individual employee's share of healthcare premiums differ depending on the employee's elections. As set forth in the attached presentation, employer premium contributions for full time employees range from 81.80% to 97.10% and the premium contribution rates for employees and retirees range from 2.9% to 18.20%. The methodology used to calculate the employer and employee contributions is intended to aid management in attracting and retaining talented employees.

Staff Recommendations

Last year's proposed employee contribution strategy included CalOptima Health covering the increase in premiums after benefiting from reduced premiums in CY 2021. For CY 2023, staff recommends no changes to the employee/retiree contribution rates to ensure that CalOptima Health remains competitive with market trends and meets its ongoing obligation to provide a comprehensive benefits package to attract and retain talent during a period of high inflation and competitive labor market.

Fiscal Impact

The fiscal impact for group health insurance policies for CalOptima Health employees and retirees in CY 2023 is estimated at a total cost not to exceed $28.5 million. The recommended action to provide group health insurance policies for CalOptima Health employees and retirees for the period of January 1,

2023, through June 30, 2023, and associated anticipated expenditures are budgeted items in the CalOptima Health Fiscal Year (FY) 2022-23 Operating Budget approved by the Board on June 2, 2022. Management will include funding for group health insurance policies for the period July 1, 2023, through December 31, 2023, in the CalOptima Health FY 2023-24 Operating Budget.

Concurrence

Troy Szabo, Kennaday Leavitt, Outside General Counsel

Attachment

1. Entities Covered by the Recommended Action
2. Attachment A: CalOptima Health 2023 Renewal Executive Summary

/s/ Michael Hunn *09/30/2022*

Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
ACI Enterprises	6480 Weathers Place, Ste 300	San Diego	CA	92121
Aetna Resources for Living EAP	10260 Meanley Drive	San Diego	CA	92131
Alliant Insurance Services	333 S. Hope Street, Suite 3650	Los Angeles	CA	90071
Amwins Group Benefits	50 Whitecap Dr.	North Kingstown	RI	02852
Blue Shield of California	100 N. Pacific Coast Hwy, 20th Floor	El Segundo	CA	90245
California Public Employees' Retirement System (CalPERS)	500 N State College Blvd Suite 750	Orange	CA	92868
Cigna Healthcare	400 North Brand Boulevard, Fourth Floor	Glendale	CA	91203
Empower	P.O. Box 173764	Denver	CO	80217
Hyatt Legal Plan	P.O. Box 78000	Detroit	MI	48278
Kaiser Permanente	1851 E. First Street, Suite 1100	Santa Ana	CA	92705
New York Life Insurance Company	400 N. Brand Boulevard, 4th Floor	Glendale	CA	91203
Public Agency Retirement Services (PARS)	4350 Von Karman Ave	Newport Beach	CA	92660
Trustmark Voluntary Benefits Solutions	8833 Perimeter Park Blvd., Suite 802,	Jacksonville	FL	32216
Sageview Advisory Group, LLC	4000 MacArthur Blvd Suite 1050	Newport Beach	CA	92660
VSP	333 Quality Drive	Rancho Cordova	CA	95670
WEX Health Inc	4321 20th Ave S	Fargo	ND	58103

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Alliant

Executive Summary

CalOptima 2023 Renewal

Your partner in new possibilities.

Board of Directors Meeting

October 6, 2023

Presented By:
Brigette Hoey

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Executive Summary

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Medical Renewals

Cigna

The initial renewal action proposed by Cigna was a 18.20% increase on all medical plans or $1,791,839 in additional premium. The renewal increase is driven by a higher than usual claims experience, which for the reporting period of July 2021 through June 2022 yielded a 106.00% loss ratio (119.00% in the most recent quarter). In response to the marketing results, after several negotiations, Cigna revised its renewal to a final 9.00% increase or $886,136 in additional premium.

Kaiser

Kaiser proposes a 14.90% increase on the active and early retiree HMO plan and a decrease of 12.10% on the Senior Advantage HMO plan, resulting in an overall additional premium of $1,506,541. The proposed renewal action on the active and early retiree HMO plan is driven by an 18.00% increase in claims utilization compared to the previous reporting period.

Amwins

The Amwins renewal is pending Centers of Medicare and Medicaid Services (CMS) approval.

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Executive Summary

Medical Renewals (Cont'd)

Medical Marketing

Blue Shield of CA proposes an overall blended increase of 11.30% over 2022 Cigna rates, with comparable plan designs, matching 99% of the current HMO providers on the Full Network HMO and 76% on the Narrow Network HMO plan. In addition, Blue Shield's proposal includes:

- $75,000 Wellness subsidy
- Special Premium Arrangement of 25.00% of the first month's premium, which equates to an estimated savings of 2.10% or $227,157
- Dental Bundling discount, which provides an additional 2.00% discount off the medical premium, an estimated savings of $219,126
- Second-year blended rate cap of 11.90%

When factoring in the Special Premium Arrangement and Dental Bundling discounts, the premium increase is 6.80% over 2022 Cigna rates.

Renewal Recommendation

Change medical carrier to Blue Shield of CA, effective January 1, 2023, replacing the current Cigna Full Network HMO, Select Network HMO, HDHP PPO, and Traditional PPO plans. Renew the current Kaiser HMO, and Kaiser Sr. Advantage plans with no changes in plan design.

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Executive Summary

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Ancillary Plan Renewals

Dental	The initial renewal action proposed by Cigna was a rate pass on both dental plans. In response to the marketing results, Cigna revised its renewal to a rate pass on the DHMO plan and a decrease on the DPPO resulting in a 3.30% decrease or $49,859 in savings.
Dental Marketing	To further mitigate the medical renewal increase, Alliant released a comprehensive dental request for proposal, asking dental carriers to provide bids for DHMO and DPPO plan options, replacing the incumbent carrier, Cigna. The market response was favorable, quoting carriers proposing decreases ranging from 5.00% to 10.00% on both plans. In addition to a 5.00% decrease in premium, Blue Shield's proposal includes a 2.00% bundling discount off the medical rates.
Vision	The VSP vision plans are currently in a rate guarantee that expires on December 31, 2025.
Life/ADD and LTD	The New York Life Basic Life, ADD, and STD plans are renewing with a rate pass guaranteed for 12 months. The LTD plan is renewing with a 37.80% increase or $98,021. The renewal increase is based on a 150.00% loss ratio for the past 12 months. Similar to the medical and dental plans, Alliant released a proposal request for competitive bids. The market response was unfavorable, with carriers unable to provide a better quote than the New York Life's renewal action.
Employee Assistance Program	ACI EAP is in a rate guarantee through 12/31/2022. To provide employees with access to additional behavioral health resources, the renewal recommendation is to change EAP providers to Aetna Resources for Living, which in addition to reducing premiums by 25.00% or $9,544 in savings, includes on-site counseling options.
Renewal Recommendation	Change dental carrier to Blue Shield of CA, effective January 1, 2023. Renew the vision, life, and disability plans with the current carriers, with no changes in benefits, for 12 months.

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Executive Summary

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Miscellaneous Recommendations

FSA & COBRA Administrator	WEX Health: The FSA & COBRA plan administration fees are renewing level for the following plan year. Renewal Recommendation: Renew FSA and COBRA administration with WEX Health.
Employer HSA Contribution	CalOptima to fund the Health Savings Accounts for employees enrolled in the Cigna HDHP with up to an annual amount of $1,250 for single and $2,500 for family coverage, pro-rated and contributed on a monthly basis.
Medical Waiver Benefit	Keep the benefit amount level at $200 per month.
Spousal Surcharge	Keep the spousal surcharge amount at $100 per month.

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2023 Financial Overview

Line of Coverage (Actives & Retirees)	EE	2022	2023 Initial	% Change	2023 Negotiated	% Change	Blue Shield Option 1	% Change
Kaiser HMO - Actives	718	$10,071,565	$11,577,154	14.9%	11,577,154	14.9%	$11,577,154	14.9%
Kaiser HMO - Early Retirees	4	$65,039	$74,773	15.0%	74,773	15.0%	$74,773	15.0%
Kaiser - KPSA	21	$72,553	$63,771	-12.1%	63,771	-12.1%	$63,771	-12.1%
AmWins Medicare	31	$256,225	*Pendina* $256,225	0.0%	*Pendina* 256,225	0.0%	$256,225	0.0%
Cigna Full HMO	346	$6,281,389	$7,424,876	18.2%	6,846,896	9.0%	*Access+ HMO* $7,034,664	12.0%
Cigna Select HMO	104	$1,619,777	$1,914,653	18.2%	1,765,612	9.0%	*Trio HMO* $1,659,324	2.4%
Cigna OAP (OOS EE's Only)	1	$27,722	$32,768	18.2%	30,217	9.0%	*Traditional PPO* $32,292	16.5%
Cigna HDHP	109	$1,914,090	$2,262,520	18.2%	2,086,389	9.0%	*HDHP* $2,230,020	16.5%
Cigna HSA Fee	109	$5,886	$5,886	0.0%	5,886	0.0%	$5,886	0.0%
ER Funded HSA ($1,250 / $2,500)	109	*ER Paid* $206,250	*ER Paid* $206,250	0.0%	206,250	0.0%	$206,250	0.0%
Cigna Dental PPO	1130	$1,427,516	$1,427,516	0.0%	1,377,657	-3.5%	*Blue Shield* $1,356,111	-5.0%
Cigna DHMO	294	$97,708	$97,708	0.0%	97,708	0.0%	*Blue Shield* $92,833	-5.0%
VSP Vision	1396	$226,750	*Rate Guarantee* $226,750	0.0%	226,750	0.0%	$226,750	0.0%
New York Life Basic Life AD&D	1446	$77,763	$77,763	0.0%	77,763	0.0%	$77,763	0.0%
New York Life STD	1442	$569,175	$569,175	0.0%	569,175	0.0%	$569,175	0.0%
New York Life LTD	1442	$259,466	$357,487	37.8%	357,487	37.8%	$357,487	37.8%
ACI EAP	1446	$38,001	*Rate Guarantee* $38,001	0.0%	*Rate Guarantee* 38,001	0.0%	*Aetna RFL* $28,457	-25.1%
COBRA Administration	1342	$7,247	*Rate Guarantee* $7,247	0.0%	7,247	0.0%	$7,247	0.0%
Flexible Spending Account	660	$26,240	$26,240	0.0%	26,240	0.0%	$26,240	0.0%
Medical Stipend ($200 per month)	136	$326,400	$326,400	0.0%	326,400	0.0%	$326,400	0.0%
TOTAL ANNUAL PREMIUM		**$23,576,761**	**$26,973,161**		**$26,017,599**		**$26,208,821**	
ESTIMATED BUNDLING DISCOUNT (2%)							**-$219,126**	
ESTIMATED PREMIUM HOLIDAY							**-$227,157**	
TOTAL ANNUAL PREMIUM AFTER DISCOUNT							**$25,762,538**	
ANNUAL DOLLAR CHANGE FROM CURRENT **ANNUAL PERCENTAGE CHANGE FROM CURRENT**			**$3,396,400** **14.4%**		**$2,440,838** **10.4%**		**$2,185,777** **9.3%**	

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Medical Renewal Plan Options

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Medical Renewal Options & Marketing: Financial Overview

Kaiser (Current)	# of Enrollees	2022	2023 Negotiated	% Change
Kaiser HMO - Actives	718	$10,071,565	$11,577,154	14.9%
Kaiser HMO - Early Retirees	4	$65,039	$74,773	15.0%
Kaiser - KPSA	21	$72,553	$63,771	-12.1%
TOTAL:	**743**	**$10,209,157**	**$11,715,698**	
INCREASE:			**$1,506,541**	**14.90%**

Cigna (Current)	# of Enrollees	2022	2023 Negotiated	% Change
Cigna Full HMO	346	$6,281,389	$6,846,896	9.0%
Cigna Select HMO	104	$1,619,777	$1,765,612	9.0%
Cigna OAP (OOS EE's Only)	1	$27,722	$30,217	9.0%
Cigna HDHP	109	$1,914,090	$2,086,389	9.0%
TOTAL:	**560**	**$9,842,977**	**$10,729,113**	
INCREASE:			**$886,136**	**9.00%**

Blue Shield (Proposed)	# of Enrollees	2023 Proposed	% Change from 2022 Cigna
Blue Shield Access+ HMO	346	$7,034,664	12%
Blue Shield Trio HMO	104	$1,659,324	2%
Blue Shield Traditional PPO	1	$32,292	17%
Blue Shield HDHP	109	$2,230,020	17%
TOTAL:	**560**	**$10,956,300**	
ESTIMATED BUNDLING DISCOUNT (2%):		**-$219,126**	
ESTIMATED PREMIUM HOLIDAY (2.1%):		**-$227,157**	
TOTAL WITH DISCOUNTS:		**$10,510,017**	
INCREASE:		**$667,040**	**6.8%**
AS COMPARED WITH CIGNA 2023 RENEWAL:		**-$219,097**	**-2.04%**

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Dental Renewal Plan Options

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Dental Renewal Options & Marketing: Financial Overview

Line of Coverage (Actives & Retirees)	EE	2022	2023 Initial	% Change	2023 Final	% Change	Blue Shield	% Change
Cigna Dental PPO	1130	$1,427,516	$1,427,516	0.0%	$1,377,657	-3.5%	$1,356,111	-5.0%
Cigna DHMO	294	$97,708	$102,713	5.1%	$97,708	0.0%	$92,833	-5.0%
TOTAL ANNUAL PREMIUM		**$1,525,224**	**$1,530,229**		**$1,475,365**		**$1,448,944**	
ANNUAL DOLLAR CHANGE FROM CURRENT			**$5,005**		**-$49,859**		**-$76,281**	
ANNUAL PERCENTAGE CHANGE FROM CURRENT			**0.3%**		**-3.3%**		**-5.0%**	

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EAP Renewal Options

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Employee Assistance Program: ACI

EAP Plan Benefits	ACI EAP Current / Renewal	Aetna RFL Proposed
Sessions		
Face-to-Face	6 sessions * in CA is 3 session per six months	6 sessions
Telephonic	Included	Included
Employee Services		
Legal	Included, Initial consult is 1 hour	Included, 30 minute consultation per new issue, for any number of issues
Financial	Telephonic financial consultation is available for an unlimited number of issues per year	Included, 30 minute consultation per new issue, per year
Dependent Care	Included	Included
Employer Services		
Management Consultations	Included	Included
Crisis Response Services	Fee-for-service of $325 per hour	Up to 10 hours per incident, for an unlimitred number of incidents
Wellness/Training	There is no limit to the number of hours available for lunch & learns	(Financials assume adding bank of 10 hours) Banks of 5 training hours can be purchased at the rate of $0.09 PEPM. The group can purchase as many banks (of 5 hours)
On-site Counselor	N/A	$195 per hour

Rate Guarantee		**3 Years (1/1/2020 - 12/31/2023)**	**3 Years (1/1/2023 - 12/31/2025)**
MONTHLY RATES	EE	**Current / Renewal**	**Proposed**
Per Employee Per Month	1446	$2.19	$1.64

MONTHLY PREMIUM	**$3,167**	**$2,371**
ANNUAL PREMIUM	**$38,001**	**$28,457**
ANNUAL $ DIFFERENCE	**$0**	**-$9,544**
ANNUAL % DIFFERENCE	**0%**	**-25%**

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Recommended Employer Contributions

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Recommended Employer Contributions – Medical Plans

Employee Contributions		Current 2022 Contributions				Renewal 2023 Contributions No change in EE contributions			
		Total	ER Cost	EE Cost	EE %	Total	ER Cost	EE Cost	EE %
Kaiser HMO - Actives	Lives								
EE Only	259	$602.90	$544.33	$58.57	9.7%	$693.03	$634.46	$58.57	8.5%
EE + Spouse	101	$1,205.80	$1,088.66	$117.14	9.7%	$1,386.06	$1,268.92	$117.14	8.5%
EE + Child(ren)	165	$1,145.51	$1,034.23	$111.28	9.7%	$1,316.75	$1,205.47	$111.28	8.5%
EE + Family	193	$1,929.28	$1,741.85	$187.43	9.7%	$2,217.68	$2,030.25	$187.43	8.5%
Annual Premium	718	$10,071,565	$9,093,134	$978,432		$11,577,154	$10,598,722	$978,432	
Kaiser HMO - Early Retirees									
EE Only	2	$903.32	$844.75	$58.57	6.5%	$1,038.51	$979.94	$58.57	5.6%
EE + Spouse	2	$1,806.64	$1,689.50	$117.14	6.5%	$2,077.02	$1,959.88	$117.14	5.6%
EE + Child(ren)	0	$1,716.30	$1,605.02	$111.28	6.5%	$1,973.16	$1,861.88	$111.28	5.6%
EE + Family	0	$2,890.61	$2,703.18	$187.43	6.5%	$3,323.22	$3,135.79	$187.43	5.6%
Annual Premium	4	$65,039	$60,822	$4,217		$74,773	$70,556	$4,217	
Kaiser KPSA									
EE Only on Medicare	10	$188.94	$166.85	$22.09	11.7%	$166.07	$143.98	$22.09	13.3%
EE + Spouse both on Medicare	11	$377.88	$333.70	$44.18	11.7%	$332.14	$287.96	$44.18	13.3%
Annual Premium	21	$72,553	$64,070	$8,483		$63,771	$55,288	$8,483	
AmWins Medicare*									
EE Only on Medicare	15	$454.30	$376.29	$78.01	17.2%	*$454.30*	*$376.29*	*$78.01*	17.2%
EE + Spouse both on Medicare	16	$908.60	$731.70	$176.90	19.5%	*$908.60*	*$731.70*	*$176.90*	19.5%
Annual Premium	31	$256,225	$208,219	$48,006		$256,225	$208,219	$48,006	

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Recommended Employer Contributions – Medical Plans

Employee Contributions		Current 2022 Contributions				Renewal 2023 Contributions No change in EE contributions			
Full Network HMO**		**Cigna Full Network**				**Blue Shield Access+**			
EE Only	103	$728.06	$669.49	$58.57	8.0%	$798.70	$740.13	$58.57	7.3%
EE + Spouse	49	$1,593.17	$1,476.03	$117.14	7.4%	$1,748.32	$1,631.18	$117.14	6.7%
EE + Child(ren)	85	$1,439.00	$1,327.72	$111.28	7.7%	$1,579.76	$1,468.48	$111.28	7.0%
EE + Family	109	$2,275.95	$2,088.52	$187.43	8.2%	$2,498.02	$2,310.59	$187.43	7.5%
Annual Premium	346	$6,281,389	$5,781,455	$499,934		$6,893,971	$6,394,037	$499,934	
Narrow Network HMO**		**Cigna Select HMO**				**Blue Shield Trio**			
EE Only	42	$638.87	$620.15	$18.72	2.9%	$641.12	$622.40	$18.72	2.9%
EE + Spouse	9	$1,398.01	$1,350.77	$47.24	3.4%	$1,403.38	$1,356.14	$47.24	3.4%
EE + Child(ren)	14	$1,262.71	$1,220.04	$42.67	3.4%	$1,268.07	$1,225.40	$42.67	3.4%
EE + Family	39	$1,997.15	$1,928.77	$68.38	3.4%	$2,005.16	$1,936.78	$68.38	3.4%
Annual Premium	104	$1,619,777	$1,566,073	$53,704		$1,626,138	$1,572,433	$53,704	
PPO (OOS Ees Only)**		**Cigna OAP**				**Blue Shield PPO**			
EE Only	0	$1,178.99	$978.87	$200.12	17.0%	$1,346.52	$1,146.40	$200.12	14.9%
EE + Spouse	0	$2,554.10	$2,077.61	$476.49	18.7%	$2,916.48	$2,439.99	$476.49	16.3%
EE + Child(ren)	1	$2,310.13	$1,879.16	$430.97	18.7%	$2,637.18	$2,206.21	$430.97	16.3%
EE + Family	0	$3,653.76	$2,939.00	$714.76	19.6%	$4,171.86	$3,457.10	$714.76	17.1%
Annual Premium	1	$27,722	$22,550	$5,172		$31,646	$26,475	$5,172	
HDHP w/ HSA**		**Cigna HDHP**				**Blue Shield HDHP**			
EE Only	53	$847.09	$743.44	$103.65	12.2%	$967.26	$863.61	$103.65	10.7%
EE + Spouse	18	$1,778.90	$1,486.52	$292.38	16.4%	$2,030.56	$1,738.18	$292.38	14.4%
EE + Child(ren)	15	$1,609.47	$1,344.93	$264.54	16.4%	$1,837.50	$1,572.96	$264.54	14.4%
EE + Family	23	$2,541.28	$2,012.61	$528.67	20.8%	$2,901.78	$2,373.11	$528.67	18.2%
Annual Premium	109	$1,914,090	$1,591,486	$322,603		$2,185,420	$1,862,817	$322,603	
MEDICAL SUBTOTAL	**1,334**	**$20,308,359**	**$18,387,809**	**$1,920,551**	**9.5%**	**$22,709,097**	**$20,788,546**	**$1,920,551**	**8.5%**
ESTIMATED MEDICAL PREMIUM HOLIDAY						***-$227,157***	***-$227,157***	***$0***	
MEDICAL TOTAL						**$22,481,940**	**$20,561,389**	**$1,920,551**	**8.5%**
DOLLAR CHANGE FROM CURRENT						**$2,173,581**	**$2,173,581**	**$0**	
PERCENT CHANGE FROM CURRENT						**10.7%**	**11.8%**	**0.0%**	

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Recommended Employer Contributions – Ancillary Plans

Employee Contributions	Lives	Cigna DPPO Total	Cigna DPPO ER Cost	Cigna DPPO EE Cost	Cigna DPPO EE %	Blue Shield DPPO Total	Blue Shield DPPO ER Cost	Blue Shield DPPO EE Cost	Blue Shield DPPO EE %
Dental PPO									
EE Only	380	$45.11	$39.91	$5.20	11.5%	$42.85	$37.65	$5.20	12.1%
EE + Spouse	190	$89.63	$73.91	$15.72	17.5%	$85.15	$69.43	$15.72	18.5%
EE + Child(ren)	216	$115.14	$94.94	$20.20	17.5%	$109.38	$89.18	$20.20	18.5%
EE + Family	344	$174.18	$142.64	$31.54	18.1%	$165.47	$133.93	$31.54	19.1%
Annual Premium	1130	$1,427,516	$1,185,407	$242,109		$1,356,111	$1,114,002	$242,109	
Dental HMO		**Cigna DHMO**				**Blue Shield DHMO**			
EE Only	112	$12.30	$12.30	$0.00	0.0%	$11.69	$11.69	$0.00	0.0%
EE + Spouse	45	$24.42	$24.42	$0.00	0.0%	$23.20	$23.20	$0.00	0.0%
EE + Child(ren)	52	$31.38	$31.38	$0.00	0.0%	$29.81	$29.81	$0.00	0.0%
EE + Family	85	$47.46	$47.46	$0.00	0.0%	$45.09	$45.09	$0.00	0.0%
Annual Premium	294	$97,708	$97,708	$0		$92,833	$92,833	$0	
VSP Vision (Core)									
EE Only	373	$6.71	$6.71	$0.00	0.0%	$6.71	$6.71	$0.00	0.0%
EE + Spouse	147	$10.42	$9.42	$1.00	9.6%	$10.42	$9.42	$1.00	9.6%
EE + Child(ren)	156	$10.85	$9.35	$1.50	13.8%	$10.85	$9.35	$1.50	13.8%
EE + Family	278	$17.37	$15.37	$2.00	11.5%	$17.37	$15.37	$2.00	11.5%
Annual Premium	954	$126,672	$115,428	$11,244		$126,672	$115,428	$11,244	
VSP Vision (Buy-Up)									
EE Only	160	$11.21	$6.71	$4.50	40.1%	$11.21	$6.71	$4.50	40.1%
EE + Spouse	83	$17.41	$9.42	$7.99	45.9%	$17.41	$9.42	$7.99	45.9%
EE + Child(ren)	62	$18.13	$9.35	$8.78	48.4%	$18.13	$9.35	$8.78	48.4%
EE + Family	137	$29.03	$15.37	$13.66	47.1%	$29.03	$15.37	$13.66	47.1%
Annual Premium	442	$100,078	$54,490	$45,587		$100,078	$54,490	$45,587	
Life & Disability									
Basic Life and AD&D	1446	$77,763	$77,763	N/A	N/A	$77,763	$77,763	N/A	N/A
Short Term Disability	1442	$569,175	$569,175	N/A	N/A	$569,175	$569,175	N/A	N/A
Long Term Disability	1442	$259,466	$259,466	N/A	N/A	$357,487	$357,487	N/A	N/A
Annual Premium		$906,404	$906,404	N/A	N/A	$1,004,425	$1,004,425	N/A	N/A

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Recommended Employer Contributions – Ancillary Plans

Employee Contributions		Total	ER Cost	EE Cost	EE %	Total	ER Cost	EE Cost	EE %
		ACI EAP				Aetna Resources For Living			
Employee Assistance Program									
Annual Premium	1446	$38,001	$38,001	N/A	N/A	$28,457	$28,457	N/A	N/A
Employer Contribution to HSA									
Annual Contribution	109	$206,250	$206,250	N/A	N/A	$206,250	$206,250	N/A	N/A
HSA Administration Fee									
Annual Administration Fee	109	$5,886	$5,886	N/A	N/A	$5,886	$5,886	N/A	N/A
FSA Administration									
Annual Administration Fee	660	$26,240	$26,240	N/A	N/A	$26,240	$26,240	N/A	N/A
COBRA Administration									
Annual Administration Fee	1342	$7,247	$7,247	N/A	N/A	$7,247	$7,247	N/A	N/A
Medical Stipend ($200 per month)									
Annual Benefit Amount	136	$326,400	$326,400	N/A	N/A	$326,400	$326,400	N/A	N/A
ANCILLARY TOTAL		**$3,268,402**	**$2,969,461**	**$298,941**	**17.1%**	**$3,280,598**	**$2,981,658**	**$298,941**	**9.1%**
GRAND TOTAL		**$23,576,761**	**$21,357,270**	**$2,219,491**	**9.4%**	**$25,762,538**	**$23,543,047**	**$2,219,491**	**8.6%**
DOLLAR CHANGE FROM CURRENT						**$2,185,777**	**$2,185,777**	**$0**	
PERCENT CHANGE FROM CURRENT						**9.3%**	**10.2%**	**0.0%**	

***Amwins renewal is pending.**

****The Blue Shield medical rates include a 2% bundling discount. Rates are illustrative pending final approval from Underwritting. Renewal totals include the premium holiday amount.**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Ratify an Amendment to Agreement 16-93274 ("Care Coordination Agreement") with the California Department of Health Care Services in Order to Continue Operation of the Dual Eligible Special Needs Plan OneCare Program

Contact

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

Recommended Action

Ratify Amendment 07 to Agreement 16-93274 between CalOptima Health and the California Department of Health Care Services in order to continue operation of the OneCare program.

Background

As a County Organized Health System, CalOptima Health contracts with the California Department of Health Care Services (DHCS) to provide health care services to Medi-Cal beneficiaries in Orange County. In December 2016, CalOptima Health entered into a new four (4)-year agreement with DHCS for the Primary Agreement. Amendments to this agreement are summarized in the attached appendix, including Amendment 54, which extends the Primary Agreement to December 31, 2022. The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima Health 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 the standalone Care Coordination Agreement, Agreement 16-93274. The Board of Directors (Board) Chairman executed the Care Coordination Agreement that was ratified during the August 2016 Board meeting. Subsequently, the Board Chairman has executed six amendments to the Care Coordination Agreement pursuant to Board authority. The Care Coordination Agreement is set to terminate on December 31, 2023. The Care Coordination Agreement contains no payment rates.

Discussion

Amendment to Agreement 16-93274 (Care Coordination Agreement)

In May 2022, the CalOptima Health Board authorized staff to execute Amendment 06 to Agreement 16-93274 in order to extend the term of the contract to December 31, 2023, and to add language required by the Centers for Medicare and Medicaid Services (CMS).

In July 2022, DHCS notified managed care plans, including CalOptima Health, that CMS informed the DHCS of deficiencies in the amendment. As a result of the identified deficiencies, DHCS drafted a subsequent Amendment 07 to correct the following provisions: A citation related to appeals and grievances in Exhibit A, Attachment 1: Coordination of Care, Section 18: Additional Guidance; and an

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update to amend the Information Sharing requirements outlined in Exhibit A, Attachment 1, Section 1.G of the amendment.

DHCS provided this revised amendment to CalOptima Health on Wednesday, August 3, 2022, and requested the signed amendment by Tuesday, August 9, 2022. Staff procured the Chair's signature on the amendment and promptly returned the amendment to DHCS for countersignature to ensure timely filing of the amendment with CMS that was completed on August 15, 2022. Please see Attachment 3 "Additional CY 2023 Agreement 16 – 93274 Detail" for further information regarding the language changes contained within Amendment 07. Staff requests and recommends that the CalOptima Health Board ratify Amendment 07 that was signed on August 9, 2022.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
CalOptima Health's execution of Amendment 07 to the Care Coordination Agreement with the DHCS is necessary to ensure that CalOptima Health meets CMS requirements in order for CalOptima Health to operate the OneCare program during 2023.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Appendix summary of amendments to Agreements with DHCS
2. CalOptima 16-93274 A07 Text
3. Additional CY 2023 Agreement 16 – 93274 Detail

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 8

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

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

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

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

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
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2022.	June 3, 2021
A–06 extends the Agreement 16–93274 with DHCS to December 31, 2023.	May 5, 2022

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

III. Exhibit A, Attachment 1, COORDINATION OF CARE, is amended to read:

1. Care Coordination

G. Information Sharing

1) D-SNP Contractor is responsible for complying with State policy implementing federal information sharing requirements for D-SNPs per 42 CFR 422.107(d)(1), for the purpose of coordinating Medicare and Medi-Cal covered services between settings of care. This State policy is in addition to federal requirements for hospitals regarding electronic notifications listed in 42 CFR 482.24(d). The goal of the information sharing policy is for D-SNP Contractor, either directly or through contracted providers or other entities, to timely notify the Member's MCP of hospital and Skilled Nursing Facilities (SNF) admissions particularly if the MCP is a different organization than the D-SNP. Timely notification supports the coordination of and referrals to Medicare and Medi-Cal Covered Services, including home and community-based services.

2) To the extent permissible under applicable federal and State law and regulations, and not inconsistent with the Member's expressed privacy preferences, D-SNP Contractor will require their contracted hospitals and SNFs to use a secure email data exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform D-SNP Contractor and the Member's MCP in a timely manner of any hospital or SNF admissions for all Members.

a) D-SNP Contractor will require contracted hospitals to make this notification either immediately prior to, or at the time of, the Member's discharge or transfer from the hospital's inpatient services, if applicable.

b) As an alternative to the hospital's notification to the Member's MCP, D-SNP Contractor may notify the Member's MCP in the same timeframe and method referenced in Paragraph a) of any hospital admission, for all Members. D-SNP Contractor must coordinate any necessary Medicare and Medi-Cal services for the Member with the MCP.

c) To the extent permissible under applicable federal and State law and regulations, and not inconsistent with the Member's expressed privacy preferences, D-SNP Contractor will require their contracted SNFs to use a secure email, a data

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exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform D-SNP Contractor and the Member's MCP of any SNF admission, discharge, or transfer for all Members. For SNF admissions, D-SNP Contractor will require contracted SNFs to make this notification within 48 hours after any SNF admission. For SNF discharges or transfers, D-SNP Contractor will require contracted SNFs to make this notification in advance if at all possible, or at the time of, the Member's discharge or transfer from the SNF.

d) As an alternative to the SNF's notification to the Member's MCP, D-SNP Contractor may notify the Member's MCP, in the same timeframe and method referenced in Paragraph c), of any SNF admission, discharge, or transfer for all Members. The D-SNP must coordinate any necessary Medicare and Medi-Cal services for the Member with the MCP.

e) In the event that the D-SNP Contractor authorizes another entity or entities to perform these notifications, D-SNP Contractor must retain responsibility for complying with this requirement. The D-SNP Contractor ultimately retains the responsibility for the notification requirements that are delegated to its contracted hospitals and SNFs.

f) For the first six (6) months of Contract Year 2023, DHCS may permit D-SNP Contractor to propose and implement an alternate approach and compliance plan to meet federal information sharing requirements, subject to DHCS and CMS review and approval. Further information will be available in the D-SNP Policy Guide.

3) D-SNPs will coordinate care management for their Members and facilitate Member access to needed LTSS to support care transitions.

4) State guidance on this "Information Sharing Policy" will be provided through CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

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18. Additional Guidance

D-SNP Contractor shall be held to the State-specific requirements described in this Contract, in addition to all existing Medicare requirements and those outlined in Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs. In addition, as D-SNP Contractor meets the definition of an applicable integrated plan per 42 CFR section 422.561, it is also required to use the unified appeals and grievance procedures under 42 CFR sections 422.629 through 422.634, 438.210, 438.400, and 438.402.

IV. All rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

Additional CY 2023 Agreement 16 – 93274 Detail

Section/Provision:	PDF page	Updates to Provision:
Exhibit A - SCOPE OF WORK		
G. Information Sharing	Page 1	**1. Purpose** - coordinating Medicare and Medi-Cal covered services between settings of care. ▸ **Goal** - timely notify the Member's Managed Care Plan (MCP) of hospital and SNF admissions, particularly if the MCP is a different organization than the D-SNP • Amendment adds further specificity to each of the provisions to detail the following requirements: **2. Electronic process** - Hospitals and SNFs to use secure email, data exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform the D-SNP and the Member's MCP of any Hospital and SNF admission, discharge or transfer of Members. **- Timely Notification** ▪ **2) a)** Require contracted Hospitals to make notification either **immediately prior to, or at the time of,** the Member's discharge or transfer from the hospital's inpatient services. ▪ **2) c)** For SNFs, will require contracted SNFs to make notification within **48 hours** after any SNF admission. For SNF discharges or transfers, will require their contracted SNFs to make this notification in advance if at all possible, or at the time of, the Member's discharge or transfer from the SNF. **2) b) and 2) d) Alternative notification** (optional) - As an alternative to the Hospital's and SNF notification to the Member's MCP, the D-SNP Contractor may notify the Member's MCP, in the same timeframe and method required of the Hospitals / SNFs in 2)a) and 2)c). **2) e)** In the event the D-SNP Contractor authorizes another entity or entities to perform these notifications, D-SNP Contractor must retain responsibility for complying with this requirement. **The D-SNP Contractor ultimately retains the responsibility for the notification requirements**

		that are delegated to its contracted Hospitals and SNFs. **2) f) Proposing Alternate Approach -** For the first six months of 2023, DHCS may permit D-SNP Contractor to propose and implement an alternate approach and compliance plan to meet federal information sharing requirements, subject to DHCS and CMS review and approval. Further information will be available in the **DHCS D-SNP Policy Guide**. **3) Care Transitions -** requires to coordinate care management for their Members and facilitate Member access to needed Long-Term Services and Supports to support care transitions. **4)** State guidance on this "Information Sharing Policy" will be provided through **DHCS D-SNP Policy Guide**.
18. Additional Guidance	Page 2	• Modifies language to specify the D-SNP is also required to use the **unified appeals and grievance procedures** under 42 CFR sections §422.629 through §422.634, §438.210, §438.400, and §438.402. • Please note: ▸ §422 regulatory citations are for Medicare Advantage regulations (*Applicable Integrated Plan - AIP*) ▸ §438 regulatory citations are for Medicaid regulations

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Approve New CalOptima Health Policy MA.2101p: Non-Monetary Member Incentive for One Care and One Care Connect

Contacts

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

Recommended Action

Approve new CalOptima Health Policy MA.2101p: Non-Monetary Member Incentive policy, in accordance with regulatory requirements.

Background

In January 2022, the Centers for Medicare & Medicaid Services (CMS) Final Rule, provided new guidance on how Medicare member rewards and incentives should be administered. Changes include the requirement that both targeted activity and reward item must be offered uniformly and identically to all plan enrollees. Consequently, health networks may not offer differing incentives to their own populations. Additionally, the CMS rule now requires that disputes on Medicare rewards and incentives be treated as grievances. This policy was established to support and enforce these regulatory requirements.

Discussion

CalOptima Health establishes new policies and procedures to implement Federal and State laws, programs regulations, contracts and business practices. Additionally, CalOptima Health staff performs annual policy review to add or update internal policies and procedures to ensure compliance with applicable requirements.

The new policy ensures the standards for the appropriate use of a Non-Monetary Member Incentive for CalOptima Health One Care and One Care Connect Programs. Further, the new policy ensures the processes and procedures for Non-Monetary Member Incentives are in compliance with Medicare Managed Care Manuals, CMS Part C Reporting Requirements, and Medicare 2002 Final Rule.

Fiscal Impact

The recommended action to approve new CalOptima Health Policy MA.2101p is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2022-23 Operating Budget.

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Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, staff recommends that the Quality Assurance Committee approve and adopt CalOptima Health Policy MA.2101p: Non-Monetary Member Incentive for One Care and One Care Connect Programs.

Concurrence

Troy Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Policy MA.2101p: Non-Monetary Member Incentive for One Care and One Care Connect
2. Attachment A: Medicare Member Incentive (MI) Program Request for Approval Form
3. Attachment B: Medicare Member Incentive (MI) Program Evaluation Form
4. Attachment C: Medicare Member Incentive (MI) Program Tracking Log

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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Policy:	MA.2101p
Title:	**Non-Monetary Member Incentive**
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima Health's standards for the appropriate use of a Non-Monetary Member Incentive for the CalOptima Health OneCare Program.

II. POLICY

A. CalOptima Health shall follow the guidelines set forth in this Policy regarding the appropriate use of a Non-Monetary Member Incentive.

B. Incentives to Medicare Members are issued at the plan level. Both the target activity and reward item must be offered uniformly and identically to all CalOptima Health OneCare Members.

C. CalOptima Health may use a Non-Monetary Member Incentive to increase Member participation, learning, and motivation for improving health outcomes, in accordance with the terms and conditions of this Policy and the Centers for Medicare & Medicaid Services (CMS) guidelines. Examples of incentive program efforts may include, but are not limited to:

1. Promoting improved health, preventing injuries and illness, and promoting efficient use of health care resources.

2. Encouraging Members to be actively engaged in their health care and, ultimately, improve and sustain their overall health and well-being.

3. Incentivizing Members to participate in health-promoting services or activities while inspiring a long-term commitment to healthy behaviors.

D. CalOptima Health shall offer incentives of a value that is expected to affect Members' behavior, the service or activity for which rewards and/or incentives are being offered should be at a level that is meaningful.

E. CalOptima Health is to ensure that rewards and incentives for each program have values that are expected to elicit intended Member behavior but may not exceed the value of the health-related service or activity.

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F. CalOptima Health shall consider including a Member support component within the incentive program design (e.g., coaches or motivators to encourage and assist Members with program engagement).

G. CalOptima Health shall ensure compliance with CMS guidelines related to the distribution of incentives to Medicare Members:

1. Only offer a Non-Monetary Incentive to existing Members.

2. Shall not offer a Non-Monetary Incentive to a potential Member.

3. Shall not offer a Non-Monetary Incentive that would result in encouraging enrollment or continuing enrollment with CalOptima Health. Rewards should be issued based on the completion of the target activity during the contract year of which the incentive program is offered.

4. May only include a description of a Non-Monetary Member Incentive program in a Member communication targeted to Members currently enrolled with CalOptima Health Medicare.

5. Shall not include a description of a Non-Monetary Member Incentive program in a communication intended for the general community or potential Members.

6. May include an incentive program in marketing materials as long as the communication is shared with all currently enrolled Medicare Members and not done in conjunction with marketing of covered benefits.

7. Must not discriminate against enrollees based on race, gender, chronic disease, institutionalization, frailty, health status or other impairments.

8. The incentive program must be designed so that all Medicare Members who qualify for participation are able to participate. Therefore, incentives should not be offered based on health outcomes. For example, Members cannot be rewarded for the amount of weight lost or for lowered blood pressure. However, all eligible Medicare Members may be offered an incentive for reporting their weights or blood pressure at regular intervals.

9. Must provide the same rewards to all qualifying participants who perform the same action under the covered benefit, not to distinguish Members based on their medical encounter history or good record or participation in preventive care services. For example; CalOptima Health may not incentivize Members who have historically not utilized appropriate/recommended services at a higher level than other Members for participating in an incentive program activity.

10. Must accommodate incentive program qualified Members who need a modified approach in order to participate, for example; Members who live in an institutional setting, lack transportation or are disabled.

11. Incentives and rewards must be earned by completing an entire service or activity (or combination of services/activities), as established by the intended program, and may not be offered for completion of less than any/all required component(s) of the eligible service or activity.

12. CalOptima Health must cover any incentive activation fee or charge on behalf of the Member.

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13. Gift cards and vouchers must include a statement that restricts the purchase of products that would pose a health risk such as alcohol, tobacco, and firearms, unless the gift card, gift certificate, or voucher is for a location that does not sell these items (e.g., a farmer's market).

14. Shall not offer a monetary incentive. A monetary incentive may include, but is not limited to:

    a. Cash;

    b. Rebates, including reduced cost sharing or premiums;

    c. An incentive that could convert to cash such as an incentive amount less than $10 as required by California Civil Code §1749.5 (b)(2) that allow cards with cash value less than $10 to be redeemable for cash; or

    d. Any other instrument that may be converted to cash.

H. CalOptima Health shall:

1. Include the incentive program in a Medicare bid as a non-benefit expense.

2. Treat disputes on rewards, and incentives as a Grievance. When a Member brings forth a dispute pertaining to a reward or the reward program, CalOptima Health shall ask the Member to submit a grievance request in accordance with CalOptima Health Policy MA.9002: Member Grievance Process.

3. Report on incentive programs through the annual Part C Medicare Advantage Reporting Requirements.

4. Document and track information regarding incentive programs and be prepared to provide this information to CMS upon request.

III. PROCEDURE

A. Request for Approval

1. The CalOptima Health department offering a Non-Monetary Member Incentive shall submit the appropriate Member Incentive Request form to the CalOptima Health Population Health Management department for review no later than sixty (60) calendar days prior to desired program start date.

    a. The CalOptima Health department shall email a Non-Monetary Member Incentive request for approval form to the Population Health Management Department via HealthEducationReview@CalOptima.org.

    b. The Population Health Management Department shall review Non-Monetary Member Incentive request forms and approve or provide feedback to the requestor. If the request is incomplete, the Population Health Management department shall require the requesting CalOptima Health department to provide further information within ten (10) business days.

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c. Upon approving the request, the Population Health Management Department shall notify the requesting department of the decision and shall add the request to the tracking log for record keeping and required reporting to CMS.

B. Reporting Requirements

1. The CalOptima Health department responsible for the implementation of the incentive program, shall submit a complete Non-Monetary Member Incentive evaluation form to the CalOptima Health Population Health Management department within thirty (30) calendar days after the program ends or on January 15, whichever occurs first.

a. The CalOptima Health department shall submit a completed Member Incentive evaluation form to the CalOptima Health Population Health Management Department email at HealthEducationReview@CalOptima.org.

b. The Population Health Management Department Health Education manager or designee shall review Non-Monetary Member Incentive evaluation forms and approve or provide feedback to the requestor. If the evaluation is incomplete, the Population Health Management department shall require the responsible CalOptima Health department to provide further information.

c. Upon approving the evaluation, the Population Health Management Department shall complete the required CMS report and submit the report to the CalOptima Health Regulatory Affairs & Compliance department for annual reporting no later than January 31.

C. CalOptima Health Oversight

1. The CalOptima Health Population Health Management Department shall maintain a tracking log that includes but is not limited to the following:

a. Date(s) of member-specific participation in incentive program services and activities;

b. Rewards and/or incentives attained;

c. How Member participation is measured;

d. Counts required for the Part C reporting requirements data elements, and;

e. Available alternative methods of participation.

2. The CalOptima Health Population Health Management Department shall provide the tracking log to the CalOptima Health Regulatory Affairs and Compliance department or to CMS and/or DHCS upon request.

IV. ATTACHMENT(S)

A. Medicare Member Incentive (MI) Program Request For Approval Form
B. Medicare Member Incentive (MI) Program Evaluation Form
C. Medicare Member Incentive (MI) Tracking Log Template

V. REFERENCE(S)

A. CalOptima Health Policy: MA.9002: Member Grievance Process
B. Medicare Managed Care Manuals: Chapter 4: Benefits and Beneficiary Protections (§100 Rewards & Incentives)
C. Title 42, Code of Federal Regulations (CFR) §§ 422.134 and Subpart V)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	MA.2101	Non-Monetary Member Incentive	OneCare

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IX. GLOSSARY

Term	Definition
CalOptima Health	For purposes of this policy, CalOptima Health shall include CalOptima Health Direct, including CalOptima Health Direct-Administrative and CalOptima Health Community Network.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Grievance	An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization or an LEP determination.
Member	A beneficiary enrolled in a CalOptima Health program.
Non-Monetary Member Incentive/Non-Monetary Incentive	A Non-Monetary Member Incentive may include: An item, as approved by CMS that promotes good health practices, including but not limited to, a gift, gift card, or gift certificate that cannot be redeemed for cash; tickets to a local event, movies, sporting event, concert, play, or amusement park; a product or merchandise that promotes or is associated with good health practices; transportation assistance such as a voucher for public transportation or taxi service; enrollment or membership fees for a program that promotes good health practices, such as a weight management or physical activity program; or raffle for an item that promotes good health.

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MEDICARE MEMBER INCENTIVE (MI) PROGRAM REQUEST FOR APPROVAL FORM

Requestor Instructions: Complete this form and email it to HealthEducationReview@CalOptima.org. The request must be for the current Medicare contract year. **CalOptima Population Health Management Manager-Health Education or designee must review and sign off on all MI Programs Requests prior to program implementation.**

Email subject line and file name must include: CalOptima Department name, targeted disease/behavior, MI request and desired start date (e.g. *CalOptima_PHM_Diabetes_MI Request_January 1, 2023*). Submit *the request thirty (60) calendar days* prior to desired program start date.

A. CalOptima Department Name: Today's Date:

1. What is the **desired** start date?
Note: Must be at least 60 calendar days prior to program start date.

2. What is the **expected** end date?
Note: Must include dates within current contract year only.

3. What health related services and/or activities are included in the program?

4. Who is eligible for the MI program (i.e., target population, eligibility criteria, etc.)?
Note: The incentive program and access to program services must be offered to all eligible members.

5. Number of members identified as **eligible** for MI program?

6. What health related services and/or activities must the member complete in order to receive the incentive (i.e. make appointment, complete lab work, have a doctor sign form, mail back to agency in email provided, etc.)?

7. What are the alternative methods of participation will you implement in order *to* **accommodate all eligible members***?*

8. **Complete the appropriate section(s) on the table below** for the type(s) of incentive that you will provide.
Note: The value of the incentive, the reason you selected the incentive and the amount offered, must be equal to the program activities.

Incentive Type	**Value**
☐ Gift card; specify type of car (e.g. Master Card, Visa, etc.): Gift cards cannot be redeemed for cash and activation cost must be paid on behalf of members. All gift card rules, stipulations, and expiration dates must be communicated to member. Gift cards and vouchers must include a statement that restricts the purchase of products that would pose a health risk such as alcohol, tobacco, and firearms, unless the gift card, gift certificate, or voucher is for a location that does not sell these items (e.g., a farmer's market). How did you select this incentive and amount:	**$**
☐ Product or merchandise; specify type (and indicate how it related to the focus of the incentive program, e.g., glucometer for diabetes): How did you select this incentive and amount:	**$**
☐ Tickets; specify type (e.g., movie, local event): How did you select this incentive and amount:	**$**
☐ Drawing/Raffle (specify drawing item(s) and maximum number of drawing winners): How did you select this incentive and amount:	**$**
☐ Points Rewards Program (how many points will be awarded?): How did you select this incentive and amount:	**$**
☐ Other, please describe: How did you select this incentive and amount:	**$**

9. How do you calculate the value of the reward?

10. How do you track member participation in the program?

11. Contact Person (person submitting the form or person responsible for the program).

Name:

Email:

Phone:

CalOptima PHM Use:

12. CalOptima Population Health Management has reviewed and approved the Member Incentive Request.

Name:

Email:

Phone:

Approval Date:

Communication/Comments:

MEDICARE MEMBER INCENTIVE (MI) PROGRAM PROGRAM EVALUATION FORM

Member Incentive (MI) Evaluations are required for all member programs that offer incentives/rewards.

Requestor Instructions: Complete this form and email it to HealthEducationReview@CalOptima.org.

Program Evaluations are due to CalOptima Population Health Management thirty (30) calendar days after that program has ended or on January 15, whichever occurs first.

Email subject line and file name must include: CalOptima Department name, targeted disease/behavior, MI evaluation and program start date (e.g. *CalOptima_PHM_Diabetes_MI Evaluation_January 1, 2023*).

A. CalOptima Department Name: Today's Date:

Complete: **Desired Start Date:**

Actual Start Date:

Date Program Ended:

---

1. Do you plan to offer this program again? No ☐ Yes ☐

If yes, what is the new start date?

2. Targeted health related services and/or activity (as listed on MI request form):

3. Number of members did you enroll into the MI program:

4. Number of members who completed the program requirements and received the incentive:

5. What alternative methods of participation were offered *to* **accommodate all eligible members***?*

6. What type(s) of incentives did you offer to the program participants, the value of each, and the reason you selected the incentive and amount? (**complete the appropriate section(s) of the table below**)

Incentive Type	**Value**	**# Provided**
☐ Gift card; specify type of car (e.g. Master Card, Visa, etc.): Gift cards cannot be redeemed for cash and activation cost must be paid on behalf of members. All gift card rules, stipulations, and expiration dates must be communicated to member. Explain any changes made to this incentive and/or amount: ☐ N/A	**$**	**#**
☐ Product or merchandise; specify type (and indicate how it related to the focus of the incentive program, e.g., glucometer for diabetes): Explain any changes made to this incentive and/or amount: ☐ N/A	**$**	**#**
☐ Tickets; specify type (e.g., movie, local event): Explain any changes made to this incentive and/or amount: ☐ N/A	**$**	**#**
☐ Drawing/Raffle (specify drawing item(s) and maximum number of drawing winners): Explain any changes made to this incentive and/or amount: ☐ N/A	**$**	**#**
☐ Points Rewards Program (how many points will be awarded?): Explain any changes made to this incentive and/or amount: ☐ N/A	**$**	**#**
☐ Other, please describe: Explain any changes made to this incentive and/or amount: ☐ N/A	**$**	**#**

7. Total monetary value of all incentives listed in question #6 table (see above):

8. List any changes you made after the incentive request form was approved. Provider a reason for each change you made.

9. Please acknowledge that you have addressed the following:

☐ Reviewed success and challenges in the **planning** process for the MI program

☐ Reviewed success and challenges in the **implementation** process for the MI program

☐ Reviewed success and challenges in the **evaluation** process for the MI program

☐ Identified success and challenges in **identifying eligible members** for the MI program

☐ Identified success and challenges in **notifying eligible members** for the MI program

☐ Identified success and challenges in **verifying** the member has completed the required action

☐ Identified success and challenges impacting the **overall member completion rate**

☐ Identified success and challenges in **partnering with providers** for the MI program, if applicable

10. Comment:

---

11. Requestor Contact Person (person submitting the form and/or person responsible for the program).

Name:

Email:

Phone:

CalOptima PHM Use:

Reviewer's Name, Title and Review Date:

Comments:

DEPT NAME	CONTACT PHONE #	LOB	REWARD AND INCENTIVE PROGRAM NAME	INCENTIVE SERVICE/ACTIVITY	REWARD MEMBERS EARN FOR PARTICIPATION	HOW IS THE REWARD VALUE CALCULATED?	HOW DO YOU TRACK MEMBER PARTICIPATION IN THE PROGRAM	NUMBER OF MEMBERS CURRENTLY ENROLLED IN THE PROGRAM	ALTERNATIVE METHODS OR PARTICIPATION TO ACCOMMODATE ALL ELIGIBLE MEMBERS	TOTAL MI COST	REQUEST SENT TO HE	HE APPROVAL DATE	START DATE (Approved Form Linked)	PROGRAM END DATE	PHM EVAL DUE DATE	RAC EVAL DUE DATE	EVAL SENT TO HE/RAC	COMMENTS

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MEDICARE MEMBER INCENTIVE (MI) PROGRAM
REQUEST FOR APPROVAL FORM

Requestor Instructions: Complete this form and email it to HealthEducationReview@CalOptima.org. The request must be for the current Medicare contract year. Keep a tracking log of all incentives issued with members name, incentive issue date and CIN for submission with the evaluation form when the program ends or on January 15, whichever occurs first.

CalOptima Population Health Management Manager-Health Education or designee must review and sign off on all MI Programs Requests prior to program implementation. Submissions are due 60 days prior to program implementation.

Email subject line and file name must include: CalOptima Department or Health Network name, targeted disease/behavior, MI request and desired start date (e.g. *CalOptima_PHM_Diabetes_MI Request_January 1, 2022*). Submit *the request thirty (60) calendar days* prior to desired program start date.

A. CalOptima Department Name: Today's Date:

---

1. What is the **desired** start date?
Note: Must be at least 60 calendar days prior to program start date.

2. What is the **expected** end date?
Note: Must include dates within current contract year only.

3. What health related services and/or activities are included in the program?

4. Who is eligible for the MI program (i.e., target population, eligibility criteria, etc.)?
Note: The incentive program and access to program services must be offered uniformly to all eligible members.

5. Number of members identified as **eligible** for MI program?

6. What health related services and/or activities must the member complete in order to receive the incentive (i.e. make appointment, complete lab work, have a doctor sign form, mail back to agency in email provided, etc.)?

7. What are the alternative methods of participation will you implement in order *to* **accommodate all eligible members***?*

8. **Complete the appropriate section(s) on the table below** for the type(s) of incentive that you will provide.
Note: The value of the incentive, the reason you selected the incentive and the amount offered, must be equal to the program activities.

Incentive Type	**Value**
☐ Gift card; specify type of car (e.g. Master Card, Visa, etc.): Gift cards cannot be redeemed for cash and activation cost must be paid on behalf of members. All gift card rules, stipulations, and expiration dates must be communicated to member. Gift cards and vouchers must include a statement that restricts the purchase of products that would pose a health risk such as alcohol, tobacco, and firearms, unless the gift card, gift certificate, or voucher is for a location that does not sell these items (e.g., a farmer's market). How did you select this incentive and amount:	**$**
☐ Product or merchandise; specify type (and indicate how it related to the focus of the incentive program, e.g., glucometer for diabetes): How did you select this incentive and amount:	**$**
☐ Tickets; specify type (e.g., movie, local event): How did you select this incentive and amount:	**$**
☐ Drawing/Raffle (specify drawing item(s) and maximum number of drawing winners): How did you select this incentive and amount:	**$**
☐ Points Rewards Program (how many points will be awarded?): How did you select this incentive and amount:	**$**
☐ Other, please describe: How did you select this incentive and amount:	**$**

9. How do you calculate the value of the reward?

10. How do you track member participation in the program?

11. Contact Person (person submitting the form or person responsible for the program).

Name:

Email:

Phone:

CalOptima PHM (HE) Use:

12. CalOptima Population Health Management (HE) has reviewed and approved the Member Incentive Request.

Name:

Email:

Phone:

Approval Date:

Communication/Comments:

MEDICARE MEMBER INCENTIVE (MI) PROGRAM
PROGRAM EVALUATION FORM

Member Incentive (MI) Evaluations are required for all member programs that offer incentives/rewards.

Requestor Instructions: Complete this form and email it to HealthEducationReview@CalOptima.org, along with your program participation tracking list showing member names, issued issue date and CIN numbers.

Program Evaluations are due to CalOptima Population Health Management thirty (30) calendar days after that program has ended or on January 15, whichever occurs first.

Email subject line and file name must include: CalOptima Department name, targeted disease/behavior, MI evaluation and program start date (e.g. *CalOptima_PHM_Diabetes_MI Evaluation_January 1, 2022*).

A. CalOptima Department Name: Today's Date:

Complete: **Desired Start Date:**

Actual Start Date:

Program End date:

---

1. Do you plan to offer this program again? No ☐ Yes ☐

   If yes, what is the new start date?

2. Program Name, Earned reward and Targeted health related services and/or activity (as listed on MI request form):

3. Number of members did you enroll into the MI program (shown only unique members):

4. Number of members who completed the program requirements and received the incentive:

5. What alternative methods of participation were offered *to* **accommodate all eligible members***?*

6. What type(s) of incentives did you offer to the program participants, the value of each, and the reason you selected the incentive and amount? (**complete the appropriate section(s) of the table below**)

Incentive Type	Value	# Provided
☐ Gift card; specify type of car (e.g. Master Card, Visa, etc.): Gift cards cannot be redeemed for cash and activation cost must be paid on behalf of members. All gift card rules, stipulations, and expiration dates must be communicated to member. Explain any changes made to this incentive and/or amount: ☐ N/A	**$**	**#**
☐ Product or merchandise; specify type (and indicate how it related to the focus of the incentive program, e.g., glucometer for diabetes): Explain any changes made to this incentive and/or amount: ☐ N/A	**$**	**#**
☐ Tickets; specify type (e.g., movie, local event): Explain any changes made to this incentive and/or amount: ☐ N/A	**$**	**#**
☐ Drawing/Raffle (specify drawing item(s) and maximum number of drawing winners): Explain any changes made to this incentive and/or amount: ☐ N/A	**$**	**#**
☐ Points Rewards Program (how many points will be awarded?): Explain any changes made to this incentive and/or amount: ☐ N/A	**$**	**#**
☐ Other, please describe: Explain any changes made to this incentive and/or amount: ☐ N/A	**$**	**#**

7. Total monetary value of all incentives listed in question #6 table (see above):

8. List any changes you made after the incentive request form was approved. Provider a reason for each change you made.

9. Please acknowledge that you have addressed the following:

☐ Reviewed success and challenges in the **planning** process for the MI program

☐ Reviewed success and challenges in the **implementation** process for the MI program

☐ Reviewed success and challenges in the **evaluation** process for the MI program

☐ Identified success and challenges in **identifying eligible members** for the MI program

☐ Identified success and challenges in **notifying eligible members** for the MI program

☐ Identified success and challenges in **verifying** the member has completed the required action

☐ Identified success and challenges impacting the **overall member completion rate**

☐ Identified success and challenges in **partnering with providers** for the MI program, if applicable

10. Comment:

---

11. Requestor Contact Person (person submitting the form and/or person responsible for the program).

Name:

Email:

Phone:

CalOptima PHM (HE) Use:

Reviewer's Name, Title and Review Date:

Comments:

CONTACT PERSON	DEPT NAME	CONTACT PHONE #	LOB	REWARD AND INCENTIVE PROGRAM NAME	INCENTIVE SERVICE/ACTIVITY	REWARD MEMBERS EARN FOR PARTICIPATION	HOW IS THE REWARD VALUE CALCULATED?	HOW DO YOU TRACK MEMBER PARTICIPATION IN THE PROGRAM	NUMBER OF MEMBERS CURRENTLY ENROLLED IN THE PROGRAM	ALTERNATIVE METHODS OR PARTICIPATION TO ACCOMMODATE ALL ELIGIBLE MEMBERS	TOTAL MI COST	REQUEST SENT TO HE	HE APPROVAL DATE	START DATE (Approved Form Linked)	PROGRAM END DATE	PHM EVAL DUE DATE	RAC EVAL DUE DATE	EVAL SENT TO HE/RAC	COMMENTS

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

10. Approve Changes to the Whole-Child Model Family Advisory Committee Chair and Vice Chair Requirements and Extend Term of Current Chair and Vice Chair

Contacts

Ladan Khamseh, Executive Director, Operations, (714) 246-8866
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

1. The Whole-Child Model Family Advisory Committee (WCM FAC) recommends extending the current term of:
   a. Kristen Rogers as the WCM FAC Chair for a one-year term ending June 30, 2023, and
   b. Kathleen Lear as WCM FAC Vice Chair for a one-year term ending June 30, 2023.
2. Allow all members of the committee to be considered for Chair and Vice Chair seats.

Background

The CalOptima Health Board of Directors established the WCM FAC by Resolution No. 17-1102-01 on November 2, 2017, to serve solely in an advisory capacity, providing input and recommendations concerning the Whole-Child Model program. The WCM FAC is comprised of 11 voting members, seven of whom are designated as family representatives and four of whom are designated as community seats representing the interests of children receiving California Children's Services (CCS). At the Board of Directors meeting on August 2, 2018, it was stipulated that only family members serve in a Chair or Vice Chair capacity.

Pursuant to Resolution No. 20-0806, the CalOptima Health Board of Directors is responsible for the appointment of the WCM FAC Chair and Vice Chair biennially from among appointed members. The Chair and Vice Chair may serve a two-year term.

Discussion

The WCM FAC has had challenges in recruiting and retaining family members on the committee. The 2022 recruitment brought forth three additional family members. The committee stands at five family members and four community-based organizations and consumer advocates for a total of nine out of 11 members on the committee.

WCM FAC members Kristen Rogers and Kathleen Lear submitted letters of interest for the WCM FAC Chair and Vice Chair, respectively. At their September 20, 2022, meeting, WCM FAC members voted to recommend that Ms. Rogers remain as the WCM FAC Chair for a one-year term through June 30, 2023; that Ms. Lear remain as the WCM FAC Vice Chair for a one-year term through June 30, 2023; and that committee members other than family members be allowed to serve as Chair or Vice Chair on the committee beginning July 1, 2023.

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WCM FAC Chair Candidate
Kristen Rogers

Ms. Rogers is the parent of a CalOptima Health member and CCS beneficiary. She is an active volunteer at Children's Health of Orange County (CHOC) and has served on the WCM FAC since 2018. In March of 2019, Ms. Rogers was appointed to the CCS Advisory Group as a representative of CalOptima Health and the WCM FAC. She has served as the WCM FAC Chair since August 2020.

WCM FAC Vice Chair Candidate
Kathleen Lear

Ms. Lear is the parent of a special needs child who receives CCS services. She is a substitute instructional assistant to special education children in the Los Alamitos Unified School District and the Chair of the Family Advisory Committee at CHOC. She is also a parent champion for CHOC's Community Outreach Parent Empowerment group where she helps provide support for families living with epilepsy. Ms. Lear was appointed to the WCM FAC as a Consumer Advocate in October 2019 and is currently an Authorized Family Member Representative as of July 1, 2021. Ms. Lear has served as the committee's Vice Chair since her appointment by the Board of Directors in August 2021.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Open nominations were held at the September 20, 2022, WCM FAC meeting based on the letters of interest received. There were no additional nominations from the floor. The WCM FAC forwards the recommended Chair and Vice Chair nominees to the Board of Directors for consideration and appointment. The WCM FAC also recommends the Board of Directors approve allowing all members to be eligible for consideration as the Chair or Vice Chair.

Concurrence
Whole-Child Model Family Advisory Committee
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Authorize Amendment to the Contract with NR Medical Associates for On-Call Services for CalOptima Health's Program of All-Inclusive Care for the Elderly

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Monica Macias, LCSW, PACE Director, (714) 468-1077

Recommended Actions

Staff recommends that the CalOptima Health Board of Directors:

1. Authorize the Chief Executive Officer to amend the contract with NR Medical Associates, effective January 1, 2023, related to a rate increases for on-call services for the Program of All-Inclusive Care for the Elderly (PACE) participants.
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $22,500 from existing reserves to fund the rate increases through June 30, 2023.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

PACE is a Medicare and Medicaid managed care service delivery model for the elderly that integrates acute, chronic, and long-term care for nursing home-certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima Health PACE currently serves approximately 433 participants. NR Medical Associates has been supporting CalOptima Health PACE with its after-hours call services for more than five years. NR Medical Associates is able to triage medical care and provide support services like prescription refills and urgent care-like assessments to prevent emergency department visits and hospitalizations and provide PACE Interdisciplinary Team staff with timely reports to continue to care for PACE members.

Discussion

NR Medical Associates has requested an increase to their current after-hours services. Authorizing the rate increase will continue to support PACE's on-call/after-hours support services to provide medical care when CalOptima Health's PACE clinic closes after 5 p.m. and on the weekends. CalOptima Health PACE staff is seeking authority to increase the rate for much needed services to its vulnerable participants. NR Medical Associates supports calls from 5 p.m. to 8 a.m. the next day, 365 days a year with a live case manager and a clinician on back-up for clinical advice. This service is being reimbursed at an annual rate of $45,000 (or about $123 a day). This is way below the market value, this is the first time NR Medical Associates is requesting a rate increase for this service.

Fiscal Impact

The Fiscal Year 2022-23 Operating Budget includes $45,000 for these after-hours call services. The fiscal impact related to the proposed rate increase would result in a current year budget shortfall of $22,500 for the period of January 1, 2023, through June 30, 2023. An appropriation from existing

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reserves will fund this action. The fiscal impact of the rate increase for on-call services equates to an overall 5% increase to the total payments to NR Medical for all contracted services. Management will include updated medical expenses in future operating budgets.

Rationale for Recommendation

Authorizing a rate increase to NR Medical Associates is essential to support the care PACE participants depend on for their medical needs when the PACE clinic is closed.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. NR Medical Associates Contract
3. Amendment I

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
NR Medical Associates	12921 Main Street, Suite B	Garden Grove	CA	92840

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Contract Summary Transmittal Form

Provider(s):	**NR Medical Associates** 12921 Main Street Suite B Garden Grove, CA. 92840 **Contracts & Amendments:** Emily Nguyen, Administrator Ph: (619) 886-0145 Fax: (800) 391-4191 Email: enguyen@360.md
TIN:	46-2913018
NPI:	1649601113
Type of provider:	Mixed PCP/Specialist Group
Specialty:	LTC PCP, PACE PCP, Hospitalist, SNFist & Palliative Care
Line of Business:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☒ PACE ☐ MSSP
Type of Document:	☒ Contract ☐ BAA Agreement ☐ Amendment ☐ Delegation Agreement ☐ Rate Amendment ☐ Certified Extension Letter for Renewal
FDR packet notification (for delegated or non-healthcare provider)	☐ Yes ☒ No
Credentialing completed by QI - (for new contracts only):	☒ Yes Date: _____ ☐ N/A Comments: _____
NetworX Agreement Pricing Code	☒MCPCPKBL129 (PCP) ☒MCSPCKBL133 (Specialist) ☒CM26PHYLB100 (OCC) ☐MXPHYKLB (MCE) ☒PC26PHYLB100 (PACE) • PACE services will be invoiced to PACE Center & PACE will send invoice to CalOp Accounting for provider payment.
Effective date of Initial Agreement:	01/01/2020
Effective date of Amendment:	N/A
Termination date of Agreement:	☐ _____ ☒ Renew for additional one-year term with Board Approval

Contract justification:

New Mixed PCP/Specialist Contract for multiple services and multiple LOBs. Standard Medi-Cal and OCC reimbursement rates.

- PACE PCP Services at PACE Center by a Physician: $205/Hr
- PACE PCP Services at PACE Center by a Non-Physician: $130/Hr
- PACE PCP Services by a Medical Director: $225/Hr
- On-Call Services provided for PACE participants: $45,000 per year

• PACE participants assigned to a professional at a clinical site other than the PACE Center: 100% of Medicare. • PACE participants assigned to a professional at a clinical site other than the PACE Center: $35pmpm for enhanced coordination & IDT. • PACE participants assigned to a professional at a clinical site other than the PACE Center: $35pmpm for physician utilizing TruChart/(EMR) for all outpatient documentation.
Financial justification: NR Medical Associates contract to replace existing HCMA contracts due to not being medi-cal enrolled.

Negotiator:	Michael Stewart
Date:	12/23/19

File path for scanned contract/ amendment:

R:\Contracts Read Only\PHYSICIAN FEE-FOR-SERVICE (FFS) CONTRACTS\PHYSICIAN FEE-FOR-SERVICE (FFS) CONTRACTS\MIXED PCP&SPEC GROUPS

File path for credentialing documentation (new contracts only): G:\Contract Status\Physician and Physician Groups.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to www.irs.gov/FormW9 for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
NR MEDICAL ASSOCIATES

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☑ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.
12921 MAIN STREET - SUITE B

Requester's name and address (optional)

6 City, state, and ZIP code
GARDEN GROVE, CA 92840

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number
[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

or

Employer identification number
[4][6] - [2][9][1][3][0][1][8]

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here Signature of U.S. person ▶ TONY NGUYEN, CEO Date ▶ 11/26/2019

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

PROFESSIONAL SERVICES CONTRACT

GENERAL PROVISIONS

This Professional Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima") and **NR Medical Associates** ("Professional"), with respect to the following:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community as amended.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. CalOptima has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to operate a Program of All-Inclusive Care for the Elderly ("PACE") as a PACE Organization for the purposes set forth in sections 1894 and 1934 of the Social Security Act, and to offer eligible individuals services through PACE.

D. CalOptima has entered into a participation contract with the State of California, acting by and through the Department of Health Care Services ("DHCS" or "State"), and the Department of Health and Human Services ("HHS"), acting by and through the Centers for Medicare & Medicaid Services ("CMS"), to furnish health care services to Medicare/Medi-Cal Members who are enrolled in CalOptima's Cal MediConnect program ("DHCS/CMS Cal MediConnect Contract").

E. Professional is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

F. CalOptima desires to engage Professional to furnish, and Professional desires to furnish, certain items and services to CalOptima Members eligible as described herein.

G. Professional intends to provide services under this Contract through the Practitioners listed on Attachment C to CalOptima Members, as identified in Attachment A.

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

NOW, THEREFORE, the parties agree to the terms and conditions set forth in these General Provisions and all Attachments, and Addendums attached or incorporated by reference in these General Provisions as follows:

ARTICLE 1

ATTACHMENTS, ADDENDUMS, PROVIDER MANUAL, POLICIES

Documents Constituting Contract. This Contract includes, and the parties agree to be bound by, each of the following:

1.1 Attachments.

1.1.1 Attachment A, Contracted Services, contains the CalOptima Programs, Physician Services and description of the responsibilities and performance requirements of Professional pursuant to this Contract based upon the type of Covered Services to be provided by Professional under this Contract.

1.1.2 Attachment B, Compensation, contains the specific payment rate(s) and/or fee(s) to be paid to Professional for the delivery of Covered Services and the compensation method to be employed pursuant to this Contract, which terms shall control in the event of a conflict with these General Provisions.

1.1.3 Attachment C, Professional's Practitioners who own, are employed by, or under contract with, Professional, and who will perform Covered Services under this Contract. Only Practitioners who CalOptima has determined meet applicable CalOptima credentialing criteria may be listed in this Attachment. This Attachment may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of

such addition or deletion at least thirty (30) days prior to the effective date of such addition or deletion.

1.1.4 Attachment D, Special Provisions, if attached to this Contract sets forth Special Provisions which are Professional specific terms and conditions as deemed needed and appropriate by CalOptima. If Special Provisions conflict with the General Provisions or any other Attachments, the Special Provisions shall govern.

1.1.5 Attachment E, Professional shall complete any changes to Professional's ownership, as identified in Article 3, Section 3.13, on Attachment E, Disclosure Form.

1.2 Addendums.

1.2.1 The Addendums are terms and conditions that apply specifically to items and services provided to Members under the CalOptima Programs as follows:

1.2.1.1 Addendum 1: Medi-Cal Program Requirements

1.2.1.2 Addendum 2: PACE Program Requirements

1.2.1.3 Addendum 3: Cal MediConnect Program Requirements

1.2.1.4 Addendum 4: Certification Regarding Lobbying

1.3 Policies. CalOptima has established, and from time to time may establish and revise, Policies and Procedures for activities related to management of Covered Services ("Policy" or "Policies"). The Policies cover, by way of example and not limitation, the following areas: network management, quality management, utilization review, credentialing, peer review, claims billing and reimbursement, member rights and responsibilities and grievances and appeals. Professional shall abide by all of the Policies that apply to the activities of Professional under this Contract. CalOptima shall set forth or describe the Policies in the Provider Manual, provider newsletters or other written communications to Professional. CalOptima shall make available to Professional new or revised Policies of which Professional must comply with those Policies.

1.4 Provider Manual. "Provider Manual" means CalOptima's Provider Manual which contains guidelines, Policies and procedures and other information relative to performance under this Contract. CalOptima will revise the Provider Manual from time to time. The Provider Manual may be revised by CalOptima by issuing updates, newsletters or bulletins, all of which will be effective upon receipt by Professional or as otherwise specified in such updates, newsletters or bulletins.

ARTICLE 2
DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments, Addendums and Schedules attached hereto, apply to the terms set forth in this Contract:

2.1 "Accreditation Organization" means any organization including without limitation, the National Committee for Quality Assurance (NCQA), The Joint Commission (TJC) and/or other entities engaged in accrediting, certifying and/or approving CalOptima, Professional and/or their respective programs, centers or services.

2.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

2.3 "Advance Directive" means a written instruction (such as that required under the Federal Patient Self-Determination Act, 42 U.S.C. Sections 1395cc(f) and 1396a(w), and implementing regulations, the California Health Care Decisions Law, Probate Code Sections 4600 *et seq.*, or durable power of attorney for health care), relating to the provision of medical care when an individual is incapacitated.

2.4 "Appeal" means a Member's actions, both internal and external to CalOptima, requesting review of the denial, reduction or termination of benefits or services from CalOptima. Appeals relating to CalOptima Covered Services shall proceed pursuant to the laws and regulations governing Medi-Cal appeals, and appeals relating to Medicare covered benefits and services shall proceed pursuant to laws and regulations relating to Medicare appeals.

2.5 "Approved Drug List" means CalOptima's continually updated list of medications and supplies that may be obtained without prior authorization.

2.6 "Assigned Members" means Members that CalOptima has assigned to a Primary Care Provider on the date of service according to CalOptima's electronic Member management information systems. CalOptima shall make no warranties or representations regarding the number of Members, if any, who will be assigned to the Primary Care Provider or the duration of the Primary Care Provider's participation in the program.

2.7 "Behavioral Health Services" means the mental health services provided through the Mental Health Plan or CalOptima or their Subcontractors, and substance use disorder services.

2.8 "Cal MediConnect" is a program to furnish health care services to Medicare/Medi-Cal Members who are enrolled in CalOptima's Cal MediConnect program. Cal MediConnect is also referred to as OneCare Connect.

2.9 "California Children's Services (CCS)" means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Services Eligible Conditions of a specific Member.

2.10 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Section 41515.2 through 41518.9.

2.11 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS Eligible Conditions.

2.12 "CalOptima Direct" or "COD" means a Medi-Cal program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

2.12.1 CalOptima Direct Members who are assigned to CalOptima's Community Network in accordance with CalOptima Policy. Members are assigned to Primary Care Providers (PCP) as their medical home, and their care is coordinated through their PCP in the Community Network.

2.12.2 "CalOptima Direct—Administrative" or "COD-Administrative," provides services to Members who reside outside of CalOptima's service area, are transitioning into a contracted Health Network, have a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any Medi-Cal enrolled practitioner for physician services and will not be assigned to a PCP.

2.13 "CalOptima Policies" means CalOptima Policies and Procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

2.14 "CalOptima Program(s)" means the Medi-Cal, Cal MediConnect, and PACE Programs administered by CalOptima. Professional participates in the specific CalOptima program(s) identified on Attachment A.

2.15 "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its Downstream Entities' activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Office of Inspector General, the Centers for Medicare and Medicaid Services, the Comptroller General of the United States, the California Department of Health Care Services, and the California Department of Managed Health Care and other government agencies that have authority to set standards and oversee the performance of the parties to the Contract.

2.16 "Care Management Services" means (i) providing Physician Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services; (ii) coordinating Medically Necessary Covered Services with other benefits not covered under this Contract; (iii) maintaining a Medical Record with documentation of referral services, and follow-up as medically indicated; (iv) ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care; (v) participating in disease management programs as applicable (vi) coordinating a Member's care with all outside agencies pertinent to their needs as addressed in the MOUs and CalOptima Policies; and (vii) coordinating care for Members transitioning from CalOptima Direct to a Health Network.

2.17 "CCS Provider(s)" or "CCS-Paneled Provider(s)", means any of the following providers when used to treat Members for a CCS condition:

(a) A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800 of Chapter 3 of Part 2 of Division 106.

(b) A licensed acute care hospital approved by the CCS Program.

(c) A special care center approved by the CCS Program.

2.18 "Child Health and Disability Prevention" or "CHDP" means a California program defined in the Health and Safety Code Section 12402.5, et seq. that covers pediatric preventive services for eligible children receiving Medi-Cal benefits. The CHDP components are incorporated into CalOptima's Pediatric Preventive Services Program, which is often referred to as CHDP. These services are provided according to the recommended schedule and standards published by the American Academy of Pediatrics (AAP).

2.19 "Claim" means a request for payment submitted by Professional in accordance with this Contract and CalOptima Policies.

2.20 "Clean Claim" means a Claim that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as further defined in the applicable CalOptima Program(s).

2.21 "Community Network" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to Primary Care Providers as their medical home, and their care is coordinated through the PCP.

2.22 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors and Providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan

2.23 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or at least 1,500 such Members in two contiguous ZIP codes.

2.24 "Coordination of Benefits" or "COB" refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

2.25 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Covered Services shall also include CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

2.26 "Downstream Entity" means all of Professional's Practitioners and other persons or entities with which Professional has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy Professional's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "Professional" as used in the terms of this Contract shall also include its Subcontractors when such Subcontractors are Subcontractors as defined herein even if not expressly referenced in the particular provision.

2.27 "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

2.28 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

2.28.1 placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

2.28.2 serious impairment to bodily functions; or

2.28.3 serious dysfunction of any bodily organ or part.

2.29 "Emergency Services" means those health care services (including inpatient and outpatient) that are Covered Services and for which Practitioners are duly licensed and qualified to furnish that are needed to evaluate or stabilize an Emergency Medical Condition.

2.30 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

2.31 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1) medical and surgical services performed by and under the direct supervision of a licensed physician for the purposes of Family Planning; 2) laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or associated with Family Planning procedures; 3) patient visits for the purpose of Family Planning; 4) Family Planning counseling services provided during a regular patient visit; 5) tubal ligations; 6) vasectomies; 7) contraceptive drugs or devices; and, 8) treatment for complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.

2.32 "Formulary" or "CalOptima Formulary" shall mean, the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional Formularies as may be designated by CalOptima and provided to PBM. There is no applicable Formulary for the PACE program.

2.33 "Government Agencies" means Federal and State agencies that are parties to the Government Contracts, including HHS/CMS, DHCS, DMHC and their respective agents and contractors, including quality improvement organizations (QIOs).

2.34 "Government Contract(s)" means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

2.35 "Government Guidance" means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Programs.

2.36 "Grievance" means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration, or Appeal made by a Member.

2.37 "Health Network" means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to Members on a capitated basis.

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

2.39 "Health Risk Assessment" or "HRA" means the assessment tool which identifies a Member's primary, acute, Long-Term Supports and Services (LTSS), Behavioral Health and functional needs.

2.40 "Hospital Services" means those Medically Necessary inpatient and outpatient hospital services, including medical services and supplies, that are Covered Services.

2.41 "Hospitalist" means a CalOptima-contracted Physician responsible for providing all Primary Care Provider services within his or her scope of practice for Members receiving inpatient care at identified hospitals.

2.42 "Individualized Care Plan" or "ICP" means the plan of care developed by a Member and/or his/her Interdisciplinary Care Team or CalOptima.

2.43 "Interdisciplinary Care Team" or "ICT" means a team comprised of the primary care provider and Care Coordinator and other providers at the discretion of the Member that work with the Member to develop, implement and maintain the ICP.

2.44 "Licenses" means all licenses and permits that Professional is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

2.45 "Long Term Care Facility" means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services or sub-acute care services.

2.46 "Medi-Cal" is the name of the Medicaid program for the State of California (*i.e.*, the program authorized by Title XIX of the Federal Social Security Act and the regulations promulgated thereunder).

2.47 "Medi-Cal Specialty Mental Health Services" mean those services specified in Title 9 CCR Section 1810.247 provided through a MHP (and not including the Medi-Cal Managed Care Behavioral Health Services specified in Welfare & Institutions Code Section 14132.03 required to be provided by CalOptima).

2.48 "Medical Necessity" or "Medically Necessary" means reasonable and necessary services to protect life, to prevent illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22, CCR Section 51303 (a) and 42 CFR 438.210 (a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d (r), and W&I Code Section 14132(v).

2.49 "Medical Record" means any record kept or required to be kept by any Provider that documents all of the medical services received by the Member, including, without limitation, inpatient, outpatient, emergency care, and Referral requests and authorizations, as required to be kept pursuant to applicable State and Federal laws and CalOptima Policies.

2.50 "Medicare" means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

2.51 "Medicare Secondary Payer" or "MSP" means the Medicare coordination of benefits (COB) requirements as incorporated in MA regulations.

2.52 "Member" means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program. Member may also be referred to as Member or Participant depending on the CalOptima Program.

2.53 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

2.54 "Mental Health Plan" or "MHP" means the entity that has contracted with DHCS to provide Medi-Cal Specialty Mental Health Services. The Orange County Health Care Agency is the MHP for Medi-Cal Specialty Mental Health Services for residents of Orange County, California.

2.55 "Minimum Provider Standards" means the minimum participation criteria established by CalOptima for specified Practitioners that must be satisfied in order for a Practitioner to submit claims and/or receive reimbursement from the CalOptima program for items and/or services furnished to CalOptima Members as identified in CalOptima Policies.

2.56 "Model of Care" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

2.57 "Non-Covered Services" means those items and services that are not covered benefits under a particular CalOptima Program in accordance with the Evidence of Coverage or Member handbook and applicable State and Federal laws and regulations.

2.58 "Non-Participating Provider" means a Provider of health care services who has not entered into a written agreement with CalOptima, either directly or through another organization, to provide Covered Services to Members.

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2.59 "Non-Physician Medical Practitioner" (Mid-Level Practitioner) means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.

2.60 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

2.61 "Participating Provider" means a Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

2.62 "Pediatric Preventive Services" means well child services which incorporate CHDP and the American Academy of Pediatrics Guidelines for Health Supervision.

2.63 "Personal Care Coordinator" or "PCC" is a dedicated non-licensed care coordinator, assigned to each Medi-Cal member with an active SPD aid code, supervised by a licensed person for the CalOptima PCC Program.

2.64 "PCC Program" means the Personal Care Coordinator Program identified in CalOptima Policies.

2.65 "Physician" means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice, or a group practice, independent practice association or other formal business arrangement comprised of persons with such licensure.

2.66 "Physician Services" means those services within Professional's scope of practice and license and which are Covered Services and furnished by a Practitioner under the direct supervision of a Physician, to Members pursuant to this Contract, as identified in Attachment A.

2.67 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) or a Non-Physician Medical Practitioner furnishing Covered Services under medical benefits, as described in CalOptima Policies and who is contracted under this Contract.

2.68 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

2.69 "Primary Care Provider (PCP)" means a Participating Provider who is a physician, clinic, a nurse practitioner or physician's assistant who:

a) is licensed by the State of California, or the state in which the PCP practices, to practice in the fields of general medicine, internal medicine, family practice, pediatrics, or obstetrics and gynecology; and

b) assumes primary responsibility for supervising, coordinating and providing initial primary and preventive care to Members, initiating referrals for specialty care, following specialty care, and maintaining continuity of care.

2.70 "Primary Care Provider Services" means Covered Services provided by a Primary Care Provider to assigned Members as set forth in Attachment A of this Contract.

2.71 "Prior Authorization" means the process by which CalOptima approves, usually in advance of the rendering, requested medical and other services pursuant to the utilization management program for the CalOptima Programs.

2.72 "Program of All-Inclusive Care for the Elderly" or "PACE" means a program that features a comprehensive medical and social services delivery system using an Interdisciplinary Team (IDT) approach in an adult day health center that is supplemented by in-home and referral services, in accordance with the Member's needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of the PACE participant and who work in an interactive and collaborative manner to

manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima.

PACE Services shall include the following:

a) All Medicare-covered items and services

b) All Medi-Cal covered items and services; and

c) Other services determined necessary by the IDT to improve and maintain the participant's overall health status.

2.73 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution that furnishes health care items or services.

2.74 "Provider Manual" means the comprehensive online document, as amended from time to time, that describes CalOptima's Policies and procedures affecting Professional services under this contract.

2.75 "QMI Program" means CalOptima Quality Management and Improvement Program.

2.76 "Referral" means the process by which a Physician directs a Member to seek and obtain Covered Services from a health professional or for care at a facility.

2.77 "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" means services provided by a Primary Care Provider to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs."

2.78 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion, and human immunodeficiency virus (HIV) testing.

2.79 "Service Area" means the geographic area that is within Orange County, California.

2.80 "Specialist Provider" means a Participating Provider of health care services who:

a) is licensed by the State of California, or the state in which the Specialist Practitioner practices, to practice in the designated specialty; and

b) assumes responsibility for providing specialty services to Members and relating pertinent information to the referring provider.

2.81 "Specialist Physician Services" means Covered Services, as set forth in Attachment A of this Contract.

2.82 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, the woman has delivered the child and the placenta.

2.83 "Subcontract" means a contract entered into by Professional with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Professional fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

2.84 "Subcontractor" means a person or entity who has entered into Subcontract with Professional for the purposes of filling Professional's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

2.85 "Termination Date" means the date identified in Section 7.1 of this Contract.

2.86 "Threshold Languages" means those languages as determined by CalOptima from time to time based upon State requirements per MMCD Policy Letter 99-03, or any update or revision thereof.

2.87 "UM Program" means CalOptima's Utilization Management Program.

2.88 "Urgent Care" means services that are not Emergency Services and are generally services to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed as specifically defined by the rules and regulations governing the applicable CalOptima Program.

2.89 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 3
FUNCTIONS AND DUTIES OF PROFESSIONAL

3.1 Provision of Services. Professional shall furnish Physician Services identified in Attachment A to eligible Members in accordance with the terms of this Contract and CalOptima Policies.

3.1.1 Professional agrees that, to the extent feasible, Physician Services provided by it will be made available and accessible to Members promptly and in a manner which ensures continuity of care.

3.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Professional shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, to meet Professional's obligation to provide Physician Services hereunder.

3.1.3 In accordance with Section 3.23 of this Contract, Professional and its Subcontractors shall furnish Physician Services to Members under this Contract in the same manner as those services are provided to other patients, and may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients.

3.1.4 Only Practitioners who CalOptima has determined meet applicable CalOptima credentialing criteria may be listed as contracted. This Contract may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of such addition or deletion at least thirty (30) days prior to the effective date of such addition or deletion. Professional shall provide an updated list of its Practitioners as needed or upon request from CalOptima.

3.2 UM Program. Professional shall comply with CalOptima's UM Program including:

3.2.1 Professional acknowledges and agrees that CalOptima has implemented and maintains a UM Program that addresses evaluations of Medical Necessity and processes to review and approve the provision of items and services, including Physician Services, to Members. Professional shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Physician Services as described in this Contract.

3.2.2 Professional shall comply with all Prior Authorization, concurrent and retrospective review and authorization requirements as set forth in CalOptima Policies and Provider Manual.

3.2.3 Professional shall permit CalOptima's UM Department staff and other qualified representatives of CalOptima to conduct on site reviews of the Medical Records of Members as applicable. CalOptima staff shall notify Professional prior to conducting such on site reviews and shall wear appropriate identification.

3.3 Transfer of Care. Upon request by a CalOptima Member, Professional shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Professional shall make available to the new provider of care for the Member, copies of the Medical Records, patient files, and other pertinent information necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

3.4 CCS Eligible Services. If Professional is not a CCS-paneled Physician authorized by CCS to provide the specific CCS-eligible Services required by Members, Professional agrees to cooperate with CalOptima in the referral of Members with CCS-eligible conditions to an appropriately authorized CCS paneled Physician.

3.5 Eligibility. Professional shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving a request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Professional shall collect SOC in accordance with CalOptima Policies.

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3.6 Licensure/Certification of Employees and Practitioners. Each of Professional's Practitioners furnishing services under this Contract shall maintain in good standing at all times during this Contract, the necessary licenses or certifications required by State and Federal law or any Accreditation Organization to provide or arrange for the provision of Covered Services to Members.

3.7 Government Program Registration. Professional represents and warrants that it has registered with Medi-Cal and Medicare as applicable, and shall maintain, during the term of this Contract, registration to provide services to beneficiaries covered by these programs.

3.8 Good Standing. Professional and Professional's Practitioners represents it is in good standing with State licensing boards (applicable to its business), DHCS, CMS and the HHS Officer of Inspector General ("OIG"). Professional agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status.

3.9 Notices and Citations. Professional shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Professional that contains a citation, sanction and/or disapproval of Professional or Professional's Practitioner's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

3.10 Professional Standards. All Physician Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized Practitioners in a manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

3.11 Marketing Requirements. Professional shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

3.12 Identification of Professional. Professional agrees that CalOptima may list the name, address, and telephone number of Professional and a description of Professional's facilities and services in CalOptima's roster of Participating Providers, which is given to Members and/or prospective Members. However, CalOptima is not obligated to list the name of any particular Provider in the roster. Professional and CalOptima agree that the use of the other party's trademarks or logos is prohibited without prior written approval of that party.

3.13 Disclosure of Professional Ownership. Professional shall provide CalOptima with the following information, as applicable: (a) names of all officers of Professional's governing board; (b) names of all owners of Professional; (c) names of stockholders owning more than five percent (5%) of the stock issued by Professional; and (d) names of major creditors holding more than five percent (5%) of the debt of Professional. Professional shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Professional shall notify CalOptima immediately of any changes to the information included by Professional in the disclosure forms submitted to CalOptima.

3.14 Clinical Laboratory Improvement Amendments. Professional shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

3.15 Newborn Services. Professional shall provide all Physician Services to any newborn child or children born to a Member for the month of birth and the following month. Newborn services shall be billed under the mother's identification and paid per the compensation rates defined in Attachment B.

3.16 Advanced Directives. Professional shall maintain written Policies and Procedures related to Advanced Directives in compliance with State and Federal laws and regulations. Professional shall document patient records with respect to the existence of an Advanced Directive in accordance with applicable law. Professional shall not discriminate against any Member on the basis of that Member's Advanced

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Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

3.17 CalOptima QMI Program. Professional acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Professional. Professional agrees that it is subject to the requirements of CalOptima's QMI Program and that it shall participate and cooperate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Professional shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Professional further agrees to participate in all quality improvement studies including, but not limited to HEDIS data collection. Professional shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Professional Services (*e.g.,* medical necessity) and shall accept as final all decisions regarding disputes over Physician Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program.

Professional shall also allow CalOptima to use performance data for quality and reporting purposes including, but not limited to, quality improvement activities and public reporting to consumers, and performance data reporting to regulators as identified in CalOptima Policies.

3.18 CalOptima Oversight. Professional understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Professional under this Contract, and that CalOptima has the authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Professional's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Professional's performance of duties described in this Contract; (iii) require Professional to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Professional fails to meet CalOptima standards in the performance of that duty. Professional shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Professional or the oversight of those duties.

3.19 CalOptima's Compliance Program and Other Guidance. Professional, its employees, board members, owners, and Practitioners furnishing services under this Contract shall comply with the requirements of CalOptima's Compliance Program, including the Fraud Waste and Abuse plan, Provider Manual and CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Professional and Professional shall make them available to Professional's Practitioners. Professional agrees to comply with, and be bound by, any and all MOUs, CalOptima financial bulletins and contract interpretation bulletins, which provide changes, updates and clarifications regarding CalOptima financial Policies and contract interpretations.

3.19.1 Prior to performing services under this contract, Provider shall complete and submit to CalOptima, any DHCS/CMS-required training and/or CalOptima required attestations related to such training and other compliance obligations.

3.20 Equal Opportunity. Professional 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. Professional 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. Professional and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Professional'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.

Professional and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Professional, 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.

Professional and its Downstream Entities 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 Professional's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Professional 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.

Professional and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Professional's 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 Professional 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.

Professional will include the provisions of this section in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Professional 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 Professional becomes involved in, or are threatened with litigation by a Subcontractor or vendor as a

result of such direction by DHCS, Professional may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.21 Compliance with Applicable Laws. Professional shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects Professional's performance under this Contract. Professional understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Professional is subject to certain laws that are applicable to individuals and entities receiving Federal funds. Professional agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions, including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act. Professional agrees to include the requirements of this section in its Subcontracts. In making payments to Participating Providers and Non-Participating Providers, Professional shall comply with all applicable Federal and State laws and Government Guidance related to claims payment.

3.22 No Discrimination/Harassment (Employees). During the performance of this Contract, Professional and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender, sexual orientation, or the use of family and medical care leave and pregnancy disability leave. Professional shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Professional and its Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Professional and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

3.23 No Discrimination (Member). Neither Professional nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (a) denying any Member any Covered Services or availability of a Physician, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or

other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services.

Professional and its Subcontractors agrees to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Professional and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

Professional and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

3.24 Fraud and Abuse Reporting. Professional shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Professional, whether by Professional, Professional's employees, Subcontractors, and/or Members within five (5) working days of the date when Professional first becomes aware of or is on notice of such activity.

3.25 Participation Status. Participation Status means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies. Professional shall have Policies and Procedures to verify the Participation Status of Professional's Practitioners. In addition, Professional attests and agrees as follows:

3.25.1 Professional and Professional's Practitioners shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.25.2 Professional shall immediately disclose to CalOptima, including, but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Professional or Professional's Practitioners occurring and/or discovered during the term of this Contract.

3.25.3 Professional shall take immediate action to remove any employee of Professional that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members which may include but not limited to adverse decisions and licensure issues.

3.25.4 Professional shall include the obligations of this Section in its Subcontracts.

3.25.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Professional shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

3.26 Physical Access for Members. Professional's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

3.27 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medi-

Cal; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Professional 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. Professional further agrees that it will insert this certification into any Subcontracts entered into that provide for children's services as described in the Act.

3.28 Member Rights. Professional shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policies and the Provider Manual, are fully respected and observed.

3.29 Professional – Member Communication. Professional shall freely communicate with patients and Members about their treatment, regardless of benefit coverage limitations. In addition, Professional, acting within the lawful scope of practice, shall freely communicate and encourage its health care professionals to freely communicate the following to patients and Members regardless of benefit coverage:

The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.29.1 Any information the Member needs in order to decide among all relevant treatment options.

3.29.2 The risks, benefits, and consequences of treatment or non-treatment.

3.29.3 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.30 Credentialing Warranties and Requirements. Professional acknowledges that its participation in this Contract is expressly conditioned upon Professional's compliance with CalOptima's credentialing requirements and standards, including, but not limited to the following:

3.30.1 Before the Effective Date, Professional's Practitioners shall have submitted credentialing applications to CalOptima, in form and substance satisfactory to CalOptima.

3.30.2 Professional warrants and represents that, as of the Effective Date and continuing through the term of this Contract, Professional's Practitioners shall meet the credentialing standards listed below:

3.30.3 Professional's Practitioners continue to meet all applicable CalOptima credentialing and recredentialing standards, including CalOptima's Board Certification policy; and

3.30.4 Professional's Physician Providers have clinical privileges in good standing and without restriction at a CalOptima-contracted hospital designated by each Physician Provider as the primary admitting facility.

3.30.5 During the entire term of this Contract, Professional's Practitioners shall maintain their professional competence and skills commensurate with the medical standards of the community, and as required by law and this Contract, shall attend and participate in approved continuing education courses.

3.30.6 Professional's Practitioners shall be credentialed and recredentialed through CalOptima's credentialing process. Notwithstanding Professional's Practitioners' representations in any pre-application questionnaire, in this Contract and/or in connection with any Health Network credentialing application, CalOptima reserves the right to verify any and all credentialing and recredentialing requirements and any other credentialing standards that CalOptima, in its sole judgment, deems necessary and appropriate to Professional's Practitioners' eligibility to participate in CalOptima's Programs. Professional's Practitioners' participation in CalOptima's Programs is subject to CalOptima's approval of Professional's Practitioners' credentialing application. The procedure and criteria for review of Professional Practitioners' credentials and Professional's initial and continued eligibility shall be established by CalOptima, and may be amended from time to time. This Contract may be terminated by CalOptima at any time a significant portion of Professional's Practitioners fail to meet the standards for continued eligibility to participate in CalOptima's Programs.

3.31 Downstream Entity Contracts. For any services under this Contract that are provided by a Downstream Entity subcontracted by Professional, Professional shall ensure that such Subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, and 438.6(1). Such Subcontracts shall include all language required by DHCS and CMS.

3.32 Accuracy of Provider Directory. Professional shall notify CalOptima within five (5) business days when either of the following occur:

3.32.1 The Professional is not accepting new Members.

3.32.2 If the Professional had previously not accepted new Members, the Professional is currently accepting new Members.

3.33 Whole Child Model Program Compliance. Professional shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9. For the identification of Members eligible for CCS Services, Professional shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that Member has a CCS Eligible Condition."

3.34 CCS Provider Compliance.

3.34.1 Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

3.34.2 If Professional is a CCS-Paneled Provider, Professional agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies

3.34.2.1 Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Professional shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

3.34.2.2 To ensure consistency in the provision of CCS Covered Services, Professional shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Professional shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Members' CCS Eligible Condition.

3.35 Provider Terminations. In the event that a provider, including a PCP, is terminated or leaves Professional, Professional shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Professional shall ensure that there is no disruption in services provided to the CalOptima Member.

3.36 Government Claims Act. Professional shall ensure that Professional and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et. seq.), including, but not limited to Government Code sections 910 and 915, for disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

3.37 Certification of Document and Data Submissions. All data, information, and documentation provided by Professional to CalOptima pursuant to this Contract and /or CalOptima Policies, which are specified in 42 CFR section 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Professional's letterhead signed by the Professional's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

3.38 Reports and Data. In addition to any other reporting obligations under this Contract, Professional shall submit reports and data relating to services covered under this Contract as required by CalOptima, including, without limitations, to comply with requests from Government Agencies to CalOptima. CalOptima shall reimburse Professional for reasonable costs for producing and delivering such reports and data."

ARTICLE 4
FUNCTIONS AND DUTIES OF CALOPTIMA

4.1 Payment. CalOptima shall pay Professional for the provision of Covered Services provided to CalOptima Members according to the terms of this Contact and CalOptima authorization guidelines. Professional agrees to accept the compensation set forth in Attachment B as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim, CalOptima shall pay Professional pursuant to CalOptima Policies and Attachment B. Notwithstanding the foregoing, Professional may also collect other amounts (e.g., co-payments, deductibles, OHC and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law.

4.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to Policies and the Provider Manual.

4.3 CalOptima Guidance. CalOptima shall make available to Professional, all applicable Provider Manuals, financial bulletins and CalOptima Policies applicable to Covered Services under this Contract.

4.4 Limitations of CalOptima's Payment Obligations. Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Professional any amounts shall be subject to CalOptima's receipt of the funding from the Federal and/or State governments.

4.5 Identification Cards. CalOptima shall provide Members with identification cards identifying Members as being enrolled in a CalOptima program.

4.6 Care Management Services. CalOptima shall offer its assistance for Care Management Services for Members through its Care Management Department.

4.7 Pediatric Preventive Services (CHDP) Notifications. CalOptima shall be responsible for notifying Members of Pediatric Preventive Service (CHDP) screening requirements based on the schedule established by the AAP.

4.8 Approved Drug List. CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

4.9 Review Of Prescriptions Not On Approved Drug List. CalOptima shall review prescriptions for medications not listed on the Approved Drug List in a timely manner.

4.10 Member Materials. CalOptima shall furnish Professional written materials to provide to Members, as appropriate.

4.11 Communication Channels. CalOptima will assign a CalOptima representative to serve as Professional's primary contact with CalOptima. The CalOptima representative will coordinate contracting, education/training, and along with facilitating communication between CalOptima and Professional will provide assistance with terms, conditions, and Policies related to this Contract.

4.12 Training and Education. CalOptima agrees to provide Participating Provider education, training and orientation in accordance with DHCS and CMS requirements.

4.13 Proposition 56 Supplemental Payments. CalOptima shall administer the Medi-Cal Provider Special Supplemental Payment Program, funded by Proposition 56 funds, in accordance with Attachment B-1 to the Contract, attached hereto and incorporated herein by this reference.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other, and the Government Agencies harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims

or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Professional Liability. Professional, at its sole cost and expense, shall ensure that Practitioners providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Professional provides. For Physician insurance, minimums shall be no less than $1,000,000 per incident/$3,000,000 aggregate per year.

5.3 Commercial General Liability/Commercial Automobile Liability. Professional at its sole cost and expense shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability: $1,000,000 per occurrence/$3,000,000 aggregate

Commercial Automobile Liability: $1,000,000 Combined Single Limit.

5.4 Workers' Compensation. Professional at its sole cost and expense shall maintain Workers' Compensation Insurance policy with minimum limits as follows:

Employers' Liability Insurance: $1,000,000 Bodily Injury by Accident – each accident

$1,000,000 Bodily Injury by Disease – policy limit

$1,000,000 Bodily Injury by Disease – each employee.

5.5 Insurer Ratings. All above insurance shall be provided by an insurer:

5.5.1 rated by Best's with a rating of B or better; and

5.5.2 "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.6 Captive Risk Retention Group/Self Insured. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.7 Cancellation or Material Change. Insurance required in this Article shall not be canceled or materially changed during the term of this Contract.

5.8 Certificates of Insurance. Prior to execution of this Contract, Professional shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further, to the extent that no expenditure by Professional is required, providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and that coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1 Disclosure of Records. Professional and its Subcontractors agree to maintain and make available contracts, books, documents, records, electronic systems, including, Medical Records, (collectively, the "records") to CalOptima, the U.S. Department of Health and Human Services ("HHS"), CMS, the Comptroller General, the U.S. Government Accountability Office ("GAO"), any Quality Improvement Organization ("QIO") or Accrediting Organizations, including NCQA, their designees, and other representatives of regulatory or Accrediting Organizations, for inspection, evaluation and auditing. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and the regulatory and other officials referred to above, shall have access to, and copies of,

at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Members, the cost of such services, and payments received by the Provider from Members (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract, or from the completion of any audit, whichever is later.

6.2 Medical Records. Professional shall establish and maintain for each Member who has obtained Covered Services, Medical Records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such Medical Records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Professional. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Professional, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

6.3 Records Retention. Professional shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Professional furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.4 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours, and shall be subject to Federal and State laws concerning confidentially and ownership of records. Professional shall pay all duplication and mailing costs associated with such audits.

6.5 Confidentiality of Member Information. Professional, its Practitioners, and Downstream Entities agree to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information, including, but not limited to the following:

6.5.1 Health Insurance Portability and Accountability Act (HIPAA). Professional shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Professional shall comply with HIPAA requirements as currently established in CalOptima Policies. Professional shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.5.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Professional shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.5.3 Declaration of Confidentiality. If Professional and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Professional and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC and/or CMS, as applicable.

6.6 Member Request For Medical Records. Professional shall furnish a copy of a Member's Medical Records to another treating or consulting Practitioner at no cost to the Member when such a transfer of records:

6.6.1 Facilitates the continuity of that Member's care; or

6.6.2 A Member is transferring from one Provider to another for treatment; or

6.6.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition; or

6.6.4 A Member's records are needed to access Medi-Cal covered services not included in this Contract, including, but not limited to mental health programs (such as Department of Developmental Services), California Children Services, and Local Educational Agency "LEA"; or

6.6.5 A Member's records are needed to access Medicare covered services not included in this Contract, including, but not limited to hospice care.

ARTICLE 7
TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date through June 30, 2020. This Contract shall then automatically extend for additional one-year-terms (July 1st through June 30th) upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract."

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Professional (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Professional prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this Article are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Professional shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Professional.

7.3 Professional's Appeal Rights. Professional may appeal CalOptima's decision to terminate the Contract for default as provided in Section 7.2 by filing a complaint pursuant to CalOptima Policies. Professional shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policies, and shall comply with applicable CalOptima Policies governing judicial claims, before commencing a civil action. Professional's rights and remedies provided in this Article shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

7.4 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, certification or accreditation required by Professional and/or Professional's Practitioners; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Professional or against Professional Practitioners in their capacities with the Professional by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of HHS' approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Professional.

7.5 Termination for Insolvency. If the Professional becomes insolvent, the Professional shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Professional, the

Professional shall assure that all tasks related to the Contract are performed in accordance with the terms of the Contract.

7.6 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally- approved Section 1915(b) waiver. CalOptima may also modify the Contract at any time if such a change would be in the best interest of Members. CalOptima shall notify Professional in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and Professional shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.7 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days prior written notice to the other party as provided herein.

7.8 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' Policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Professional as soon as practicable.

7.9 Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Professional shall continue to provide authorized Professional Services to Members who retain eligibility and who are under the care of Professional at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Professional shall continue to provide Professional Services to hospitalized Members or coordinate with contracted Hospitalist to provide services in accordance with generally accepted medical standards and practices until the earlier of the Member's discharge from hospital; or alternate coverage is arranged for by CalOptima.

7.9.1 Payment for any continued Covered Services provided to Members shall be paid as follows:

a) Medi-Cal eligible beneficiaries as described in this Section shall be paid at the same amount paid by DHCS for the same services rendered to beneficiaries in the Medi-Cal FFS program.

b) PACE program beneficiaries as described in this Section shall be paid at the lesser of the Medicare fee schedule or the contracted rates set forth in the respective CalOptima' Program's Attachment B.

c) Cal MediConnect program beneficiaries as described in this Section shall be paid at the Medicare rate for services covered under the Medicare benefit. Services for benefits not covered by Medicare but covered under Medi-Cal, the Medi-Cal rate as stated in the above paragraph "a" shall apply.

7.9.2 Prior to the termination or expiration of this Contract and upon request by CalOptima or one of its Government Agencies to assist in the orderly transfer of Members' medical care, Professional shall make available to CalOptima and/or such Government Agency, copies of any pertinent information, including information maintained by Professional necessary for efficient case management of Members. Costs of reproduction shall be borne by CalOptima or the Government Agency, as applicable. For purposes of this section only, "under the care of Professional" shall mean that a Member has an authorization from CalOptima to receive services from the Professional issued prior to the Termination, all of the services authorized under that authorization have not yet been completed, and the time period covered by the authorization has not yet expired.

7.10 Approval by and Notice to Government Agencies. Professional acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Professional shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention

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of the State or Federal contracting officer for the pertinent CalOptima Program. Professional acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

7.10.1 Professional shall not furnish services under CalOptima's Cal MediConnect program unless and until CalOptima is authorized by DHCS and CMS to proceed with such program and CalOptima provides written notice to Professional of the commencement date of such services.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 Grievances. CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider, including Professional, shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Professional complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Professional agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

ARTICLE 9
MISCELLANEOUS GENERAL PROVISIONS

9.1 Assignment and Assumption. Professional acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Professional have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Professional, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Professional, (c) the merger, reorganization, or consolidation of Professional with another entity with respect to which Professional is not the surviving entity, and/or (d) a change in the management of Professional from management by persons appointed, elected or otherwise selected by the governing body of Professional (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Professional and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including, but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Professional shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such proceeding shall be brought in the Central District Court of California.

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

9.6 Independent Contractor Relationship. CalOptima and Professional agree that the Professional, in performance of this Contract, shall act in an independent capacity and not as officers or employees of CalOptima. Professional's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Professional's personnel performing services under this Contract shall be at all times under Professional's exclusive direction and control and shall be employees or Participating Providers of Professional and not employees of CalOptima. Professional shall pay all wages, salaries and other amounts due its employees and Participating Providers in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Professional hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability thereof.

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Priority, Certified or Registered mail, return receipt requested, postage prepaid, addressed to the party to whom Notice is to be given, at such party' address set forth below or such other address provided by Notice. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Professional:

NR Medical Associates
Name

Title

12865 Main St, Ste 105
Address

Garden Grove, CA 92840

9.10 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

9.11 Prohibited Interests. Professional covenants that, except as provided by law, for the term of this Contract, no director, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof.

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

9.15 Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Professional 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.

9.16 Lobbying Restrictions and Disclosure Certification. Professional shall complete and submit the lobbying disclosure form required by federal law, when applicable, as set forth in Addendum 4.

9.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

9.16.2 Certification and Disclosure Requirements

9.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Addendum 4, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 9.16.3 of this provision.

9.16.2.2 Each recipient shall file a disclosure (in the form set forth in Addendum 4, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 9.16.3 of this provision if paid for with appropriated funds.

9.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 9.16.2.2 herein. An event that materially affects the accuracy of the information reported includes:

9.16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

9.16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

9.16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

9.16.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 9.16.2.1 of this provision a contract, subcontract, grant or

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

9.16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 19.16.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

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

9.17 Debarment Certification. Professional 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.

9.17.1 Professional certifies to the best of its knowledge and belief, that it and its principals:

(i) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

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

(iii) are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in sub-provision (ii) herein;

(iv) 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;

(v) 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

(vi) 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.

9.17.2 If Professional is unable to certify to any of the statements in this certification, the Professional shall submit an explanation to CalOptima.

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

9.17.4 If Professional knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

ARTICLE 10
EXECUTION

Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts, and the approval

of this Contract by the Government Agencies, this Contract shall become effective on the first day of the first month following execution of this Contract by both parties, (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

Professional	CalOptima
Signature	Signature
Tony Tan Nguyen, MD	Ladan Khamseh
Print Name	Print Name
Chief Executive Officer	Chief Operating Officer
Title	Title
12/20/19	12/24/19
Date	Date
1609839299	
NPI# - Type 1	
1649601113	
NPI# - Type 2 (If Applicable)	

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ATTACHMENT A

CONTRACTED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS AND SERVICES

1.1 CalOptima Program. Professional shall furnish Covered Services to eligible Members in the following CalOptima Programs:

__X__ OneCare Connect Cal MediConnect Plan (Medicare – Medicaid Plan)

__X__ Medi-Cal Program (Community Network and COD-Administrative)

__X__ PACE Program (Program of All-Inclusive Care for the Elderly)

1.2 Physician Services. Professional shall furnish:

__X__ Primary Care Provider Covered Services to eligible Members in the CalOptima program, who are assigned to Professional.

- PCP Services
- Long Term Care (LTC PCP) Services
- PACE PCP Services

__X__ Specialist Provider Covered Services to eligible Members in the CalOptima program, who are referred to Professional in accordance with CalOptima referral Policies.

- Specialist Services
- Hospitalist Services
- SNFist & Palliative Care Services

ARTICLE 2
GENERAL RESPONSIBILITIES

In addition to the CalOptima Provider Manual, the following general responsibility shall apply. Refer to the Provider Manual for specific program instructions and guidelines.

2.1 Physician Services. Physician Services for CalOptima Members are those Covered Services set forth in the CalOptima Program in which the Member is assigned.

Services include, but are not limited to, health promotion, disease prevention, health maintenance, counseling, patient education, and the diagnosis and treatment of acute and chronic illness, and that are: (a) included as covered services under the applicable Government Contract, (b) within Professional's normal scope of practice, and (c) Medically Necessary.

2.1.1 The actual provision of any Physician Service is subject to CalOptima's Utilization Management Policies and Procedures and the Medical Necessity of the service. Professional shall provide assessment and evaluation services ordered by a court or legal mandate.

2.1.2 Decisions concerning whether to provide or authorize covered Physician Services shall be based solely on Medical Necessity. Disputes between the Professional and Members about Medical Necessity can be appealed pursuant to CalOptima Policies.

2.2 Days to Appointment. Professional shall ensure that appointments for non-Emergency or non-Urgent Care Covered Services are scheduled within ten (10) business days for Primary Care Provider and fifteen (15) business days for Specialist Physician of a Member's request; that health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) calendar days of Member's request for an appointment, and that, if Professional supplies maternity Covered Services, Physician Group shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure

of quality for perinatal services. Professional shall also have a process in place for follow-up on Member missed appointments.

2.3 Office Waiting Times. Professional shall ensure that office wait times will be kept to a maximum of forty-five (45) minutes.

2.4 Health Education and Prevention. Professional shall provide Members with health education during office visits in accordance with CalOptima Policies. Professional shall also refer Members to CalOptima's health education referral line for classes provided to Members.

2.5 Coordination and Continuation of Care. Referrals for Medically Necessary specialty Covered Services must follow CalOptima Policies and Provider Manual for Prior Authorization. All Prior Authorizations shall be made through CalOptima's Utilization Management Department. Professional agrees to refer Members to other Participating Providers in all circumstances except when an authorization has been granted in advance by CalOptima to refer to a Non-Participating Provider, or when necessary due to an Emergency Medical Condition.

2.6 Approved Drug List Compliance. Professional shall comply with the CalOptima Approved Drug List and its associated drug utilization or disease management guidelines and protocols. Medications not included on the Approved Drug List shall require Prior Authorization by CalOptima. The prescribing Physician must obtain authorization in accordance with CalOptima's Policies. The prescribing Physician shall provide CalOptima with all information necessary to process Prior Authorization requests.

2.6.1 Professional shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

2.6.2 Professional shall participate in any CalOptima pharmacy cost containment programs as developed.

2.6.3 Professional shall provide all information requested by CalOptima, including, but not limited to Medical Necessity documentation, which pertains to a Member's condition and drug therapy regimen, untoward effects or allergic reactions.

2.7 Obstetrical Services for Medi-Cal Members. If Professional provides obstetrical services, Professional is required to complete the program specific CalOptima Pregnancy Notification Report (PNR) for all pregnant CalOptima Members. PNRs must be received by CalOptima within five (5) days following initiation of obstetrical-related services.

2.8 Referrals. Professional shall refer Members to Participating Providers in accordance with CalOptima referral Policies.

2.9 Professional shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member's medical needs, initiating referrals of Members for specific Covered Services to Participating Providers, monitoring progress of Members' care and coordinating utilization of services to facilitate the return of Member's care to their assigned PCP as soon as medically appropriate.

2.10 Professional shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Professional shall ensure that Members with disabilities have access to effective communication methods when making health care decisions, and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

2.11 Professional shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including, but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic Prior Authorization transactions in accordance with CalOptima Policy and Procedure.

2.12 PCP should be informed of the progress of a referred Member's care. Professional shall forward the results of diagnostic procedures and consultations to Member's assigned PCP in a timely manner in order to ensure that the Member's care is efficiently coordinated and that the responsibility for care is returned to PCP as soon as medically appropriate.

2.13 Additional Responsibilities of Primary Care Provider for Medi-Cal Members

2.13.1 PCP shall be responsible for coordinating care of certain services including:

a) PCP shall document all Pediatric Preventive Services (CHDP) on the CMS-1500, UB-04 claim form, or electronic equivalent. PCP shall submit the CMS-1500, UB-04 claim form, or electronic equivalent to CalOptima within thirty (30) calendar days following the month of service.

b) PCP providing Pediatric Preventive Services agrees to coordinate with the Orange County CHDP Program.

c) PCP shall comply with CalOptima's Policies and for periodicity and content of pediatric health assessments.

d) PCP shall make referrals to the Women, Infants and Children Food Supplementation Program ("WIC") in accordance with WIC program Policies and Procedures.

e) PCP shall make referrals to the Regional Center of Orange County when appropriate.

f) PCP shall refer all Members between the ages of three (3) and twenty-one (21) to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment.

g) PCP may provide Outpatient Mental Health Services within the scope of his/her practice. PCP shall refer Members with mild to moderate impairment in functioning requiring mental health Covered service beyond or outside the scope of PCP's practice to CalOptima for referral to CalOptima's contracted mental health specialists. PCP shall refer Members with significant impairment in functioning and Members requiring emergency or inpatient mental health care, to the Orange County Health Care Agency (HCA) or other agency as appropriate.

h) PCP shall refer Members requiring alcohol and drug treatment to CalOptima for referral to Short-Doyle Medi-Cal alcohol and drug treatment programs.

i) PCP shall refer all Members in the Seniors and Persons with Disability (SPD) aid codes, which is the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal covered services, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system to CalOptima.

2.13.2 Appointment Pediatric Preventive Covered Services. Primary Care Provider shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule. Immunizations are to be provided according to the latest guidelines published by the AAP and Advisory Committee on Immunization Practices (ACIP). If there is a conflict in the recommendations, the higher standard will be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

2.13.3 Alcohol and Substance Use Disorder Treatment Services. Physician shall ensure the SBIRT services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond SBIRT. Physician shall document SBIRT services in Members Medical Record.

2.14 Professional shall also provide services to COD-Administrative Members under this Contract. The scope of such services shall be as defined in the CalOptima Medi-Cal Provider Manual and CalOptima Policy, rather than as set forth in Article 2 of this Attachment A.

2.15 Health Risk Assessments (HRAs) - Professional will be required to complete HRAs in accordance with each of CalOptima Programs requirements and CalOptima Policy.

2.16 Professional shall comply with CalOptima's Model of Care specified for each of CalOptima programs.

2.17 Professional shall cooperate and coordinate Mental Health and Behavioral Health in accordance with

each of CalOptima's Programs and CalOptima Policy.

2.18 Professional shall cooperate with CalOptima's Personal Care Coordinator or "PCC" in accordance with CalOptima's PCC Program Policies and guidance.

2.19 Professional shall participate with CalOptima's Interdisciplinary Care Team "ICT" and contribute to the Individualized Care Plan or "ICP" in accordance with CalOptima's Program guidelines, Policies and Procedures.

2.20 Initial Health Assessment Appointment. If Professional is a Member's Primary Care Provider, Professional shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment and development of care plans as appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under twenty-one (21) years of age and include annual dental referrals made with the eruption of the child's first tooth or at twelve (12) months of age, whichever occurs first. Professional shall ensure that Members are referred to appropriate Medi-Cal dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. Professional's failure to perform at or in excess of minimum performance requirements shall subject Professional to sanctions in accordance with this Contract and CalOptima Policies. Physician shall ensure that health assessment information shall be recorded in the Member's Medical Record.

ARTICLE 3
LONG-TERM CARE (PCP) SERVICES

3.1 Definitions

3.1.1 "Long-Term Care (LTC) Program Member" shall mean a CalOptima Cal MediConnect Member who resides in a Long-Term Care Facility and chooses to be part of CalOptima's Long-Term Care Program.

3.1.2 "LTC PCP" shall mean a CalOptima Cal MediConnect Primary Care Provider (PCP) who has agreed to provide PCP services to Cal MediConnect Members residing in Long-Term Care facilities, in accordance with the requirements outlined in this Article 3 and in CalOptima Policy. For purposes of this Article 3, the LTC PCP shall also mean "Professional".

3.1.3 "Treat-in-Place" shall mean the ability to treat LTC Program Members at the LTC/Skilled Nursing Facility where the Member resides, at a higher intensity level for Members who may otherwise be hospitalized upon an acute change in condition. Requires LTC PCP to be available twenty-four (24) hours a day, three hundred and sixty-five (365) days a year to direct and/or render services to LTC Members.

3.2 LTC PCP serving LTC Members shall meet the following qualifications throughout its participation in LTC Program.

3.2.1 LTC PCP to be available 24/7/365 to provide Treat-in-Place services at the LTC Member's resident facility

3.2.2 LTC PCP is able to visit Members residing in LTC facilities with enough frequency to meet the goals of the Member's Care Plan. LTC PCP can meet this need through the use

of non-physician practitioners appropriately trained to meet the Member's then-current needs, such as geriatric nurse practitioners, registered nurses, or licensed clinical social workers.

3.3 In addition to the PCP services identified in Article 2 of this Attachment A as applicable, LTC PCP serving LTC Program Members shall provide PCP services to Members in the LTC Program, as follows:

3.3.1 LTC PCP must provide a minimum of three (3) visits by LTC PCP and/or the non-physician practitioners appropriately trained to meet the member's then current needs, such as geriatric nurse practitioners, registered nurses, or licensed clinical social workers during the first month Member is assigned to LTC PCP.

3.3.2 For established Members, LTC PCP shall visit assigned Members on a weekly or bi-weekly basis depending on Member need. Within fifteen (15) days of Member enrollment, LTC PCP will receive the assigned LTC Program Member's completed Health Risk Assessment (HRA), initial care plan and a claims-based medication review. Within thirty (30) days of enrollment, LTC PCP will review the HRA with Member and establish care goals. LTC PCP must annotate and sign the attestation of the initial care plan and return plan to CalOptima within forty-five (45) days of receipt of HRA.

3.3.3 LTC PCP shall participate on Inter-disciplinary Care Team (ICT) meetings annually and/or as needed at the Member's resident facility for each LTC Member assigned to LTC PCP.

3.3.4 LTC PCP shall coordinate care with Hospitalist treating Member in the acute care setting as applicable

3.3.5 LTC PCP shall initiate Treat-in-Place when appropriate. LTC PCP is required to have coverage by licensed personnel twenty-four (24) hours a day, three hundred sixty five (365) days a year to provide verbal communication and medical orders to treat a LTC Program Member in their long term care facility when a higher level of care is required. Both LTC PCP and facility must be equipped to provide timely services as clinically indicated.

3.3.6 LTC PCP shall comply with CalOptima's OneCare Connect Model of Care.

3.3.7 LTC PCP shall, as appropriate, discuss Palliative Care as an option with a Member when discussing treatment options.

3.3.8 In addition to the above, LTC PCP shall provide the following care management services to LTC PCP's assigned Members. LTC PCP will:

3.3.8.1 Complete an admission assessment;

3.3.8.2 Manage LTC Program Member referral to emergency services/acute care facilities as appropriate and communicate all pertinent information to the facility Emergency Department and/or Emergency Physician;

3.3.8.3 Review appropriateness in level of care (skilled vs. custodial), and complete all documentation requirements and updates.

3.3.8.4 Initiate communication with and inform family members of Member's condition and treatment plan, to the extent authorized by the Member in accordance with CalOptima Policy.

3.4 LTC PCP Provider Incentive Program.
To the extent that the LTC PCP produces savings over the traditional model of providing care to Cal MediConnect Members in LTC facilities, CalOptima may develop and implement a Provider Incentive Program for LTC PCPs based on the provider meeting quality performance standards, and

in compliance with all the applicable state and federal laws and contractual requirements.

ARTICLE 4
PACE PRIMARY CARE SERVICES (NON LTC)

4.1 PACE PCP Services. PCP Services for PACE Participants are those Covered Services set forth for PACE, which include, but are not limited to, health promotion, disease prevention, health maintenance, counseling, patient education, referrals to appropriate medical specialists, and the diagnosis and treatment of acute and chronic illness, and that are: (a) included as covered services under the applicable Government Contract, (b) within the PACE PCP's normal scope of practice, and (c) Medically Necessary.

4.1.1 The actual provision of any PCP Service is subject to CalOptima's Policies and Procedures and the Medical Necessity of the service. PACE PCPs may also be required to provide assessment or evaluations services ordered by a court, or otherwise required by law.

4.1.2 Decisions concerning whether to provide or authorize covered Services shall be based solely on Medical Necessity. Disputes between a PACE PCP and Participants about Medical Necessity can be appealed pursuant to CalOptima Policies.

4.2 Health Education and Prevention. PACE PCPs shall provide Participants with comprehensive history and physicals on new referrals. Provide health education during office visits in accordance with CalOptima Policies. Perform interval history and physicals on established participants, completed quarterly or as indicated.

4.3 Coordination and Continuation of Care. PACE PCPs shall participate as a member of the PACE Interdisciplinary Team (IDT) to facilitate the ongoing care of the PACE Participants.

4.3.1 Coordinate the care being delivered to participants when they are in the E.R. setting and Inpatient hospital setting in coordination with the hospitalist. (a) Communicate with the attending regularly; (b) Provide updates to the IDT on a regular basis; (c) Judiciously utilize specialty consultants; (d) Coordinate discharge planning with the hospitalist and IDT.

4.3.2 Oversee and coordinate the care being delivered to participants when they are in a skilled Nursing Facility. (a) Communicate with the attending regularly; (b) Perform telephone contacts with nursing home staff as required; (c) Judiciously utilize specialty consultants; (d) Coordinate discharge planning with the SNF attending and IDT.

4.3.3 Provide care for participants in their home as needed.

4.3.4 Actively participate in family conferences regarding care planning and implementation.

4.3.5 Coordinate 24-hour care delivery.

4.3.6 Document participant changes appropriately in the medical records and communicate participant changes to IDT in a timely manner.

4.4 Approved Drug List Compliance. Professional shall comply with the CalOptima Approved Drug List and its associated drug utilization or disease management guidelines and protocols.

4.5 Quality and Performance Improvement. PACE PCPs shall:

4.5.1 Cooperate and participate, as appropriate, with the CalOptima organization-wide Quality Assessment Performance Improvement ("QAPI") Plan and quality assurance committees as they pertain to the PACE program.

4.5.2 Participate in work groups, as assigned.

4.5.3 Provide input to the PACE administration and PACE Quality Assurance Department to evaluate and review risk management, compliance, and quality concerns for the PACE program.

4.5.4 Maintain updated knowledge and understanding of all applicable government health regulations and licensure requirements that impact clinical service delivery for the PACE program.

4.5.5 Maintain updated knowledge and understanding of all PACE Policies.

4.5.6 Troubleshoot and resolve Participant complaints or problems related to clinical service delivery in the PACE program.

4.5.7 Participate in IDT meetings, as necessary.

4.5.8 Uphold the CalOptima PACE participants rights.

4.6 PACE PCPs shall participate, as appropriate, with orientation and training programs of clinical staff and support personnel.

4.7 PACE PCPs shall oversee and be responsible for the provision of services provided by Non-Physician Medical Practitioners.

4.8 PACE PCPs shall also carry out other duties, as reasonably requested within the scope of the PCP Services.

4.9 Professional shall possess the ability to effectively interact with a wide range of health care and social services staff, working together as an interdisciplinary team.

4.10 Experience & Education

4.10.1 Valid MD license, in good standing, to practice medicine in the State of California.

4.10.2 Graduate of an accredited School of Medicine.

4.10.3 Minimum of five years clinical experience or completion of a geriatric medicine fellowship are preferred.

4.11 Knowledge of:

4.11.1 Geriatric medicine; special needs of complex geriatric patients.

4.11.2 The PACE model of care.

4.11.3 Industry and professional standards of health care, utilization management, quality improvement and other medical management functions.

4.11.4 Culture and needs of the socially and ethnically diverse population CalOptima serves.

4.11.5 Principles and practices of healthcare administration.

ARTICLE 5
HOSPITALIST SERVICES

In addition to the CalOptima Provider Manual, the following general responsibility shall apply. Refer to the Provider Manual for specific program instructions and guidelines.

5.1 Professional shall be responsible for providing all Hospitalist Services within his or her scope of practice for Members receiving inpatient care at those facilities identified in Article 3 of this Attachment A ("Covered Facilities").

5.2 Throughout the duration of this Contract, Professional Providers shall maintain clinical privileges in good standing and without restriction at each of the Covered Facilities, authorizing Professional Providers to supply the hospitalist services detailed herein. Professional shall notify CalOptima immediately if said privileges are revoked, suspended, or otherwise restricted.

5.3 All Hospitalist Covered Services shall be provided in accordance with CalOptima policies. Covered Hospitalist Services include, but are not limited to, the following:

5.3.1 Admission of Members as medical and surgical patients to Covered Facilities. Provision of prompt medical assessment of Members in emergency departments as called, and effectuation of a disposition of each Member to the medically appropriate level of care, including transfer of a Member from facility inpatient to an appropriate skilled nursing facility.

5.3.2 Coordination of the provision of Covered Services, including internal medicine and critical care medical services, and all procedures and sub-specialist consultations in Covered Facilities.

5.3.3 Provision of medical coordination and utilization management of inpatient medical transfers for Members.

5.3.4 In conjunction with the CalOptima Utilization Management Department, coordinate all inpatient ancillary and post-hospital services related to the inpatient episode of care, including durable medical equipment, home health and infusion services, etc.

5.3.5 Medical coordination of discharge planning needs with Members, Members' families and their case managers/discharge planners.

5.3.6 Provision of written feedback to the primary care physician, as required, including a discharge summary within 24 hours of discharge.

5.3.7 Provision of a post-admission telephone follow-up call to all PCPs within twenty-four hours (24 hrs).

5.3.8 Response to the CalOptima Medical Director or designee as soon as possible regarding patient management.

5.3.9 Response to calls from ER Department within thirty (30) minutes.

5.3.10 Response to PCP as soon as possible regarding direct admits from PCP office.

5.3.11 Management of the efficient continuity of care from one level to another through the proactive identification and elimination of potential obstructions and delays to coordination of care with the Covered Facilities and CalOptima.

5.3.12 Performance of telephonic consultations with emergency department physicians of Covered Facilities for Members.

5.3.13 Management of pharmacy utilization, including use of formulary drugs during admission and on discharge.

5.4 Consistent with CalOptima policies, Hospitalist Case Management Services shall include, but are

not limited to, the following:

5.4.1 Ensure timely communication with CalOptima Concurrent review staff to:

5.4.1.1 Provide information on new admissions;

5.4.1.2 Provide an up-to-date hospital census;

5.4.1.3 Provide clinical review of the Members and their treatment plans to ensure compliance with evidence-based criteria for hospital stay;

5.4.1.4 Meet with the CalOptima concurrent review staff daily to review all Members on hospital census;

5.4.1.5 Identify for CalOptima Concurrent review staff ancillary services required by Member at different levels of care, up to and including home care;

5.4.1.6 Serve as a liaison for communication between all members of the patient care team; and

5.4.1.7 Coordinate with CalOptima Concurrent review staff on the Initiation coordination of dialogue with all new patients, family and provide education on discharge planning and post discharge care.

5.4.2 For new patient admissions, contact PCP and obtains history, medications, referrals and previous work-up information.

5.4.3 Initiate action plans for Members preparing for discharge, resolve Member issues, and ensures that clinical information is available to expedite decision-making

5.4.4 Proactively follow-up on physician orders.

5.4.5 Participate in applicable CalOptima utilization and quality management activities, including audits and timely reporting of quality concerns to CalOptima's Utilization Management program.

5.4.6 Identify and prevent potential delays in care.

5.4.7 Perform administrative and communication tasks required to expedite patient care.

5.5 Facilities covered by this contract. All PACE Servicing Hospitals.

ARTICLE 6
SNFIST AND PALLIATIVE CARE SERVICES

In addition to the CalOptima Provider Manual, the following general responsibility shall apply. Refer to the Provider Manual for specific program instructions and guidelines.

6.1 Post acute SNF rounding services: Professional will provide Practitioner coverage to identified SNFs as follows:

6.1.1 Cover Skilled Nursing Facility

6.1.1.1 Ensure patients receive the appropriate level of care by:

6.1.1.1.1 Providing a system to assure that Provider visits are appropriate to the patients' needs and comply with regulatory guidelines.

6.1.1.1.2 Providing 24 hours a day/7 days a week telephone triage and case management in coordination with the PACE Center.

6.1.2 Perform all functions associated with the care management of patients in the Post Acute/Skilled Nursing setting. These include:

6.1.2.1 Completing an admission assessment.

6.1.2.2 Managing SNF patient re-hospitalization to ensure appropriateness and quality of life considerations.

6.1.2.3 Formulating and implementing a treatment plan and concurrently initiating discharge planning in conjunction with PACE.

6.1.2.4 Coordinating and facilitating utilization management with PACE.

6.1.2.5 Adhere to the communication requirements established by PACE.

6.1.2.6 Review appropriateness in level of care (skilled vs. custodial), length of stay and bed days.

6.1.2.7 Coordinate ancillary services such as pharmacy, rehab, lab/x-ray.

6.1.2.8 Coordinate appropriate us of specialty consults and referrals.

6.1.2.9 Initiating communication with and informing family members of patient condition and treatment plan and involving the family in the discharge planning process.

6.1.2.10 Reviewing and discussing patient treatment plan and conditions with the utilization management team at CalOptima.

6.1.2.11 Managing the ordering, timely completion and reporting of all patient studies, tests and procedures during the course of post acute stay.

6.1.2.12 Provide PACE a copy of the written discharge instructions.

6.1.3 Document quality/performance in achieving the stated objectives by:

6.1.3.1 Providing PACE quarterly trended quality/ performance reports measuring:

6.1.3.1.1 Effectiveness of care – discharge reports on patients

6.1.3.1.2 Efficiency of care – utilization and cost performance (as agreed upon with PACE)

6.1.3.1.3 Perception of care – satisfaction survey

6.1.3.1.4 Conducting monthly performance review and analysis (as agreed upon with PACE)

6.2 Health Education and Prevention. Professional shall provide Members with health education during office visits in accordance with CalOptima Policies. Professional shall also refer Members to CalOptima's health education referral line for classes provided to Members.

6.3 Coordination and Continuation of Care. Referrals for Medically Necessary specialty Covered Services, must follow CalOptima Policies and Provider Manual for Prior Authorization. All Prior Authorizations shall be made through CalOptima's Utilization Management Department. Professional agrees to refer Members to other Participating Providers in all circumstances except when an authorization has been granted in advance by CalOptima to refer to a Non-Participating Provider, or when necessary due to an Emergency Medical Condition.

6.4 Approved Drug List Compliance. Professional shall comply with the CalOptima Approved Drug List and its associated drug utilization or disease management guidelines and protocols. Medications not included on the Approved Drug List shall require Prior Authorization by CalOptima. The prescribing Physician must obtain authorization in accordance with CalOptima's Policies. The prescribing Physician shall provide CalOptima with all information necessary to process Prior Authorization requests.

6.4.1 Professional shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

6.4.2 Professional shall participate in any CalOptima pharmacy cost containment programs as developed.

6.4.3 Professional shall provide all information requested by CalOptima, including, but not limited to Medical Necessity documentation, which pertains to a Member's condition and drug therapy regimen, untoward effects or allergic reactions.

6.5 Referrals. Professional shall refer Members to Participating Providers in accordance with CalOptima referral Policies.

6.6 Professional shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member's medical needs, initiating referrals of Members for specific Covered Services to Participating Providers, monitoring progress of Members' care and coordinating utilization of services to facilitate the return of Member's care to their assigned PCP as soon as medically appropriate.

6.7 Professional shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Professional shall ensure that Members with disabilities have access to effective communication methods when making health care decisions, and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

6.8 Professional shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including, but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic Prior Authorization transactions in accordance with CalOptima Policy and Procedure.

ATTACHMENT B

COMPENSATION

CalOptima shall reimburse Professional and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. MEDI-CAL PROGRAM

A. Primary Care Services

For Covered Services provided to Assigned COD-Administrative and Community Network Members, or as otherwise noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

    1.1. **129%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **primary care**, as defined in CalOptima Policies.

    1.2. **100%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **non professional services**, as defined in CalOptima Policies.

    1.3. NOT APPLICABLE TO THIS CONTRACT

2. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

    2.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **forty percent (40%)** of billed charges and must follow Medi-Cal billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

    2.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

    2.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

    2.4. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

3. Supplemental Pay-for-Performance Payment. CalOptima may authorize supplemental payments to PCP yearly or quarterly based on PCP's quality performance and achievement of specified program goals which are determined by CalOptima. The amount of supplemental compensation may be a certain percentage of Community Network's annual fee-for-service payments made to the PCP. CalOptima shall not pay PCP any supplemental payments if this Contract is terminated.

B. Specialist Services

For Covered Services provided to referred Community Network Members in accordance with CalOptima referral Policies, and as to COD Administrative Members as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

    1.1. **Specialist Professional** services shall be paid at **133%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for, as defined in the CalOptima Policies.

    1.2. NOT APPLICABLE TO THIS CONTRACT

1.3. **Non Professional** services shall be paid at **100%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

1.4. NOT APPLICABLE TO THIS CONTRACT

1.5. For **Professional services** provided by a qualifying **CCS paneled Specialist Professional** to a Community Network or COD-Administrative Member less than 21 years of age, CalOptima shall pay Professional **140%** of the **Current Medi-Cal Fee Schedule**, as defined in CalOptima Policy, for services for which CalOptima is financially responsible. **Non Professional** services shall be paid at **100%** of the **Current Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

1.6. For Specialist Physician Services provided to an **Adult Expansion Member** in accordance with CalOptima Policies, and as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges, or

CPT Code Range	Type of Service	Fee Schedule
10000-69999	**Surgical Range**	**156% of Medi-Cal**
70000-79999	**Radiology and Radiation Therapy Professional and Technical Components**	**100% of Medi-Cal**
80000-89999	**Lab and Pathology**	**100% of Medi-Cal**
90000-99999	**Professional Services**	**156% of Medi-Cal**
HCPC Codes		**100% of Medi-Cal**

1.6.1. Rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future payments to CalOptima, CalOptima will adjust payments made to Professional.

1.6.2. Subject to approval by the CalOptima Board of Directors, the specialist rates identified in Section 1.6 shall be extended effective **July 1, 2018**.

2. Professional shall not be paid for services provided to **Community Network Members** if Member is not referred by a Participating PCP to Professional in accordance with CalOptima referral Policies, except with regard to Emergency Services and CHDP Services, as provided in this Contract. This shall be effective upon the implementation of the Community Network program. Professional will be advised by CalOptima on the implementation date of the Community Network program.

3. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

3.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **forty percent (40%)** of billed charges and must follow Medi-Cal billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

3.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

3.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

3.4. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

II. PACE PROGRAM

A. Primary Care Services (Non LTC)

For Covered Services provided to PACE Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the following amounts.

1.1 Amount. Subject to the requirements set forth in this Attachment B, Section 1.2, below, CalOptima shall pay Professional, and Professional shall accept as payment in full from CalOptima, the following amounts:

1.1.1 For PCP Services provided by a Physician at the CalOptima PACE center, CalOptima shall pay Professional at the rate of two hundred five dollars ($205.00) per hour.

1.1.2 For PCP Services provided by a Non-Physician Medical Practitioner at the CalOptima PACE center, CalOptima shall pay Professional at the rate of one hundred thirty dollars ($130.00) per hour.

1.1.3 For PCP Services provided by a Medical Director at the CalOptima PACE center, CalOptima shall pay Professional at the rate of two hundred twenty-five dollars ($225.00) per hour.

1.1.4 For on-call services provided for PACE Participants, CalOptima shall pay Professional at a rate of forty-five thousand dollars ($45,000) per year.

1.1.5 For those PACE participants who are assigned to Professional at a clinical site other than the CalOptima PACE center, CalOptima shall pay Professional one hundred percent (100%) of current year Medicare Allowable Participating Provider Fee Schedule for locality 26.

1.1.6 For those PACE participants who are assigned to Professional at a clinical site other than the CalOptima PACE center, CalOptima shall pay Professional a monthly capitation of thirty-five dollars ($35.00) PMPM. This payment is for enhanced coordination of care which includes, but not limited to, participation in IDT and family conferences as required.

1.1.7 For those PACE participants who are assigned to Professional at a clinical site other than the CalOptima PACE center, CalOptima shall pay Professional a monthly capitation of thirty-five dollars ($35.00) PMPM. This payment is for Physicians utililzing the CalOptima PACE program's Electronic Medical Record, TruChart, for all outpatient documentation.

1.1.8 Billing Submission. Professional shall submit monthly invoices to PACE for all PCP services consisting of hourly, fee-for-service, and per member per month (pmpm) capitation for reimbursement by the fifth (5th) of every month. PACE will forward invoice and submit purchase order (PO) to Accounting for reimbursement to Professional. Professional shall mail invoices directly to the PACE Center or electronically mailed to an email address designated by the PACE Director.

CalOptima PACE Center
Attn: PACE Director
13300 Garden Grove Blvd
Garden Grove, CA 92843

1.1.9 CalOptima shall pay Professional within thirty (30) days of receipt of Professional Time Report for those services that are paid out monthly.

1.2 Reports.

1.2.1 Payment of the compensation described in this Exhibit B, Section 1.1 is conditioned on Physician's proper maintenance of monthly time reports, in the form substantially acceptable by PACE and CalOptima; Professional's timely provision of such time reports to CalOptima; and CalOptima's reasonable verification of such time reports. Professional's time reports shall be considered timely received by CalOptima if they are submitted to CalOptima within ten (10) days after the end of each month.

1.2.2 Physician shall indicate on the monthly time report the proper time allocation to the category of duties performed by Physician or Nurse Practitioner. PACE will review and approve monthly time report. CalOptima Finance department will receive approved time report from PACE and pay Professional for services.

1.2.3 Professional and CalOptima shall retain Physician's time reports for ten (10) years after the cost reporting period to which the report applies.

B. Specialist Services

1. Billed charges, or
2. **100%** of the current Medicare Allowable Participating Provider Fee Schedule for locality 26.
3. Prior authorization rules apply for payment of services.
4. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.
5. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

5.1 "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **forty percent (40%)** of billed charges and must follow Medicare billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

5.2 Professional shall utilize current payment codes and modifiers for Medicare.

5.3 CPT or HCPC codes not contained in the Medicare fee schedule at the time of service are not reimbursable.

5.4 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

6. Should Medicare consider a service as non-covered, then Medi-Cal guidelines shall be applied. Provider may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

III. CAL MEDICONNECT

For Covered Services provided to Cal MediConnect Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima the lesser of:

1. Billed charges, or **one hundred percent (100%)** of the Current Medicare Allowable Participating Provider Fee Schedule for locality 26.
2. Prior authorization rules apply for payment of services.

3. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.

4. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   4.1 "By Report & Unlisted" codes will be paid at forty percent (40%) of billed charges and must follow Medicare billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

   4.2 Professional shall utilize current payment codes and modifiers for Medicare.

   4.3 CPT or HCPCS codes not contained in the Medicare fee schedule at the time of service are not reimbursable.

   4.4 Should Medicare consider a service as non-covered, then Medi-Cal guidelines and reimbursement shall be applied in accordance to the guidelines identified in this contract. Professional may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

   4.5 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

IV. PAYMENT PROCEDURES

1. CalOptima agrees to grant Professional access to Member management information systems. Professional agrees to verify each Member's eligibility to receive Covered Services on the date of service. In addition, for PCP services, Professional must verify that CalOptima has not assigned Member receiving Covered Services from Professional to a Provider other than Professional prior to providing such services.

2. Billing and Claims Submission. Professional shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

3. Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and Procedures.

4. Claim Completion and Accuracy. Professional shall be responsible for the completion and accuracy of all Claims submitted, whether on paper forms or electronically, including claims submitted for the Professional by other parties. Use of a billing agent does not abrogate Professional's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Professional acknowledges that Professional remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

5. Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Professional notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

6. Coordination of Benefits (COB). Professional shall coordinate benefits with other programs or entitlements recognizing where Other Health Coverage (OHC) is primary coverage in accordance with CalOptima Program requirements. Professional acknowledges that Medi-Cal is the payor of last resort.

7. NOT APPLICABLE TO THIS CONTRACT

8. Crossover Claims – Dual Eligible Members. "Crossover Claims" are claims for Dual Eligible

Members where Medi-Cal is the secondary payer and Medicare or other health care coverage (OHC) is the Primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services (Refer to Welfare and Institutions Code, Section 14109.5.)

"Dual Eligible Members" are members who are eligible for both Medicare or other health care coverage (OHC) and Medi-Cal benefits.

The Medi-Cal reimbursement rates in this contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims payment CalOptima will reimburse in accordance with CalOptima Policies, and state and federal regulations.

9. Member Financial Protections. Professional shall comply with Member financial protections as follows:

9.1 Professional agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Professional for any amounts which are owed by, or are the obligation of, CalOptima.

9.2 Professional agrees to hold Member harmless and not liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Professional may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Professional will:

1) accept the plan payment as payment in full, or

2) bill the appropriate State source.

9.3 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or the Professional's insolvency, or breach of this contract by CalOptima, shall the Professional, or any of its Practitioners, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Professional may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

9.4 This provision does not prohibit Professional from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

9.5 Upon receiving notice of Professional invoicing or balance billing a Member for the difference between the Professional's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Professional or take other action as provided in this Contract.

This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between Professional and its Practitioners. Language to ensure the foregoing shall be included by Professional in all of Professional's Subcontracts.

ATTACHMENT B

EXHIBIT 1 – PACE PCP INCENTIVE PROGRAM

2018-2019 CalOptima PACE PCP Incentive Program Grid

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
QI: Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	FY	October (2018 Survey results equals 25% of score and 2019 Survey results equals 75% of score.)	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<90%	$0 PMPM	January
					>/= 90%	$1 PMPM	January
					>/= 95%	$2 PMPM	January
QI: Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	FY	October (2018 Survey results equals 25% of score and 2019 Survey results equals 75% of score.)	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 90%	$0 PMPM	January
					>/= 90%	$1 PMPM	January
					>/= 92%	$2 PMPM	January
QI: Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Falls plus Tricyclic Antidepressants or Antipsychotics	PACE participants with a history of falls will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	FY	August	TruChart Analytics and Pharmacy Utilization Report. 2016 HEDIS Quality Compass 90th percentile is <38.91%.	>/=38.91%	$0 PMPM	January
					<38.91%	$2 PMPM	
QI: Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	FY	August	TruChart Analytics and Pharmacy Utilization Report. 2016 HEDIS Quality Compass 90th percentile is <37.50%.	>/=37.50%	$0 PMPM	January
					<37.50%	$2 PMPM	
QI: Functional Status Assessment	At a minimum, all participants need a complete Functional Status Assessment every 6 months. This ensures that the services and treatment being provided reflect their current needs.	FY	August	The PACE QI Department will pull this data from TruChart Analytics.	<100%	$0 PMPM	January
					100%	$2 PMPM	January
Total Potential QI Incentive						$10	January

PACE Community PCP's will be eligible for the QI incentive based on the member months of the members assigned to them
PACE PCP incentives will be based on the member months of all member's not assigned to PACE Community PCP's.
Individual PACE PCP incentives will be calculated based on the number of hours worked at the PACE center
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.

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ATTACHMENT B

EXHIBIT 2 – PACE PCP INCENTIVE PROGRAM

2018-2019 CalOptima PACE PCP Incentive Program Grid: UM Cost Savings Sharing

Measure	Background	Time Period	Source	Metric Detail	Tier	Performance (% below Budget)	Maximum % Savings from Inpatient Budget	% of UM Savings to Cal Optima by Tier	% of UM Savings to PCPs by Tier	% of PCP UM Cost Savings Sharing Incentive to PCPs performing Clinic-Based Services	% of PCP UM Cost Savings Sharing Incentive to PCPs performing Non-Clinic Based Services (IP, ER. SNIF, Home Visits)	Cumulative % of UM Savings to Cal Optima	Cumulative % of UM Savings to PACE PCP's UM Incentive	Paid
UM; CalOptima PACE Actual Inpatient Performance	Effective clinic and non-clinic PCP care are important factors in avoiding unnecessary inpatient admissions. Non-clinc PCP care including real-time evaluations in the evenings and weekends at the participant's homes, ER's and SNF's will be important in ensuring participants gets timely, appropriate care. The structure of this program avoids any risk to the PCP.	FY 2019	Audited FY Performance	PCP receives % of the actual inpatient cost savings calculated from the audited FY financial.	Budget	100%								Nov-2019
					Tier 1	95%-100%	5%	100%	0%	N/A	N/A	100%	0%	
					Tier 2	90%-95%	10%	50%	50%	25%	75%	75%	25%	
					Tier 3	85%-90%	15%	50%	50%	20%	80%	67%	33%	
					Tier 4	80%-85%	20%	50%	50%	15%	85%	63%	38%	
					Tier 5	75%-80%	25%	50%	50%	10%	90%	60%	40%	

PACE Community PCP's will be eligible for the QI Incentive based on the member months of the members assigned to them.
PACE PCP Incentives will be based on the member months of all members not assigned to PACE Community
PCP's.
Individual PACE PCP Incentives will be calculated based on the number of hours worked at the PACE
Center

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ATTACHMENT B-1
SUPPLEMENTAL COMPENSATION
PROPOSITION 56 FUNDING

This Attachment B-1 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to Professionals for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to pay certain Prop 56 Increases to Professional, if Professional qualifies as an Eligible Contracted Provider, for rendering Qualifying Services (both as defined in this Attachment) effective July 1, 2017.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment B-1:

   1.1 "Eligible Contracted Provider" shall mean a Provider who is contracted with CalOptima to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

   1.2 "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Professional Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

   1.3 Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. CalOptima shall administer the Prop 56 Increase in accordance with the Exhibit for applicable state fiscal year included in this Attachment, federal requirements and CalOptima policies. CalOptima shall forward payment to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services at the rates established by the Proposition 56 Medi-Cal Physician Supplemental Payment Program and shall be in addition to any payment paid to the Eligible Contracted Provider under their existing contractual arrangements.

3. Any Proposition 56 funds paid to an ineligible provider or for non-qualifying services shall constitute an overpayment, which shall be recouped from provider by CalOptima.

4. CalOptima shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service, Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments made after July 1, 2018 and through July 30, 2019 and beyond if so directed by the DHCS.

5. Professional acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 Increase Payments identifies invalid payments, Professional shall return such Prop 56 Increase Payments to CalOptima immediately upon notice from CalOptima.

6. As long as the State of California extends the Prop 56 Increase payments to CalOptima, CalOptima will continue to make Prop 56 Increase payments to Professional which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

Attachment B-1, Exhibit 1
SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018)

CalOptima shall make payments to Eligible Contracted Providers based on Dates of Service referenced in this Attachment and based on the codes and amounts in the table below.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90292	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$ 5.00

Attachment B-1, Exhibit 2
SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019)

CalOptima shall make payments to Eligible Contracted Providers based on Dates of Service referenced in this Attachment and based on the codes and amounts in the table below

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$18.00
99202	Office/Outpatient Visit New	$35.00
99203	Office/Outpatient Visit New	$43.00
99204	Office/Outpatient Visit New	$83.00
99205	Office/Outpatient Visit New	$107.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$23.00
99213	Office/Outpatient Visit Est	$44.00
99214	Office/Outpatient Visit Est	$62.00
99215	Office/Outpatient Visit Est	$76.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with medical Services	$35.00
90863	Pharmacologic Management.	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1-year-old)	$77.00
99382	Initial Comprehensive Preventive Med E&M (1-4 Years old	$80.00
99383	Initial Comprehensive Preventive Med E&M (5-11 years old)	$77.00
99384	Initial Comprehensive Preventive Med E&M (12-17 Years old)	$83.00
99385	Initial Comprehensive Preventive Med E&M (18-39 Years old)	$30.00
99391	Periodic comprehensive preventive med E&M (<1-year-old)	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	$72.00
99395	Periodic comprehensive preventive med E&M (18-19 years old)	$27.00

ATTACHMENT C

PROFESSIONAL / PRACTITIONER

Professional's Name NR Medical Associates

Address 12865 Main St, Ste 105, Garden Grove, CA 92840

Phone Number (800) 560-9999 Fax Number (800) 391-4191

Federal Tax ID Number 46-2913018 NPI Number 1649601113

Email Address enguyen@360.md

Note: The email address will be used to send communication electronically when applicable. Please indicate the appropriate contact's email address.

Date 12/20/19

This Attachment may be amended from time to time, and shall incorporate Practitioners who (i.) own, are employed by, or under contract with, Professional, including locum tenens; and (ii.) will perform Covered Services under this Contract. Only Practitioners who CalOptima has determined meet applicable CalOptima requirements and credentialing criteria may be listed in this Attachment. This Attachment may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of such addition or deletion at least 30 days prior to the effective date of such addition or deletion. CalOptima shall maintain the roster of Professional's Practitioners with the applicable effective date of addition and/or deletion. Please attach separate list with the information below, if necessary.

ATTACHMENT D
SPECIAL PROVISIONS

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ATTACHMENT E

DISCLOSURE FORM

NR Medical Associates
Name of Provider

The undersigned hereby certifies that the following information regarding NR Medical Associates (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):
Tony Tan Nguyen, MD – Chief Executive Officer
David Riker, MD – President

Co-Owner(s):
Tony Tan Nguyen, MD ; David Riker, MD

Stockholder(s) owning more than five percent (5%) of the Provider's stock:
Tony Tan Nguyen, MD (50%)
David Riker, MD (50%)

Major creditor(s) holding more than five percent (5%) of the Provider's debt:
N/A

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):
Corporation

Dated: 12/20/19

Signature: [signature]

Name: Tony Tan Nguyen, MD
(Please type or print)

Title: Chief Executive Officer
(Please type or print)

ADDENDUM 1
MEDI-CAL PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medi-Cal Programs: These terms and conditions are additive to those contained in the General Provisions. In the event that these terms and conditions conflict with those in the General Provisions, these terms and conditions shall prevail. For purpose of this Addendum 1, "State Contract" means the written agreement between CalOptima and DHCS pursuant to which CalOptima is obligated to arrange and pay for the provision of Medi-Cal Covered Services to Members in Orange County, California.

1. Professional and other Providers of Services. Upon request, Professional shall provide CalOptima with a list of approved Practitioners providing Covered Services, together with any information requested by CalOptima for credentialing and/or the administration of its QMI Program. Professional shall, as warranted, immediately restrict or suspend Practitioners from providing Physician Services to Members when: (i) the Practitioner ceases to meet Minimum Provider Standards and/or other licensing/certification requirements or other professional standards described in this Contract; or (ii) CalOptima reasonably determines that there are serious deficiencies in the professional competence, conduct or quality of care of the applicable Practitioner that does or could adversely affect the health or safety of Members. Professional shall immediately notify CalOptima of any of Professional's Practitioner(s) who ceases to meet Minimum Provider Standards or licensing/certification requirements and Professional's action.

2. Emergency Services. Professional shall comply with all applicable State and Federal laws and regulations, as well as State Contract, Exhibit A, Attachment 8, Provision 13, governing the provisions and payment of Emergency Services including, without limitation, the following requirements:

   2.1 Professional shall furnish Emergency Services on a twenty four (24) hours per day, seven (7) days a week basis. CalOptima shall reimburse Professional for Emergency services without Prior Authorization.

   2.2 Payment will not be denied where the Member had an Emergency Medical Condition but the absence of immediate medical attention would not have resulted in an outcome as defined in Section 2.28.

   2.3 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms.

   2.4 The attending emergency Provider, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.

   2.5 Professional shall refer any Community Network Member not assigned to Professional back to the assigned Primary Care Provider, and shall facilitate the transfer of any applicable records to such Physician.

   2.6 Professional and Professional's Practitioners shall be and remain during the period of this Contract duly licensed to practice in their profession in the State of California or in the state in which Professional will be providing Physician Services to Members. Professional is currently in good standing, and at all times during the term of this Contract shall maintain good standing, with the following:

      2.6.1 all licenses, certificates and/or approvals required under State and Federal Law for the performance of Covered Services required by this Contract; and

      2.6.2 certification under Medi-Cal and Medicare; and

      2.6.3 Board certification to the extent required by CalOptima Policies.

3. Hospital Admissions. Professional may not admit a Member to a hospital on a non-emergency basis without first receiving Prior Authorization from CalOptima's UM Department. Professional shall coordinate care with Hospitalists for Member hospital admissions and provide history, medications, referrals and previous work-up information.

4. Admissions to Long Term Care Facility. Professional shall plan the admission of Members to Long Term Care Facilities, as determined by CalOptima Policies. Professional shall prospectively notify CalOptima of possible admissions to Long-Term Care Facilities and comply with the planning process for the assessment of Members identified as needing long-term care as determined by CalOptima Policies. For Members assessed as appropriate for long-term care, Professional shall assist CalOptima as required to place Members in Long-Term Care Facilities contracted with CalOptima.

5. Confidentiality of Sensitive Services Information. If a Professional supplies Sensitive Services, including Family Planning Services, Professional shall comply with State confidentiality laws, regulations and other requirements relating to Members' Family Planning information and records and Professional acknowledges that he or she is solely responsible for developing and implementing Policies and Procedures to ensure compliance with such confidentiality requirements. Family Planning information and records shall not be released to any third party without the consent of the Member. Notwithstanding the foregoing, Professional shall provide Family Planning information to CalOptima, or authorized representatives of the State or federal government to maintain consistency of the Member's Medical Record.

6. Linguistic and Cultural Sensitivity Services. Professional shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Professional shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Professional shall, in its Policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Professional shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6th) grade reading level. Professional shall comply with the language assistance standards developed pursuant to Health & Safety Code section 1367.01.

7. Provision of Interpreters. Professional shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication regarding treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract and CalOptima Policies. Professional shall ensure provision of interpreter services to Members at all provider sites.

   Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Professional shall not require a Member to use friends or family as interpreters. However, a friend or family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

   The provision of interpreter services required by this section may be undertaken in accordance with the Provider Manual and CalOptima Policy.

8. Overpayments and CalOptima Right to Recover. Professional has an obligation to report any overpayment identified by Professional, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Professional, or of receipt of notice of an overpayment identified by CalOptima. Professional acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Professional, CalOptima shall have the right to recover such amounts from Professional by recoupment or offset from current or future amounts due from CalOptima to Professional, after giving Professional notice and an opportunity to return/pay such amounts. This

right to recoupment or offset shall extend to any amounts due from Professional to CalOptima, including, but not limited to, amounts due because of:

8.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.

8.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.

8.3 Unpaid Conlon reimbursements owed by Professional to a Member.

8.4 Payments made for services provided by a Professional that has entered into a private contract with a Medicare beneficiary for Covered Services.

9. Professional Subcontracts. If the Professional is an individual sole practitioner, the Professional shall not subcontract for the provision of Covered Services to Members.

10. Vaccines. CalOptima shall not reimburse Professional for the cost of vaccines that are available under the Vaccines for Children (VFC) program, a federal program, which provides free vaccines for eligible populations, including Medi-Cal covered children, age eighteen (18) years and younger. CalOptima will reimburse Professional at the current CalOptima Medi-Cal Fee schedule for vaccines that are recommended by the CHDP/AAP for ages nineteen and over when billing is submitted on a CMS-1500, UB-04 claim form, or electronic equivalent.

11. Electronic Transactions. Professional agrees to engage in exchange of electronic transactions with CalOptima, including, but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions.

12. Records Retention. Professional and its Subcontractors shall maintain and retain all records of all items and services provided to Members: (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (b) at the Professional's or Subcontractor's place of business or at such mutually agreeable location in California; and (c) for a term of at least ten (10) years from the final date of the State Contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Professional's books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Physician's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Professional shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

13. Access to Books and Records.

13.1 Professional agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination and/or copying, including but not limited to Access Requirements and the State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, Department of Justice (DOJ), Bureau of Medi-Cal Fraud, Comptroller General and any

other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at Professional's place of business or at such other mutually agreeable location in California, (c) in a form maintained in accordance with the general standards applicable to such book or record keeping, (d) for a term of at least ten (10) years from the final date of the State Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, and (e) including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Professional shall provide access to all security areas and shall provide reasonable cooperation and assistance to State representatives in the performance of their duties. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Professional at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Professional from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

13.2 Through the end of the records retention period specified in Section 13.1, above, Professional shall allow CalOptima, DHCS, the DHHS Office of the Inspector General, the Comptroller General of the United States, DOJ Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives or designees, including DHCS' External Quality Review organization contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, facilities, contracts, computers, or other electronic systems maintained by Professional pertaining to these services at any time pursuant to 42 CFR 438.3(h). Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, subcontracts, information systems and procedures, and any other documentation pertaining to medical and non medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 13.1, above, Professional shall furnish any record, or copy of it, to CalOptima, DHCS, or any other entity listed in this section, at Professional's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the Professional's primary care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations, as well as requirements of DHCS and this Contract.

13.3 Authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of Professional's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Professional, Subcontractor, and provider facilities, management systems and procedures, and books and records, as the Director of DHCS deems appropriate, at any time, pursuant to 42 CFR section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State of California, and their authorized representatives and designees, will have the right to premises access, with or without notice to Professional. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima or authorized State agencies will have access to all security areas and Professional will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of Professional or the Subcontractor(s).

13.4 The provisions of this Section 13 shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

14. Form of Records. Professional's books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

15. Medical Records. All Medical Records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Professional shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Professional site.

16. Downstream Contracts. In the event that Professional is allowed to Subcontract for services under this Contract, and does so subcontract, then Professional shall, upon request, provide copies of such Subcontracts to CalOptima or DHCS. Professional shall ensure that all Subcontracts are in writing and require that the Professional and its Subcontractors:

16.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

16.2 Retain such books and all records and documents through the end of the records retention period specified in Section 13.1

17. Assignment and Delegation. Professional agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Professional or Subcontractor; (iii) the merger, reorganization, or consolidation of Professional or Subcontractor with another entity with respect to which Professional or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Professional or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Professional or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

18. Third Party Tort Liability/Estate Recovery. Professional shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Professional shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

19. Records Related to Recovery for Litigation. Upon request by CalOptima, Professional shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Professional's possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Professional asserts that any requested documents are covered by a privilege, Professional shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Professional acknowledges that time may be of the essence in responding to such request. Professional shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Professional related to this Contract.

19.1 Professional further agrees to timely gather, preserve, and provide to DHCS any records in the Professional's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

20. Medi-Cal Policies. Covered Services provided under this Contract shall comply with all applicable Medi-Cal Managed Care Division (MMCD) Policy Letters.

21. LEFT BLANK INTENTIONALLY

22. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Professional's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

23. Confidentiality of Medi-Cal Members. Professional and its employees, agents, or Providers 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 Professional, its employees, agents, or Providers as a result of services performed under this Contract, except for statistical information not identifying any such person. Professional and its employees, agents, or Providers shall not use such identifying information for any purpose other than carrying out Professional's obligations under this Contract. Professional and its employees, agents, or Providers shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Professional shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Professional from unauthorized disclosure. Physician may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Professional 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 Professional:

23.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

23.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

23.3 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

23.4 will, at the termination of this Contract, return all such information to CalOptima that Professional is not legally or contractually required to retain and make available, and maintain all other such information according to written procedures sent to the Professional by CalOptima for this purpose.

24. DHCS Directions. If required by DHCS, Professional shall cease specified activities for CalOptima Members, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

25. Additional Subcontracting Requirements. Professional shall require all Subcontractors that relate to the provision of Medi-Cal Covered Services to Members pursuant to this Contract include the following:

25.1 Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

25.2 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract.

25.3 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 of the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

25.4 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 17 of this Addendum 1, and (b) to notify DHCS in the manner provided in Section 7.10 of the Contract in the event the Subcontract is amended or terminated

25.5 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Section 3.38 of the Contract and Section 26 of this Addendum 1, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Sections 19 and 19.1 of this Addendum 1.

25.6 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 13 of this Addendum 1.

25.7 An agreement to maintain and make available to DHCS, CalOptima, and/or Professional, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Sections 16.1 to 16.2 of this Addendum 1.

25.8 An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies) and the requirements set forth in Section 27 of this Addendum 1.

25.9 An agreement to assist Professional and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract or the Contract for any reason, in accordance with Section 29 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

25.10 An agreement to hold harmless the State, Members, and CalOptima in the event the Professional cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section IV.9 of Attachment B of the Contract.

25.11 An agreement to the requirements for cultural and linguistic sensitivity and the provision of interpreter services to be provided as set forth in Sections 6 and 7 of this Addendum 1.

25.12 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract for issues arising under the Subcontract related to the provision of Medi-Cal services to CalOptima Medi-Cal Members, as provided in CalOptima Policies relative to the Medi-Cal program, and excluding any contract disputes between Professional and Subcontractor, particularly regarding, but not limited to, payment for services under the Subcontract.

25.13 An agreement to participate and cooperate in quality improvement system as set forth in Section 3.17 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima, and/or Professional determines that the Subcontractor has not performed satisfactorily.

25.14 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 32 of this Addendum 1 and Section 6.5.3 of the Contract.

25.15 An agreement by the Professional to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.6 of the Contract.

25.16 An agreement for the establishment and maintenance of and access to medical and administrative records as set forth in Sections 6.2 to 6.3 of the Contract and Sections 12 to 13 of this Addendum 1.

25.17 An agreement that Subcontractors shall notify Professional of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

26. Professional shall submit to CalOptima complete, accurate, reasonable, and timely provider data, Encounter Data, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

27. Professional shall comply with (a) DHCS Medi-Cal Provider Bulletins and Manuals, (b) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, Medi-Cal Managed Care Division Policy Letters and All Plan Letters, and (c) all monitoring provisions of this Contract and the State Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS.

28. Professional shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay for services performed by Professional pursuant to the Contract.

29. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Professional shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor, necessary for efficient case management of Members, and the continuity, to the extent possible, of Member-Provider relationships. Cost of reproduction shall be borne by DHCS and CalOptima as applicable.

29.1 Professional agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

30. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS.

31. Notwithstanding anything in this Contract to the contrary, Professional shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

32. If and to the extent that the Professional is responsible for the coordination of care for Members, CalOptima shall share with the Professional, in accordance with the appropriate Declaration of Confidentiality signed by Professional and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Professional shall receive the utilization data provided by CalOptima and use it as the Professional is able for the purpose of Member care coordination.

ADDENDUM 2
PACE PROGRAM REQUIREMENTS

The terms and requirements of this Addendum 2 shall apply for services provided by Professional to Members who are enrolled in the CalOptima PACE program only. These terms and conditions are additive to those contained in the General Provisions. In the event that these terms and conditions conflict with those in the General Provisions, these terms and conditions shall prevail.

1. State Approval and Termination.

   1.1 This Addendum to the Contract shall not become effective until approved in writing by the California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services, (CMS), or by operation of law where DHCS and CMS have acknowledged receipt, verbally or in writing, and has failed to approve or disapprove the proposed contract within sixty (60) days of receipt.

   1.2 Amendments to this Contract and amendments to any subcontract agreements between Professional and Subcontractor shall be submitted to DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor disapproved by DHCS shall become effective by operation of law within thirty (30) days after DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later.

   1.3 CalOptima may terminate this Contract as it applies to providing services to CalOptima PACE participants if CalOptima's PACE Agreement or State Medi-Cal contract is terminated for any reason. CalOptima shall notify Professional of any such termination immediately upon its provision of notice of termination of the PACE Agreement or State Medi-Cal contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS/CMS, or the State Medi-Cal Contract from DHCS.

2. Professional's Responsibilities applicable to providing services to CalOptima PACE Members. Professional shall be accountable to CalOptima in accordance with the terms of this Contract. For CalOptima PACE Members, Professional agrees to do the following:

   2.1 Professional shall make available a location that is accessible to PACE participants within the PACE service area of Orange County, California.

   2.2 Duties Related to Professional's Position. Professional shall perform all the duties related to its position, as specified in this Contract.

   2.3 Services Authorized. Professional shall furnish only those services authorized by the CalOptima PACE Interdisciplinary Team (IDT); PCP referral is deemed as an IDT authorization.

   2.4 Interdisciplinary Team Meeting Participation. If necessary for the benefit of a CalOptima PACE participant's care delivery or planning, Professional shall participate in CalOptima PACE Interdisciplinary Team meetings as required. Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

   2.5 Hold Harmless. In accordance with the Medi-Cal Contract and the PACE Agreement, Professional will not bill the State of California, CMS or CalOptima PACE participants in the event CalOptima cannot or will not pay for services performed by Professional pursuant to this Contract.

   2.6 Reporting. Professional shall provide such information and written reports to CalOptima, DHCS, and HHS, as may be necessary for compliance by CalOptima with its statutory obligations, and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

2.7 Coverage of Non-Network Providers. Professional agrees that should arrangements be made by Professional with another physician/provider who is not under contract with CalOptima to provider Covered Services required under this Contract, such physician/provider shall (a) accept Professional's fees from CalOptima as full payment for services delivered to CalOptima PACE participants, (b) bill services provided through Professional's office, unless Professional has made other billing arrangements with CalOptima, (c) not bill CalOptima PACE participants directly, under any circumstances, and (d) cooperate with and participate in CalOptima's quality assurance and improvement program.

2.8 Participant Bill of Rights. Professional shall cooperate and comply with the CalOptima PACE Participant Bill of Rights. A copy of the CalOptima PACE Participant Bill of Rights is attached. CalOptima may, at its sole discretion, make reasonable changes to this document from time to time, and a copy of the revised document will be sent to Professional.

2.9 Provision of Direct Care Services to PACE Participants. Professional hereby represents and warrants that Professional and all employees of Professional providing direct care to CalOptima PACE participant shall, at all time covered by this Contract, meet the requirements set forth in this Section. Professional agrees to cooperate with CalOptima PACE's competency evaluation program and direct participant care requirements, and to notify CalOptima immediately if Professional or any employee of Professional providing services to CalOptima PACE participants no longer meets any of these requirements. All providers of direct care services to CalOptima PACE Members shall meet the following requirements:

2.9.1 Comply with any State or Federal requirements for direct patient care staff in their respective settings;

2. 9.2 Meet Medicare, Medi-Cal and CalOptima requirements applicable to the services Professional furnishes;

2. 9.3 Have verified current certifications or licenses for their respective positions;

2. 9.4 Have not been excluded from participation in Medicare, or Medi-Cal;

2. 9.5 Have not been convicted of criminal offenses related to their involvements with Medicare, Medi-Cal, or other health insurance or health care programs, or any social service programs under Title XX of the Act;

2. 9.6 Not pose a potential risk to CalOptima PACE participants because of a conviction for physical, sexual, drug or alcohol abuse;

2. 9.7 Be free of communicable diseases, and up to date with immunizations, before performing direct patient care; and

2. 9.8 Participate in an orientation to the PACE program presented by CalOptima PACE, and agree to abide by the philosophy, practices and protocols of CalOptima PACE.

2.10 The CalOptima PACE program director or his or her designee shall be designated as the liaison to coordinate activities between Professional and PACE.

3. Records Retention. Professional and its Subcontractors shall maintain and retain all records, including encounter data, of all items and services provided Members for ten (10) years from the close of the latest DHCS fiscal year in which the date of service occurred, in which the records or data were created or applied, and for which the financial record was completed. Records involving

matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Professional's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Professional's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable, and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Professional shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

4. Access to Books and Records. Professional and its Subcontractors agree to make all of its books and records pertaining to the goods and services furnished under, or in any way pertaining to, the terms of Contract and any Subcontract, available for inspection, examination and copying by the Government Agencies, including the DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, at all reasonable times at the Professional's or Subcontractor's place of business or such other mutually agreeable location in California, in a form maintained in accordance with general standards applicable to such book or record keeping. Professional shall provide access to all security areas and shall provide and require Subcontractors to provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

   Professional and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Professional may possess in order to verify Professional's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

5. Medical Records. All Medical Records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1396a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Professional shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Participating Practitioner or Subcontractor site.

6. Downstream Contracts. In the event that Professional is allowed to subcontract for services under this Contract, and does so subcontract, then Professional shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Assignment and Delegation. This Contract is not assignable, nor are the duties hereunder delegable, by the Professional, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima. For purposes of this Section and this Contract, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional (whether in a single transaction or in a series of transactions); (ii) the change

of more than twenty-five percent (25%) of the directors or trustees of Professional; (iii) the merger, reorganization, or consolidation of Professional with another entity with respect to which Professional is not the surviving entity; and/or (iv) a change in the management of Professional from management by persons appointed, elected or otherwise selected by the governing body of Professional (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

8. Third Party Tort Liability/Estate Recovery. Professional shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Professional shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

9. Records Related to Recovery for Litigation. Upon request by CalOptima, Professional shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Professional's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Professional asserts that any requested documents are covered by a privilege, Professional shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Professional acknowledges that time may be of the essence in responding to such request. Professional shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Professional or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

10. DHCS Policies. Covered Services provided under this Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Long-Term Care Division (LTCD).

11. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Professional's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

12. Confidentiality of Medi-Cal Members. Professional 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 Professional, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Professional and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Professional's obligations under this Contract. Professional and its employees, agents, or Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Professional shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

12.1 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq.,

Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Professional from unauthorized disclosure. Professional may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Professional 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 Professional or its Subcontractors, Professional:

12.1.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

12.1.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

12.1.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

12.1.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Professional by CalOptima for this purpose.

13. DHCS Directions. If required by DHCS, Professional and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

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ADDENDUM 3
CAL MEDICONNECT PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Cal MediConnect Program. These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Professional shall provide services or perform other activity pursuant to the Contract in accordance with (i) applicable DHCS and CMS laws, regulations, and instructions, including, but not limited to 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414, (ii) contractual obligations with CalOptima, and (iii) CalOptima's contractual obligations to CMS and DHCS,
2. Professional shall (i) safeguard Member privacy and confidentiality of Member health records, (ii) comply with all federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information, (iii) ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (iv) maintain the records and information in an accurate and timely manner, (v) ensure timely access by Members to the records and information that pertain to them, and (vi) comply with all DHCS and CMS confidentiality requirements.
3. The performance of the Professional and its Downstream Entities is monitored by CalOptima on an ongoing basis and CalOptima may impose corrective action as necessary. Professional shall comply with all CalOptima and DHCS monitoring of performance and any monitoring requests by CalOptima and DHCS.
4. Professional shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities, monitoring, and, public reporting to consumers as identified in CalOptima policy.
5. Professional shall submit timely and accurate encounter data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
6. Professional acknowledges and agrees that medical providers' Emergency Medical Treatment and Active Labor Act (EMTALA) obligations shall not create any conflicts with hospital actions required to comply with EMTALA.
7. Professional shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. Professional shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Professional shall, in its policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural and ethnic backgrounds. Professional shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6th) grade reading level.
8. Professional shall not close or limit their practice or acceptance of CalOptima Members as patients unless the same limitations apply to all commercially insured Members as well.
9. Professional shall not be prohibited from communicating or advocating on behalf of a Member who is a prospective, current, or former patient of the Professional. Professional may freely communicate the provisions, terms or requirements of CalOptima's health benefit plans as they relate to the needs of such Member, or communicate with respect to the method by which such Professional is compensated by CalOptima for services provided to the Member. CalOptima will not refuse to contract or pay Professional for the provision of covered services under the CalOptima Cal MediConnect Program solely because Professional has in good faith communicated or advocated on behalf of a Member as set forth above.

10. CMS Participation Requirements. Professional represents and warrants that: (i) neither Professional nor any of its contracted Physicians, employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("Federal Health Care Program(s)"); (ii) Professional has not arranged or contracted with (by employment or otherwise) with any employee, contractor or agent that Professional knows or should know are excluded from participation in Federal Health Care Programs; (iii) no action is pending against Professional or any of its contracted Physicians, employees or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Professional agrees to immediately notify CalOptima in the event that it learns that it is or has employed or contracted with a person or entity that is excluded from participation in any Federal Health Care Program. In the event Professional fails to comply with the above, CalOptima reserves the right to require Professional to pay immediately to CalOptima, the amount of any sanctions or other penalties that may be imposed on CalOptima by DHCS and/or CMS for violation of this prohibition, and Professional shall be responsible for any resulting overpayments.

11. Downstream Entity Contracts.

11.1 If any services under this Contract are to be provided by a Downstream Entity on behalf of Professional, Professional shall ensure that such subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, 438.3(k), 438.414 and 438.6(1). Such subcontracts shall include all language required by DHCS and CMS as provided in this Contract, including, but not limited to, the following:

11.1.1 An agreement that any services or other activity performed under the subcontract shall comply with Section 1 of this Addendum 3 and Section 3.21 of the Contract.

11.1.2 An agreement to (i) Member financial protections in accordance with Section 9 of Article IV of Attachment B of the Contract, including prohibiting Downstream Entities from holding an Enrollee liable for payment of any fees that are the obligation of the Professional, and (ii) safeguard Member privacy and confidentiality of Member health records.

11.1.3 An agreement to comply with the inspection, evaluation, and/or auditing requirements of Section 12 of this Addendum 3 and the reporting requirements of Section 5 of this Addendum 3.

11.1.4 An agreement to (i) the revocation of the delegation activities and related reporting requirements or other specified remedies in accordance with Section 13 of this Addendum 3 and 3.18 of the Contract, and (ii) monitoring and corrective action in accordance with Section 3 of this Addendum 3.

11.1.5 If the subcontract is for credentialing of medical providers, an agreement to the requirements of Section 14 of this Addendum 3.

11.1.6 An agreement to provide a written statement to provider of the reason(s) for termination for cause as set forth in Section 15 of this Addendum 3.

11.2 In addition to Section 11.1 of this Addendum 3, Professional shall further ensure any subcontracts with its Downstream Entities for medical providers include the following:

11.2.1 Term of the subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received from the Professional.

11.2.2 An agreement that the contracted medical providers are paid under the terms of the Subcontract, including but not limited to, a mutually agreeable prompt payment provision.

11.2.3 An agreement that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and

diverse cultural and ethnic backgrounds, in accordance with Section 7 of this Addendum 3.

11.2.4 An agreement to comply with (i) the confidentiality requirements of Member records and information in accordance with Section 2 of this Addendum 3, and (ii) EMTALA obligations as set forth in Section 6 of this Addendum 3.

11.2.5 An agreement that (i) providers shall not close or otherwise limit their acceptance of Members as patients unless the same limitations apply to all commercially insured Members, and (ii) Members shall not be held liable for Medicare Part A and B cost sharing in accordance with Section 9.2 of Article IV of Attachment B of the Contract and Section 20 of this Addendum 3.

11.2.6 An agreement regarding (i) provider communication or advocacy on behalf of Members as set forth in Section 9 of this Addendum 3, and (ii) specified circumstances where indemnification is not required by provider as set forth in Section 17 of this Addendum 3.

11.2.7 An agreement that the medical provider assist the Professional and/or CalOptima in the transfer of care of a Member in accordance with Section 16 of this Addendum.

11.2.8 An agreement (i) that the assignment or delegation of the subcontract will be void unless prior written approval is obtained pursuant to Section 18 of this Addendum 3, and (ii) to notify DHCS in the manner set forth in Section 7.10 of the Contract in the event the subcontract is amended or terminated.

11.2.9 An agreement to (i) gather, preserve, and provide records as set forth in Section 19 of Addendum 3, and (ii) provider's right to submit a grievance in accordance with Section 8.1 of the Contract for issues arising under the subcontract related to the provision of services to CalOptima Members under CalOptima Cal MediConnect Program, as provided in CalOptima Policies relative to the Cal MediConnect Program, and excluding any contract disputes between Professional and medical provider, particularly regarding, but not limited to, payment for services under the subcontract.

11.2.10 An agreement to (i) participate and cooperate in equality improvement system as set forth in Section 3.17 of the Contract, and (ii) the provision of interpreter services for Members at all provider sites.

12. Right of Inspection, Evaluation, and Audit of Records. Professional and its Downstream Entities agree to maintain and make available contracts, books, documents, records, computer, other electronic systems, medical records, and any other pertinent information related to the Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Professional's provision of health care services to Members, the cost of such services, and payments received by Professional from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

13. Professional and its Downstream Entities agree to the revocation of the delegation of activities or obligations and related reporting requirements or other remedies set forth in Section 3.18 of the Contract in instances where CMS, DHCS, and/or CalOptima determines that the Professional and/or its Downstream Entities have not performed satisfactorily.

14. Review of Credentials. Professional shall ensure that the credentials of medical professionals affiliated with the Professional are reviewed by it. Professional agrees that CalOptima will review, approve, and audit Professional's credentialing process on an ongoing basis.

15. Provider Terminations. In the event a provider is terminated for cause by Professional, Professional shall provide the provider with written notice of the reason or reasons for the action and as required by applicable Federal and State laws. In the event Professional terminates a provider for deficiencies in the quality of care provided, Professional shall give notice of the action to the appropriate licensing and disciplinary agencies.

16. In addition to Section 3.3 of the Contract, Professional agrees to assist CalOptima in the transfer of care of a Member. Professional shall further assist CalOptima in the transfer of care of a Member in the event of Subcontract termination for any reason.

17. Professional is not required to indemnify CalOptima for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, or other policies, guidelines, or actions relative to CalOptima Cal MediConnect Program.

18. Assignment or Delegation. Professional agrees that the assignment or delegation of this Contract or subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional or Downstream Entity (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors of trustees of Professional or Downstream Entity; (iii) the merger, reorganization, or consolidation of Professional or Downstream Entity, with another entity with respect to which Professional or Downstream Entity is not the surviving entity; and/or (iv) a change in the management of Professional or Downstream Entity from management by persons appointed, elected or otherwise selected by the governing body of Professional or Downstream Entity (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

19. Professional agrees to timely gather, preserve, and provide to DHCS or CalOptima, as applicable, any records in the Professional's or its Subcontractor's possession.

20. In addition to Section 9.2 of Article IV of Attachment B of the Contract, Professional acknowledges and agrees that Medicare Parts A and B services shall be provided at zero-cost sharing to Members.

ADDENDUM 4

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.

NR Medical Associates	Tony Tan Nguyen, MD
Name of Contractor	Printed Name of Person Signing for Contractor
	Signature of Person Signing for Contractor
Contract / Grant Number	
12/20/19	Chief Executive Officer
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

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:
contract grant cooperative agreement loan loan guarantee loan insurance	bid/offer/application initial award post-award	initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, D

AMENDMENT 1

PROFESSIONAL SERVICES CONTRACT

THIS AMENDMENT 1 TO THE PROFESSIONAL SERVICES CONTRACT ("Amendment") is effective as of **September 1, 2020**, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **NR Medical Associates** ("Professional"), with respect to the following facts:

RECITALS

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

B. CalOptima and Professional desire to amend the Contract to administer directed payments per CalOptima policy and procedure.

NOW, THEREFORE, the parties agree as follows:

1. Article 4, Section 4.13 of the Contract shall be amended to add the following requirement:

   "4.13 Directed Payments for Qualifying Medi-Cal Covered Services. Effective July 1, 2020, CalOptima shall administer directed payments for qualifying Medi-Cal Covered Services relevant to this Contract in accordance with CalOptima Policy FF.2012, including, without limitations, those described in Attachment B-1 of this Contract."

2. ATTACHMENT B-1 "Supplemental Compensation Proposition 56 Funding" shall be deleted and replaced with the attached ATTACHMENT B-1-Amendment 1, "Supplemental Compensation Proposition 56 Funding".

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and NR Medical Associates have executed this Amendment.

FOR PROFESSIONAL:	FOR CALOPTIMA:
Tony Nguyen, MD Tony Nguyen, MD (Aug 13, 2020 17:34 PDT)	Ladan Khamseh Ladan Khamseh (Aug 14, 2020 11:49 PDT)
Signature	Signature
TONY NGUYEN, MD	Ladan Khamseh
Print Name	Print Name
CEO	Chief Operating Officer
Title	Title
Aug 13, 2020	Aug 14, 2020
Date	Date

Back to Agenda Back to Item

ATTACHMENT B-1 -AMENDMENT 1
SUPPLEMENTAL COMPENSATION
PROPOSITION 56 FUNDING

This Attachment B-1 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to Professional for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to Professionals who render Qualifying Services (both as defined in this Attachment B-1) effective July 1, 2017.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment B-1:

   1.1 "Eligible Contracted Provider" shall mean a Provider who is contracted with Professional to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

   1.2 "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

   1.3 Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. CalOptima shall administer the Prop 56 increase in accordance with the Exhibit for the applicable State fiscal year attached to this Attachment, applicable state and federal requirements and CalOptima policies. CalOptima shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment in addition to any payment paid by CalOptima to the Eligible Contracted Professional under their existing contractual arrangements.

3. CalOptima shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments for dates of service between July 1, 2017 and July 30, 2019 and beyond if so directed by DHCS.

4. Professional acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 Increase Payments identifies invalid payments, Professional shall return such Prop 56 Increase Payments to CalOptima immediately upon notice from CalOptima.

5. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to Professional, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

6. Notwithstanding other provisions of this Attachment B-1, effective July 1, 2020, CalOptima shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program pursuant to Article 4, Section 4.13 of the Contract.

ATTACHMENT B-1, Exhibit 1

SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018)

CalOptima shall make payments to Eligible Contracted Providers based on Dates of Service referenced in this Attachment and based on the codes and amounts in the table below.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with medical Services	$35.00
90863	Pharmacologic Management.	$5.00

ATTACHMENT B-1, Exhibit 2

SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019)

CalOptima shall make payments to Eligible Contracted Providers based on Dates of Service referenced in this Attachment and based on the codes and amounts in the table below.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$18.00
99202	Office/Outpatient Visit New	$35.00
99203	Office/Outpatient Visit New	$43.00
99204	Office/Outpatient Visit New	$83.00
99205	Office/Outpatient Visit New	$107.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$23.00
99213	Office/Outpatient Visit Est	$44.00
99214	Office/Outpatient Visit Est	$62.00
99215	Office/Outpatient Visit Est	$76.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with medical Services	$35.00
90863	Pharmacologic Management.	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1-year-old)	$77.00
99382	Initial Comprehensive Preventive Med E&M (1-4 Years old	$80.00
99383	Initial Comprehensive Preventive Med E&M (5-11 years old)	$77.00
99384	Initial Comprehensive Preventive Med E&M (12-17 Years old)	$83.00
99385	Initial Comprehensive Preventive Med E&M (18-39 Years old)	$30.00
99391	Periodic comprehensive preventive med E&M (<1-year-old)	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	$72.00
99395	Periodic comprehensive preventive med E&M (18-19 years old)	$27.00

NR Medical Associates - Professional Services Contract, Amendment 1

Final Audit Report 2020-08-14

Created:	2020-08-13
By:	CalOptima Contracting (eSignProviderContracts@caloptima.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAAvVwRpHSd1Xk86Q8B1jqBXd9x5G5EhjXi

"NR Medical Associates - Professional Services Contract, Amendment 1" History

Document created by CalOptima Contracting (eSignProviderContracts@caloptima.org)
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Document emailed to Tony Nguyen, MD (tnguyen@360.md) for signature
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Document e-signed by Tony Nguyen, MD (tnguyen@360.md)
Signature Date: 2020-08-14 - 0:34:51 AM GMT - Time Source: server- IP address: 23.124.249.22

Document emailed to Ladan Khamseh (lkhamseh@caloptima.org) for signature
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Document e-signed by Ladan Khamseh (lkhamseh@caloptima.org)
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Signed document emailed to all eligible parties.
2020-08-14 - 6:49:49 PM GMT

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

12. Authorize Expenditures in Support of CalOptima Health's Participation in a Community Event

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Deanne Thompson, Executive Director, Marketing and Communications, (714) 954-2141

Recommended Actions

1. Authorize expenditures of up to $6,000 and CalOptima Health staff participation in the following event:
    - Vietnamese Physician Association of Southern California (VPASC) Foundation's 2022 OC Free Health Fair on Sunday, October 16, 2022, at Freedom Hall at Mile Square Park in Fountain Valley;
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the event and expenditures.

Background

CalOptima Health has a long history of participating in community events, health and resource fairs, and other public activities in furtherance of the organization's statutory purpose. CalOptima Health has offered financial participation from time to time when participation benefits the public good, in furtherance of CalOptima Health's mission and statutory purpose, and encourages broader participation in CalOptima Health's programs and services or promotes health and wellness. As a result, CalOptima Health has developed a strong reputation with Orange County's community partners, providers, and key stakeholders.

Requests for participation are considered based on the following factors: the number of people reached; the outreach and education benefits accrued to CalOptima Health; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

The VPASC Foundation's Free Health Fair provides an opportunity to strengthen CalOptima Health's relationship with Vietnamese healthcare professionals, including physicians, specialists, and others serving our members. This event provides a variety of health services to the community, including immunization shots (flu and COVID-19), breast examinations, dental services, blood-sugar and blood-pressure screenings, bone-density screenings, and cholesterol screenings. The event is open to the public and all health and education services will be provided

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at no cost. VPASC estimates it will serve over one thousand five hundred (1,500) individuals at this event.

Staff recommends the authorization of expenditures for participation in VPASC Foundation's Free Health Fair. CalOptima Health has participated in this event for four years. Staff recommends CalOptima Health's continued support for this event with a $6,000 financial commitment, which includes: CalOptima Health's name and logo on all promotional flyers; email blasts; website; social media, including Facebook, Instagram, and Twitter; television, radio, and newspaper recognition; one (1) resource booth at the event; one (1) sponsor banner (up to 8'x3'); and business cards and brochures in attendee gift bags.

This is an educational event that will allow staff to provide outreach and education to the Vietnamese community and serve members speaking one or more of CalOptima Health's threshold languages. Employee time will be used to participate in this event.

CalOptima Health staff reviewed the request, and it meets the requirements for participation as established in CalOptima Health Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach
2. The marketing benefits accrued to CalOptima Health
3. The strength of the partnership or level of involvement with the requesting entity
4. Past participation
5. Staff availability
6. Available budget

As part of its consideration of the recommended actions, approval of this item is based on the Board making a finding that proposed activities and expenditures are in the public interest and in furtherance of CalOptima Health's statutory purpose.

Fiscal Impact

Funding for the recommended action of up to $6,000 is included as part of the Community Events budget under the CalOptima Health Fiscal Year 2022-23 Operating Budget approved by the Board on June 2, 2022.

Rationale for Recommendation

Staff recommends approval of the recommended actions as an opportunity to educate the community, specifically CalOptima Health's Vietnamese-speaking members and potential members, and the community at large about CalOptima Health and Medi-Cal programs and services while supporting our provider community.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Entities Covered by this Recommended Board Action
2. VPASC Sponsorship Request Letter

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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Attachment to October 6, 2022 Board of Directors Meeting – Agenda Item 12

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
Vietnamese Physician Association of Southern California Foundation	8 Last Bloom	Irvine	CA	92602

VIETNAMESE PHYSICIAN ASSOCIATION of SOUTHERN CALIFORNIA

VPASocal.com

September 12, 2022

VPASC

To Our Valued Community Partner,

The Vietnamese Physician Association of Southern California Foundation (FOUNDATION) and the Vietnamese Physician Association of Southern California (VPASC) seek partners to support their annual Health Fair that provides free health screening and examinations to the community. The Foundation is a non-profit 501(c)(3) public benefit corporation whose mission is to promote the health of the underserved communities of Orange County and to support the development of future generations of healthcare professionals. VPASC is a mutual benefit corporation that complements and implements the Foundation's mission by providing a forum for scientific, educational, cultural, charitable, and social interaction among its members. Each year, VPASC's well attended Health Fair provides a variety of free services to the community at large including immunization shots (flu and COVID-19), breast examinations, dental services, blood-sugar examinations and blood-pressure examinations, bone-density screenings, and cholesterol screenings.

This year, we are hosting our Health Fair at FREEDOM HALL, at the Mile Square Regional Park in Fountain Valley, California on Sunday, October 16th, 2022, from 9am to 2pm.

We ask that your organization participate in and join VPASC's community efforts by making a generous donation to the FOUNDATION that will continue to make VPASC and the annual Health Fair event important resources for the Vietnamese community and Orange County in general. For your convenience, we offer the following sponsorship levels from which to choose: Platinum Sponsorship ($6,000); Diamond Sponsorship ($4,000); Gold Sponsorship ($2,000); and Booth Participation ($1,500). Further Sponsorship details may be found in the attached file.

VPASC's work is not possible without the support of our community partners, and we ask your organization to support the Health Fair and enable VPASC to continue to provide this important community service. Thank you in advance for your support.

Sincerely,
VPASC FOUNDATION
8 Last Bloom
Irvine, CA 92602
EIN 45-3844398

Duc Do, M.D.
VPASC Foundation President

Phoenix Nguyen, M.D.
VPASC President

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VIETNAMESE PHYSICIAN ASSOCIATION
of
SOUTHERN CALIFORNIA

http://VPASoCal.com

One life to share. One family to love. One community to serve.

V.P.A.S.C

2022 Health Fair

To improve the health of our community through education, dental services, and medical exams and screenings

TOGETHER WE CAN MAKE A DIFFERENCE

SUNDAY OCTOBER 16, 2022

FREEDOM HALL

16801 Euclid St, Fountain Valley, CA 92708

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SPONSORSHIP

Thank you for your consideration and genorosity

PLATINUM SPONSORSHIP $6,000

Name on the bottom section of all Health Fair Flyers

Television/Radio/Newspaper Recognition

1 Display Table/Booth at side of Health Fair / 1 Sponsor Banner (up to 8′ x 3′) display inside site

Business cards/brochures in attendee gift bag

Email blast / Website / Social Media (Facebook/Instagram/Twitter)

DIAMOND SPONSORSHIP $4,000

Name on the bottom section of all Health Fair Flyers

Radio/Newspaper Recognition

1 Display Table/Booth at site of Health Fair / 1 Sponsor Banner (up to 5′ x 3′) display inside site

Business cards/brochures in attendee gift bag

Email Blast / Website / Social Media (Facebook/Instagram/Twitter)

GOLD SPONSORSHIP $2,000

Newspaper Recognition

1 Display Table/Booth at site of Health Fair / 1 Sponsor Banner (up to 5′ x 3′) display inside site

Business cards/brochures in attendee gift bag

Email Blast / Website / Social Media (Facebook/Instagram/Twitter)

BOOTH PARTICIPATION $1,500

1 Display Table/Booth at site of Health Fair

Email Blast / Website / Social Media (Facebook/Instagram/Twitter)

PLEASE MAKE CHECKS PAYABLE TO: VPASC FOUNDATION - 501(C)3 - TAX ID#: 45-3844398

VIETNAMESE PHYSICIAN ASSOCIATION of SOUTHERN CALIFORNIA

http://VPASoCal.com

One life to share. One family to love. One community to serve.

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Financial Summary

August 31, 2022

Board of Directors Meeting
October 6, 2022

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

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

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Financial Highlights: August 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
925,756	915,761	9,995	1.1%	Member Months	1,846,942	1,831,291	15,651	0.9%
348,906,387	332,502,391	16,403,996	4.9%	Revenues	669,824,867	664,882,836	4,942,031	0.7%
332,679,915	313,062,603	(19,617,312)	(6.3%)	Medical Expenses	636,851,097	623,750,770	(13,100,327)	(2.1%)
13,369,852	17,497,194	4,127,342	23.6%	Administrative Expenses	27,802,626	34,400,917	6,598,291	19.2%
2,856,620	**1,942,594**	**914,026**	**47.1%**	**Operating Margin**	**5,171,143**	**6,731,149**	**(1,560,006)**	**(23.2%)**
(644,270)	(772,801)	128,531	16.6%	Non Operating Income (Loss)	4,259,627	(181,966)	4,441,593	2440.9%
2,212,350	**1,169,793**	**1,042,557**	**89.1%**	**Change in Net Assets**	**9,430,770**	**6,549,183**	**2,881,587**	**44.0%**
95.3%	94.2%	1.2%		Medical Loss Ratio	95.1%	93.8%	1.3%	
3.8%	5.3%	1.4%		Administrative Loss Ratio	4.2%	5.2%	1.0%	
0.8%	0.6%	0.2%		Operating Margin Ratio	0.8%	1.0%	(0.2%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima Health

Consolidated Performance: August 2022 (in millions)

August				July-August		
Actual	Budget	Variance		Actual	Budget	Variance
4.3	3.2	1.0	Medi-Cal	6.6	9.2	(2.6)
(1.9)	(0.6)	(1.3)	OCC	(2.3)	(1.1)	(1.2)
0.4	(0.6)	1.0	OneCare	0.7	(1.2)	1.9
0.1	(0.1)	0.3	PACE	0.2	(0.2)	0.4
(0.1)	(0.0)	(0.0)	MSSP	(0.1)	(0.1)	0.0
2.9	**1.9**	**0.9**	**Operating**	**5.2**	**6.7**	**(1.6)**
(0.6)	(0.8)	0.1	Inv/ Rent/Tax/Other Inc	4.3	(0.2)	4.4
(0.6)	**(0.8)**	**0.1**	**Non-Operating**	**4.3**	**(0.2)**	**4.4**
2.2	**1.2**	**1.0**	**TOTAL**	**9.4**	**6.5**	**2.9**

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CalOptima Health

FY2022-23: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) August 2022: $2.2 million, favorable to budget $1.0 million or 89.1%
  - Year To Date (YTD) July – August 2022: $9.4 million, favorable to budget $2.9 million or 44.0%
- Enrollment
  - MTD: 925,756 members, favorable to budget 9,995 or 1.1%
  - YTD: 1,846,942 members, favorable to budget 15,651 or 0.9%

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CalOptima Health

FY2022-23:Management Summary (cont.)

- Revenue
  - MTD: $348.9 million, favorable to budget $16.4 million or 4.9% driven by Medi-Cal Line of Business (MC LOB):
    - $7.4 million due to favorable volume related variance and prior year retroactive eligibility changes
    - $4.3 million due to net of Proposition 56, COVID-19, and Enhanced Care Management (ECM) risk corridor reserves
    - $3.7 million due to COVID-19 Vaccination Incentive Program (VIP) payment
  - YTD: $669.8 million, favorable to budget $4.9 million or 0.7% driven by MC LOB:
    - $9.0 million due to favorable volume related variance and prior year retroactive eligibility changes
    - $3.7 million due to COVID-19 VIP payment
    - Offset by net $9.2 million due to Proposition 56, COVID-19, and ECM risk corridor reserves

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CalOptima Health

FY2022-23:Management Summary (cont.)

- Medical Expenses
  - MTD: $332.7 million, unfavorable to budget $19.6 million or 6.3% driven by MC LOB:
    - Facilities Claims expense unfavorable variance of $15.4 million due to Incurred But Not Reported (IBNR) claims
    - Managed Long-Term Services and Supports (MLTSS) expense unfavorable variance of $6.7 million due to IBNR claims
    - Provider Capitation expense unfavorable variance of $4.8 million due to Whole Child Model (WCM) program
    - Offset by all other expenses favorable variance of $7.7 million

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FY2022-23:Management Summary (cont.)

- Medical Expenses
  - YTD: $636.9 million, unfavorable to budget $13.1 million or 2.1% driven by MC LOB:
    - Facilities Claims expense unfavorable variance of $15.2 million due primarily to IBNR claims
    - MLTSS expense unfavorable variance of $11.0 million due to IBNR claims
    - Offset by all other expenses favorable variance of $12.2 million

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CalOptima Health

FY2022-23:Management Summary (cont.)

- Administrative Expenses
  - MTD: $13.4 million, favorable to budget $4.1 million or 23.6%
    - Other Non-Salary expenses favorable variance of $2.2 million
    - Salaries & Benefits expense favorable variance of $1.9 million
  - YTD: $27.8 million, favorable to budget $6.6 million or 19.2%
    - Other Non-Salary expenses favorable variance of $3.9 million
    - Salaries & Benefits expense favorable variance of $2.6 million

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CalOptima Health

FY2022-23:Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: ($0.6) million, favorable to budget $0.1 million or 16.6%
  - YTD: $4.3 million, favorable to budget $4.4 million or 2,440.9%
    - Unfavorable variance is due to unrealized gains from the rise in interest rates

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CalOptima Health

FY 2022-23: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 95.3%, Budget 94.2%
  - YTD: Actual 95.1%, Budget 93.8%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 3.8%, Budget 5.3%
  - YTD: Actual 4.2%, Budget 5.2%
- Balance Sheet Ratios
  - *Current ratio: 1.5
  - Board-designated reserve funds level: 1.78
  - Net-position: $1.4 billion, including required Tangible Net Equity (TNE) of $105.2 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations

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CalOptima Health

Enrollment Summary: August 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category	Actual	Budget	$ Variance	% Variance
123,945	122,270	1,675	1.4%	SPD	247,283	244,270	3,013	1.2%
303,015	306,805	(3,790)	(1.2%)	TANF Child	606,399	613,610	(7,211)	(1.2%)
131,177	135,957	(4,780)	(3.5%)	TANF Adult	261,830	271,913	(10,083)	(3.7%)
3,242	3,321	(79)	(2.4%)	LTC	6,499	6,634	(135)	(2.0%)
334,353	317,914	16,439	5.2%	MCE	665,629	635,926	29,703	4.7%
11,945	11,734	211	1.8%	WCM	23,821	23,450	371	1.6%
907,677	**898,001**	**9,676**	**1.1%**	**Medi-Cal Total**	**1,811,461**	**1,795,803**	**15,658**	**0.9%**
14,771	**14,665**	**106**	**0.7%**	**OneCare Connect**	**28,974**	**29,328**	**(354)**	**(1.2%)**
2,874	**2,641**	**233**	**8.8%**	**OneCare**	**5,638**	**5,256**	**382**	**7.3%**
434	**454**	**(20)**	**(4.4%)**	**PACE**	**869**	**904**	**(35)**	**(3.9%)**
470	**568**	**(98)**	**(17.3%)**	**MSSP**	**936**	**1,136**	**(200)**	**(17.6%)**
925,756	**915,761**	**9,995**	**1.1%**	**CalOptima Health Total**	**1,846,942**	**1,831,291**	**15,651**	**0.9%**

*CalOptima Health Total does not include MSSP

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CalOptima Health

Consolidated Revenue & Expenses: August 2022 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	One Care Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	561,379	334,353	11,945	907,677	14,771	2,874	434	470	925,756
REVENUES									
Capitation Revenue	164,714,940	$ 127,016,562	$ 22,215,533	$ 313,947,034	$ 27,154,682	$ 3,932,507	$ 3,665,437	$ 206,728	$ 348,906,387
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	164,714,940	127,016,562	22,215,533	313,947,034	27,154,682	3,932,507	3,665,437	206,728	348,906,387
MEDICAL EXPENSES									
Provider Capitation	46,179,649	51,562,726	13,789,760	111,532,135	10,816,747	1,050,384			123,399,266
Facilities	40,022,803	35,759,745	8,276,194	84,058,742	4,464,764	821,791	895,305		90,240,602
Professional Claims	21,527,167	13,888,243	1,678,111	37,093,521	1,615,116	127,906	1,069,275		39,905,817
Prescription Drugs	(1,471,174)	(85,429)		(1,556,603)	7,412,871	1,251,673	443,408		7,551,350
MLTSS	49,224,899	5,444,767	2,314,622	56,984,288	1,620,554		52,618	23,513	58,680,973
Incentive Payments	2,030,480	2,270,390	40,309	4,341,178	489,861	5,667	5,425		4,842,131
Medical Management	2,946,897	2,025,457	398,788	5,371,143	1,026,718	58,966	884,187	149,688	7,490,702
Other Medical Expenses	342,769	216,818	9,486	569,073					569,073
Total Medical Expenses	160,803,490	111,082,717	26,507,271	298,393,477	27,446,633	3,316,386	3,350,219	173,201	332,679,915
Medical Loss Ratio	97.6%	87.5%	119.3%	95.0%	101.1%	84.3%	91.4%	83.8%	95.3%
GROSS MARGIN	**3,911,450**	**15,933,845**	**(4,291,738)**	**15,553,557**	**(291,951)**	**616,121**	**315,218**	**33,527**	**16,226,472**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				8,495,668	705,250	71,981	146,423	76,269	9,495,590
Professional fees				349,543	20,388	9,054	1,575	1,333	381,893
Purchased services				764,120	89,639	17,733	5,842		877,335
Printing & Postage				235,761	65,351	7,176	1,977		310,266
Depreciation & Amortization				385,759			539		386,299
Other expenses				1,425,231	94	-	4,791	5,935	1,436,051
Indirect cost allocation & Occupancy				(369,887)	723,040	109,710	13,006	6,550	482,419
Total Administrative Expenses				**11,286,195**	**1,603,761**	**215,655**	**174,154**	**90,087**	**13,369,852**
Admin Loss Ratio				3.6%	5.9%	5.5%	4.8%	43.6%	3.8%
INCOME (LOSS) FROM OPERATIONS				4,267,362	(1,895,712)	400,466	141,064	(56,560)	2,856,620
INVESTMENT INCOME									126,132
NET RENTAL INCOME									86,804
TOTAL MCO TAX				(1,070)					(1,070)
TOTAL GRANT INCOME				(863,636)					(863,636)
OTHER INCOME				7,500					7,500
CHANGE IN NET ASSETS				**$ 3,410,155**	**$ (1,895,712)**	**$ 400,466**	**$ 141,064**	**$ (56,560)**	**$ 2,212,350**
BUDGETED CHANGE IN NET ASSETS				1,871,442	(556,231)	(576,543)	(113,456)	(46,254)	1,169,793
VARIANCE TO BUDGET - FAV (UNFAV)				$ 1,538,713	$ (1,339,481)	$ 977,009	$ 254,520	$ (10,306)	$ 1,042,557

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CalOptima Health

Consolidated Revenue & Expenses: August 2022 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	1,122,011	665,629	23,821	1,811,461	28,974	5,638	869		1,846,942
REVENUES									
Capitation Revenue	312,420,291	$ 244,604,401	$ 43,018,182	$ 600,042,874	$ 54,665,466	$ 7,376,645	$ 7,266,209	$ 473,673	$ 669,824,867
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	312,420,291	244,604,401	43,018,182	600,042,874	54,665,466	7,376,645	7,266,209	473,673	669,824,867
MEDICAL EXPENSES									
Provider Capitation	89,928,840	102,438,216	20,865,742	213,232,798	22,477,175	1,938,216			237,648,189
Facilities	73,187,244	65,190,639	13,840,229	152,218,112	8,424,829	1,585,351	1,881,473		164,109,765
Professional Claims	44,384,279	28,267,337	3,445,437	76,097,053	2,924,080	319,924	1,903,976		81,245,034
Prescription Drugs	(1,509,767)	(155,553)		(1,665,320)	13,931,113	2,218,473	825,830		15,310,096
MLTSS	95,240,973	10,287,591	4,036,076	109,564,640	3,238,439		275,524	47,299	113,125,903
Incentive Payments	4,076,268	4,525,314	78,132	8,679,714	865,555	(85)	10,863		9,556,047
Medical Management	5,492,632	3,732,027	741,273	9,965,933	2,043,442	90,700	1,743,279	294,564	14,137,917
Other Medical Expenses	1,036,948	652,455	28,744	1,718,146					1,718,146
Total Medical Expenses	311,837,417	214,938,027	43,035,633	569,811,077	53,904,634	6,152,579	6,640,945	341,863	636,851,097
Medical Loss Ratio	99.8%	87.9%	100.0%	95.0%	98.6%	83.4%	91.4%	72.2%	95.1%
GROSS MARGIN	**582,874**	**29,666,374**	**(17,451)**	**30,231,797**	**760,832**	**1,224,066**	**625,264**	**131,810**	**32,973,770**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				17,587,595	1,338,120	199,935	284,976	157,016	19,567,642
Professional fees				814,740	10,814	62,839	1,575	2,667	892,635
Purchased services				1,515,297	193,020	30,632	56,124		1,795,072
Printing & Postage				662,988	93,949	13,194	7,375		777,506
Depreciation & Amortization				736,236			1,079		737,315
Other expenses				3,122,861	271	-	10,244	11,629	3,145,005
Indirect cost allocation & Occupancy				(811,680)	1,445,960	218,370	21,702	13,100	887,452
Total Administrative Expenses				**23,628,037**	**3,082,134**	**524,970**	**383,074**	**184,412**	**27,802,626**
Admin Loss Ratio				3.9%	5.6%	7.1%	5.3%	38.9%	4.2%
INCOME (LOSS) FROM OPERATIONS				6,603,761	(2,321,302)	699,097	242,190	(52,602)	5,171,143
INVESTMENT INCOME									5,751,589
NET RENTAL INCOME									212,066
TOTAL MCO TAX				(2,618)					(2,618)
TOTAL GRANT INCOME				(1,727,273)					(1,727,273)
OTHER INCOME				25,863					25,863
CHANGE IN NET ASSETS				**$ 4,899,733**	**$ (2,321,302)**	**$ 699,097**	**$ 242,190**	**$ (52,602)**	**$ 9,430,770**
BUDGETED CHANGE IN NET ASSETS				7,867,567	(1,086,718)	(1,160,439)	(164,328)	(88,569)	6,549,183
VARIANCE TO BUDGET - FAV (UNFAV)				$ (2,967,834)	$ (1,234,584)	$ 1,859,536	$ 406,518	$ 35,967	$ 2,881,587

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CalOptima Health

Balance Sheet: As of August 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$969,671,845	Accounts Payable	$40,538,777
Short-term Investments	932,034,481	Medical Claims liability	1,325,324,238
Capitation receivable	390,315,812	Accrued Payroll Liabilities	15,806,640
Receivables - Other	77,034,531	Deferred Revenue	8,002,226
Prepaid expenses	20,713,713	Deferred Lease Obligations	86,148
		Capitation and Withholds	203,246,618
Total Current Assets	**2,389,770,382**	**Total Current Liabilities**	**1,593,004,647**
Capital Assets			
Furniture & Equipment	48,861,260		
Building/Leasehold Improvements	5,059,408		
Construction in Progress	2,613,400		
505 City Parkway West	52,746,429		
500 City Parkway West	22,631,500		
	131,911,996		
Less: Accumulated Depreciation	(65,502,773)	**Other Liabilities**	
Capital assets, net	66,409,223	GASB 96 Subscription Liabilities	-
GASB 96 Capital Assets		**Other (than pensions) post**	
GASB 96 Subscription Assets	-	employment benefits liability	22,263,658
		Net Pension Liabilities	366,289
Less: GASB 96 Accumulated Depreciation	-	Bldg 505 Development Rights	-
GASB 96 Capital assets, net	-		
Total Capital Assets	66,409,223		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,615,634,594**
Homeless Health Reserve	40,636,739		
Board-designated assets:			
Cash and Cash Equivalents	8,650,853		
Investments	560,930,846	**Deferred Inflows**	
Total Board-designated Assets	569,581,699	Excess Earnings	686,563
		OPEB 75 Difference in Experience	4,822,000
		Change in Assumptions	1,909,305
Total Other Assets	610,518,438	OPEB Changes in Assumptions	3,389,000
		Diff in Projected vs Actual Earnings	20,982,636
		Net Position	
TOTAL ASSETS	**3,066,698,043**	TNE	105,225,526
		Funds in Excess of TNE	1,323,674,012
Deferred Outflows		**TOTAL NET POSITION**	1,428,899,538
Contributions	1,931,845		
Difference in Experience	2,353,671		
Excess Earning	-		
Changes in Assumptions	2,325,077		
OPEB 75 Changes in Assumptions	2,486,000		
Pension Contributions	529,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,076,323,636**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,076,323,636**

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CalOptima Health

Board Designated Reserve and TNE Analysis: As of August 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	231,764,154				
	Tier 1 - MetLife	230,315,658				
Board-designated Reserve		462,079,812	342,746,317	534,734,250	119,333,495	(72,654,438)
	Tier 2 - Payden & Rygel	53,879,643				
	Tier 2 - MetLife	53,622,244				
TNE Requirement		107,501,887	105,225,526	105,225,526	2,276,361	2,276,361
	Consolidated:	**569,581,699**	**447,971,843**	**639,959,775**	**121,609,856**	**(70,378,077)**
	Current reserve level	*1.78*	*1.40*	*2.00*		

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CalOptima Health

Net Assets Analysis: As of August 2022

Category	Item Description	Amount (Millions)	Spend to Date	%
	Total Net Position @ 08/31/2022:	**$1,428.9**		**100.0%**
Resources Assigned	Board Designated Reserve*	**$569.6**		**39.9%**
	Capital Assets, net of depreciation	**$66.4**		**4.6%**
Resources Allocated	Homeless Health Initiative**	$100.0	$34.6	1.8%
	Intergovernmental Transfers (IGT)	$111.7	$64.5	1.3%
	Mind OC Grant	$1.0	$1.0	0.0%
	CalFresh Outreach Strategy	$2.0	$0.4	0.1%
	Digital Transformation and Workplace Modernization	$100.0	$0.0	7.0%
	Coalition of Orange County Community Health Centers Grant	$50.0	$10.0	2.8%
	Subtotal:	**$364.7**	**$110.5**	**25.5%**
Resources Available for New Initiatives:	Unallocated/Unassigned*	**$428.2**		**30.0%**

*Total of Board Designated reserve and unallocated reserve amount can support approximately 90 days of CalOptima Health's current operations

**See Summary of Homeless Health Initiatives and Allocated Funds for list of Board approved initiatives

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CalOptima Health

Homeless Health Initiative and Allocated Funds: As of August 2022

		Amount
Program Commitment		**$100,000,000**
Funds Allocation, approved initiatives:		
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	
Recuperative Care	8,250,000	
Medical Respite	250,000	
Day Habilitation (County for HomeKey)	2,500,000	
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	
CalOptima Homeless Response Team	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,693,261	
FQHC (Community Health Center) Expansion and HHI Support	570,000	
HCAP Expansion for Telehealth and CFT On Call Days	1,700,000	
Vaccination Intervention and Member Incentive Strategy	400,000	
Street Medicine	8,000,000	
Outreach and Engagement Team	7,000,000	
Funds Allocation Total		**$59,363,261**
Program Commitment Balance, available for new initiatives*		**$40,636,739**

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 Health's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

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UNAUDITED FINANCIAL STATEMENTS

August 31, 2022

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CalOptima Health - Consolidated
Financial Highlights
For the Two Months Ended August 31, 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
925,756	915,761	9,995	1.1%	Member Months	1,846,942	1,831,291	15,651	0.9%
348,906,387	332,502,391	16,403,996	4.9%	Revenues	669,824,867	664,882,836	4,942,031	0.7%
332,679,915	313,062,603	(19,617,312)	(6.3%)	Medical Expenses	636,851,097	623,750,770	(13,100,327)	(2.1%)
13,369,852	17,497,194	4,127,342	23.6%	Administrative Expenses	27,802,626	34,400,917	6,598,291	19.2%
2,856,620	**1,942,594**	**914,026**	**47.1%**	**Operating Margin**	**5,171,143**	**6,731,149**	**(1,560,006)**	**(23.2%)**
(644,270)	(772,801)	128,531	16.6%	Non Operating Income (Loss)	4,259,627	(181,966)	4,441,593	2440.9%
2,212,350	**1,169,793**	**1,042,557**	**89.1%**	**Change in Net Assets**	**9,430,770**	**6,549,183**	**2,881,587**	**44.0%**
95.3%	94.2%	1.2%		Medical Loss Ratio	95.1%	93.8%	1.3%	
3.8%	5.3%	1.4%		Administrative Loss Ratio	4.2%	5.2%	1.0%	
0.8%	0.6%	0.2%		Operating Margin Ratio	0.8%	1.0%	(0.2%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima Health
Financial Dashboard
For the Two Months Ended August 31, 2022

MONTH - TO - DATE

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	907,677	898,001	9,676	1.1%
OneCare Connect	14,771	14,665	106	0.7%
OneCare	2,874	2,641	233	8.8%
PACE	434	454	(20)	(4.4%)
MSSP	470	568	(98)	(17.3%)
Total*	925,756	915,761	9,995	1.1%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 3,410	$ 1,871	1,539	82.3%
OneCare Connect	(1,896)	(556)	(1,340)	(241.0%)
OneCare	400	(577)	977	169.3%
PACE	141	(113)	254	224.8%
MSSP	(57)	(46)	(11)	(23.9%)
Buildings	87	91	(4)	(4.4%)
Investment Income	126	500	(374)	(74.8%)
Total	$ 2,211	$ 1,170	1,041	89.0%

MLR	Actual	Budget	% Point Var
Medi-Cal	95.0%	93.9%	1.2
OneCare Connect	101.1%	95.3%	5.8
OneCare	84.3%	108.2%	(23.9)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 11,286	$ 14,924	$ 3,638	24.4%
OneCare Connect	1,604	1,880	276	14.7%
OneCare	216	322	106	33.0%
PACE	174	271	97	35.7%
MSSP	90	100	10	10.2%
Total	$ 13,370	$ 17,497	$ 4,127	23.6%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,129	1,296	167
OneCare Connect	164	197	33
OneCare	12	20	8
PACE	90	114	23
MSSP	21	23	2
Total	1,415	1,649	234

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	804	693	(111)
OneCare Connect	90	75	(16)
OneCare	238	130	(108)
PACE	5	4	(1)
MSSP	23	25	2
Total	654	555	(99)

YEAR - TO - DATE

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	1,811,461	1,795,803	15,658	0.9%
OneCare Connect	28,974	29,328	(354)	(1.2%)
OneCare	5,638	5,256	382	7.3%
PACE	869	904	(35)	(3.9%)
MSSP	936	1,136	(200)	(17.6%)
Total*	1,846,942	1,831,291	15,651	0.9%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 4,900	$ 7,868	(2,968)	(37.7%)
OneCare Connect	(2,321)	(1,087)	(1,234)	(113.5%)
OneCare	699	(1,160)	1,859	160.3%
PACE	242	(164)	406	247.6%
MSSP	(53)	(89)	36	40.4%
Buildings	212	182	30	16.5%
Investment Income	5,752	1,000	4,752	475.2%
Total	$ 9,431	$ 6,550	2,881	44.0%

MLR	Actual	Budget	% Point Var
Medi-Cal	95.0%	93.5%	1.4
OneCare Connect	98.6%	95.3%	3.3
OneCare	83.4%	108.5%	(25.0)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 23,628	$ 29,314	$ 5,686	19.4%
OneCare Connect	3,082	3,720	638	17.1%
OneCare	525	637	112	17.6%
PACE	383	533	150	28.1%
MSSP	184	197	12	6.2%
Total	$ 27,803	$ 34,401	$ 6,598	19.2%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	2,263	2,589	325
OneCare Connect	331	394	62
OneCare	20	41	20
PACE	181	227	46
MSSP	39	46	7
Total	2,834	3,296	461

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	800	694	(107)
OneCare Connect	87	75	(13)
OneCare	276	129	(147)
PACE	5	4	(1)
MSSP	24	25	1
Total	652	556	(96)

Note:* Total membership does not include MSSP

CalOptima Health - Consolidated
Statement of Revenues and Expenses
For the One Month Ended August 31, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	925,756		915,761		9,995	
REVENUE						
Medi-Cal	$ 313,947,034	$ 345.88	$ 297,273,844	$ 331.04	$ 16,673,190	$ 14.84
OneCare Connect	27,154,682	1,838.38	28,105,909	1,916.53	(951,227)	(78.15)
OneCare	3,932,507	1,368.30	3,110,784	1,177.88	821,723	190.42
PACE	3,665,437	8,445.71	3,758,337	8,278.28	(92,900)	167.43
MSSP	206,728	439.85	253,517	446.33	(46,789)	(6.48)
Total Operating Revenue	348,906,387	376.89	332,502,391	363.09	16,403,996	13.80
MEDICAL EXPENSES						
Medi-Cal	298,393,477	328.74	279,114,580	310.82	(19,278,897)	(17.92)
OneCare Connect	27,446,633	1,858.14	26,782,102	1,826.26	(664,531)	(31.88)
OneCare	3,316,386	1,153.93	3,365,531	1,274.34	49,145	120.41
PACE	3,350,219	7,719.40	3,600,910	7,931.52	250,691	212.12
MSSP	173,201	368.51	199,480	351.20	26,279	(17.31)
Total Medical Expenses	332,679,915	359.36	313,062,603	341.86	(19,617,312)	(17.50)
GROSS MARGIN	16,226,472	17.53	19,439,788	21.23	(3,213,316)	(3.70)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	9,495,590	10.26	11,396,538	12.44	1,900,948	2.18
Professional fees	381,893	0.41	902,984	0.99	521,091	0.58
Purchased services	877,335	0.95	1,197,824	1.31	320,489	0.36
Printing & Postage	310,266	0.34	513,332	0.56	203,066	0.22
Depreciation & Amortization	386,299	0.42	525,900	0.57	139,601	0.15
Other expenses	1,436,051	1.55	2,434,437	2.66	998,386	1.11
Indirect cost allocation & Occupancy expense	482,419	0.52	526,179	0.57	43,760	0.05
Total Administrative Expenses	13,369,852	14.44	17,497,194	19.11	4,127,342	4.67
INCOME (LOSS) FROM OPERATIONS	2,856,620	3.09	1,942,594	2.12	914,026	0.97
INVESTMENT INCOME						
Interest income	4,168,062	4.50	500,000	0.55	3,668,062	3.95
Realized gain/(loss) on investments	(725,926)	(0.78)	-	-	(725,926)	(0.78)
Unrealized gain/(loss) on investments	(3,316,004)	(3.58)	-	-	(3,316,004)	(3.58)
Total Investment Income	126,132	0.14	500,000	0.55	(373,868)	(0.41)
NET RENTAL INCOME	86,804	0.09	90,835	0.10	(4,031)	(0.01)
TOTAL MCO TAX	(1,070)	-	-	-	(1,070)	-
TOTAL GRANT INCOME	(863,636)	(0.93)	(1,363,636)	(1.49)	500,000	0.56
OTHER INCOME	7,500	0.01	-	-	7,500	0.01
CHANGE IN NET ASSETS	**2,212,350**	**2.39**	**1,169,793**	**1.28**	**1,042,557**	**1.11**
MEDICAL LOSS RATIO	**95.3%**		**94.2%**		**1.2%**	
ADMINISTRATIVE LOSS RATIO	**3.8%**		**5.3%**		**1.4%**	

CalOptima Health- Consolidated
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	1,846,942		1,831,291		15,651	
REVENUE						
Medi-Cal	$ 600,042,874	$ 331.25	594,390,201	$ 330.99	$ 5,652,673	$ 0.26
OneCare Connect	54,665,466	1,886.71	56,294,739	1,919.49	(1,629,273)	(32.78)
OneCare	7,376,645	1,308.38	6,194,413	1,178.54	1,182,232	129.84
PACE	7,266,209	8,361.58	7,496,449	8,292.53	(230,240)	69.05
MSSP	473,673	506.06	507,034	446.33	(33,361)	59.73
Total Operating Revenue	669,824,867	362.67	664,882,836	363.07	4,942,031	(0.40)
MEDICAL EXPENSES						
Medi-Cal	569,811,077	314.56	555,844,681	309.52	(13,966,396)	(5.04)
OneCare Connect	53,904,634	1,860.45	53,661,573	1,829.70	(243,061)	(30.75)
OneCare	6,152,579	1,091.27	6,717,876	1,278.13	565,297	186.86
PACE	6,640,945	7,642.05	7,127,680	7,884.60	486,735	242.55
MSSP	341,863	365.24	398,960	351.20	57,097	(14.04)
Total Medical Expenses	636,851,097	344.81	623,750,770	340.61	(13,100,327)	(4.20)
GROSS MARGIN	32,973,770	17.86	41,132,066	22.46	(8,158,296)	(4.60)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	19,567,642	10.59	22,216,210	12.13	2,648,568	1.54
Professional fees	892,635	0.48	1,790,605	0.98	897,970	0.50
Purchased services	1,795,072	0.97	2,395,648	1.31	600,576	0.34
Printing & Postage	777,506	0.42	1,026,663	0.56	249,157	0.14
Depreciation & Amortization	737,315	0.40	1,051,800	0.57	314,485	0.17
Other expenses	3,145,005	1.70	4,868,874	2.66	1,723,869	0.96
Indirect cost allocation & Occupancy expense	887,452	0.48	1,051,117	0.57	163,665	0.09
Total Administrative Expenses	27,802,626	15.05	34,400,917	18.79	6,598,291	3.74
INCOME (LOSS) FROM OPERATIONS	5,171,143	2.80	6,731,149	3.68	(1,560,006)	(0.88)
INVESTMENT INCOME						
Interest income	7,098,287	3.84	1,000,000	0.55	6,098,287	3.29
Realized gain/(loss) on investments	(1,709,980)	(0.93)	-	0.00	(1,709,980)	(0.93)
Unrealized gain/(loss) on investments	363,282	0.20	-	0.00	363,282	0.20
Total Investment Income	5,751,589	3.11	1,000,000	0.55	4,751,589	2.56
NET RENTAL INCOME	212,066	0.11	181,670	0.10	30,396	0.01
TOTAL MCO TAX	(2,618)	0.00	-	0.00	(2,618)	0.00
TOTAL GRANT INCOME	(1,727,273)	(0.94)	(1,363,636)	(0.74)	(363,637)	(0.20)
OTHER INCOME	25,863	0.01	-	0.00	25,863	0.01
CHANGE IN NET ASSETS	**9,430,770**	**5.11**	**6,549,183**	**3.58**	**2,881,587**	**1.53**
MEDICAL LOSS RATIO	**95.1%**		**93.8%**		**1.3%**	
ADMINISTRATIVE LOSS RATIO	**4.2%**		**5.2%**		**1.0%**	

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended August 31, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	561,379	334,353	11,945	907,677	14,771	2,874	434	470	925,756
REVENUES									
Capitation Revenue	164,714,940	$ 127,016,562	$ 22,215,533	$ 313,947,034	$ 27,154,682	$ 3,932,507	$ 3,665,437	$ 206,728	$ 348,906,387
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	164,714,940	127,016,562	22,215,533	313,947,034	27,154,682	3,932,507	3,665,437	206,728	348,906,387
MEDICAL EXPENSES									
Provider Capitation	46,179,649	51,562,726	13,789,760	111,532,135	10,816,747	1,050,384			123,399,266
Facilities	40,022,803	35,759,745	8,276,194	84,058,742	4,464,764	821,791	895,305		90,240,602
Professional Claims	21,527,167	13,888,243	1,678,111	37,093,521	1,615,116	127,906	1,069,275		39,905,817
Prescription Drugs	(1,471,174)	(85,429)		(1,556,603)	7,412,871	1,251,673	443,408		7,551,350
MLTSS	49,224,899	5,444,767	2,314,622	56,984,288	1,620,554		52,618	23,513	58,680,973
Incentive Payments	2,030,480	2,270,390	40,309	4,341,178	489,861	5,667	5,425		4,842,131
Medical Management	2,946,897	2,025,457	398,788	5,371,143	1,026,718	58,966	884,187	149,688	7,490,702
Other Medical Expenses	342,769	216,818	9,486	569,073					569,073
Total Medical Expenses	160,803,490	111,082,717	26,507,271	298,393,477	27,446,633	3,316,386	3,350,219	173,201	332,679,915
Medical Loss Ratio	97.6%	87.5%	119.3%	95.0%	101.1%	84.3%	91.4%	83.8%	95.3%
GROSS MARGIN	**3,911,450**	**15,933,845**	**(4,291,738)**	**15,553,557**	**(291,951)**	**616,121**	**315,218**	**33,527**	**16,226,472**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits	8,495,668	705,250	71,981	146,423	76,269	9,495,590			
Professional fees	349,543	20,388	9,054	1,575	1,333	381,893			
Purchased services	764,120	89,639	17,733	5,842		877,335			
Printing & Postage	235,761	65,351	7,176	1,977		310,266			
Depreciation & Amortization	385,759			539		386,299			
Other expenses	1,425,231	94	-	4,791	5,935	1,436,051			
Indirect cost allocation & Occupancy	(369,887)	723,040	109,710	13,006	6,550	482,419			
Total Administrative Expenses	**11,286,195**	**1,603,761**	**215,655**	**174,154**	**90,087**	**13,369,852**			
Admin Loss Ratio	3.6%	5.9%	5.5%	4.8%	43.6%	3.8%			
INCOME (LOSS) FROM OPERATIONS	4,267,362	(1,895,712)	400,466	141,064	(56,560)	2,856,620			
INVESTMENT INCOME						126,132			
NET RENTAL INCOME						86,804			
TOTAL MCO TAX	(1,070)					(1,070)			
TOTAL GRANT INCOME	(863,636)					(863,636)			
OTHER INCOME	7,500					7,500			
CHANGE IN NET ASSETS	**$ 3,410,155**	**$ (1,895,712)**	**$ 400,466**	**$ 141,064**	**$ (56,560)**	**$ 2,212,350**			
BUDGETED CHANGE IN NET ASSETS	1,871,442	(556,231)	(576,543)	(113,456)	(46,254)	1,169,793			
VARIANCE TO BUDGET - FAV (UNFAV)	$ 1,538,713	$ (1,339,481)	$ 977,009	$ 254,520	$ (10,306)	$ 1,042,557			

Note:* Total membership does not include MSSP

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Two Months Ended August 31, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	1,122,011	665,629	23,821	1,811,461	28,974	5,638	869	936	1,846,942
REVENUES									
Capitation Revenue	312,420,291	$ 244,604,401	$ 43,018,182	$ 600,042,874	$ 54,665,466	$ 7,376,645	$ 7,266,209	$ 473,673	$ 669,824,867
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	312,420,291	244,604,401	43,018,182	600,042,874	54,665,466	7,376,645	7,266,209	473,673	669,824,867
MEDICAL EXPENSES									
Provider Capitation	89,928,840	102,438,216	20,865,742	213,232,798	22,477,175	1,938,216			237,648,189
Facilities	73,187,244	65,190,639	13,840,229	152,218,112	8,424,829	1,585,351	1,881,473		164,109,765
Professional Claims	44,384,279	28,267,337	3,445,437	76,097,053	2,924,080	319,924	1,903,976		81,245,034
Prescription Drugs	(1,509,767)	(155,553)		(1,665,320)	13,931,113	2,218,473	825,830		15,310,096
MLTSS	95,240,973	10,287,591	4,036,076	109,564,640	3,238,439		275,524	47,299	113,125,903
Incentive Payments	4,076,268	4,525,314	78,132	8,679,714	865,555	(85)	10,863		9,556,047
Medical Management	5,492,632	3,732,027	741,273	9,965,933	2,043,442	90,700	1,743,279	294,564	14,137,917
Other Medical Expenses	1,036,948	652,455	28,744	1,718,146					1,718,146
Total Medical Expenses	311,837,417	214,938,027	43,035,633	569,811,077	53,904,634	6,152,579	6,640,945	341,863	636,851,097
Medical Loss Ratio	99.8%	87.9%	100.0%	95.0%	98.6%	83.4%	91.4%	72.2%	95.1%
GROSS MARGIN	**582,874**	**29,666,374**	**(17,451)**	**30,231,797**	**760,832**	**1,224,066**	**625,264**	**131,810**	**32,973,770**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits	17,587,595	1,338,120	199,935	284,976	157,016	19,567,642			
Professional fees	814,740	10,814	62,839	1,575	2,667	892,635			
Purchased services	1,515,297	193,020	30,632	56,124		1,795,072			
Printing & Postage	662,988	93,949	13,194	7,375		777,506			
Depreciation & Amortization	736,236			1,079		737,315			
Other expenses	3,122,861	271	-	10,244	11,629	3,145,005			
Indirect cost allocation & Occupancy	(811,680)	1,445,960	218,370	21,702	13,100	887,452			
Total Administrative Expenses	**23,628,037**	**3,082,134**	**524,970**	**383,074**	**184,412**	**27,802,626**			
Admin Loss Ratio	3.9%	5.6%	7.1%	5.3%	38.9%	4.2%			
INCOME (LOSS) FROM OPERATIONS	6,603,761	(2,321,302)	699,097	242,190	(52,602)	5,171,143			
INVESTMENT INCOME						5,751,589			
NET RENTAL INCOME						212,066			
TOTAL MCO TAX	(2,618)					(2,618)			
TOTAL GRANT INCOME	(1,727,273)					(1,727,273)			
OTHER INCOME	25,863					25,863			
CHANGE IN NET ASSETS	**$ 4,899,733**	**$ (2,321,302)**	**$ 699,097**	**$ 242,190**	**$ (52,602)**	**$ 9,430,770**			
BUDGETED CHANGE IN NET ASSETS	7,867,567	(1,086,718)	(1,160,439)	(164,328)	(88,569)	6,549,183			
VARIANCE TO BUDGET - FAV (UNFAV)	$ (2,967,834)	$ (1,234,584)	$ 1,859,536	$ 406,518	$ 35,967	$ 2,881,587			

Note:* Total membership does not include MSSP

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CalOptima Health

August 31, 2022 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $2.2 million, $1.0 million favorable to budget
- Operating surplus is $2.9 million, with a deficit in non-operating income of $0.6 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $9.4 million, $2.9 million favorable to budget
- Operating surplus is $5.2 million, with a surplus in non-operating income of $4.3 million

Change in Net Assets by Line of Business (LOB) ($ millions):

August				July-August		
Actual	Budget	Variance		Actual	Budget	Variance
4.3	3.2	1.0	Medi-Cal	6.6	9.2	(2.6)
(1.9)	(0.6)	(1.3)	OCC	(2.3)	(1.1)	(1.2)
0.4	(0.6)	1.0	OneCare	0.7	(1.2)	1.9
0.1	(0.1)	0.3	PACE	0.2	(0.2)	0.4
(0.1)	(0.0)	(0.0)	MSSP	(0.1)	(0.1)	0.0
2.9	**1.9**	**0.9**	**Operating**	**5.2**	**6.7**	**(1.6)**
(0.6)	(0.8)	0.1	Inv/ Rent/Tax/Other Inc	4.3	(0.2)	4.4
(0.6)	**(0.8)**	**0.1**	**Non-Operating**	**4.3**	**(0.2)**	**4.4**
2.2	**1.2**	**1.0**	**TOTAL**	**9.4**	**6.5**	**2.9**

CalOptima Health - Consolidated
Enrollment Summary
For the Two Months Ended August 31, 2022

Month-to-Date					Year-to-Date			
		$	%				$	%
Actual	**Budget**	**Variance**	**Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**Variance**	**Variance**
123,945	122,270	1,675	1.4%	SPD	247,283	244,270	3,013	1.2%
303,015	306,805	(3,790)	(1.2%)	TANF Child	606,399	613,610	(7,211)	(1.2%)
131,177	135,957	(4,780)	(3.5%)	TANF Adult	261,830	271,913	(10,083)	(3.7%)
3,242	3,321	(79)	(2.4%)	LTC	6,499	6,634	(135)	(2.0%)
334,353	317,914	16,439	5.2%	MCE	665,629	635,926	29,703	4.7%
11,945	11,734	211	1.8%	WCM	23,821	23,450	371	1.6%
907,677	**898,001**	**9,676**	**1.1%**	**Medi-Cal Total**	**1,811,461**	**1,795,803**	**15,658**	**0.9%**
14,771	**14,665**	**106**	**0.7%**	**OneCare Connect**	**28,974**	**29,328**	**(354)**	**(1.2%)**
2,874	**2,641**	**233**	**8.8%**	**OneCare**	**5,638**	**5,256**	**382**	**7.3%**
434	**454**	**(20)**	**(4.4%)**	**PACE**	**869**	**904**	**(35)**	**(3.9%)**
470	**568**	**(98)**	**(17.3%)**	**MSSP**	**936**	**1,136**	**(200)**	**(17.6%)**
925,756	**915,761**	**9,995**	**1.1%**	**CalOptima Health Total**	**1,846,942**	**1,831,291**	**15,651**	**0.9%**
				Enrollment (by Network)				
210,935	211,785	(850)	(0.4%)	HMO	421,121	423,554	(2,433)	(0.6%)
237,194	239,636	(2,442)	(1.0%)	PHC	474,194	479,262	(5,068)	(1.1%)
225,190	222,888	2,302	1.0%	Shared Risk Group	450,132	445,775	4,357	1.0%
234,358	223,692	10,666	4.8%	Fee for Service	466,014	447,212	18,802	4.2%
907,677	**898,001**	**9,676**	**1.1%**	**Medi-Cal Total**	**1,811,461**	**1,795,803**	**15,658**	**0.9%**
14,771	**14,665**	**106**	**0.7%**	**OneCare Connect**	**28,974**	**29,328**	**(354)**	**(1.2%)**
2,874	**2,641**	**233**	**8.8%**	**OneCare**	**5,638**	**5,256**	**382**	**7.3%**
434	**454**	**(20)**	**(4.4%)**	**PACE**	**869**	**904**	**(35)**	**(3.9%)**
470	**568**	**(98)**	**(17.3%)**	**MSSP**	**936**	**1,136**	**(200)**	**(17.6%)**
925,756	**915,761**	**9,995**	**1.1%**	**CalOptima Health Total**	**1,846,942**	**1,831,291**	**15,651**	**0.9%**

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2023

	July	August	September	October	November	December	January	February	March	April	May	June	YTD Actual	YTD Budget	Variance
HMOs															
SPD	11,237	11,250											22,487	21,884	603
BCCTP													-		0
Disabled													-		0
TANF Child	58,966	58,892											117,858	119,212	(1,354)
TANF Adult	38,926	38,983											77,909	84,205	(6,296)
LTC	1	2											3		3
MCE	99,022	99,788											198,810	194,032	4,778
WCM	2,034	2,020											4,054	4,221	(167)
Total	**210,186**	**210,935**											**421,121**	**423,554**	**(2,433)**
PHCs															
SPD	7,040	7,022											14,062	13,990	72
BCCTP													-		0
Disabled													-		0
TANF Child	158,385	158,345											316,730	320,108	(3,378)
TANF Adult	16,704	16,780											33,484	35,638	(2,154)
LTC		1											1		1
MCE	47,505	47,574											95,079	95,066	13
WCM	7,366	7,472											14,838	14,460	378
Total	**237,000**	**237,194**											**474,194**	**479,262**	**(5,068)**
Shared Risk Groups															
SPD	10,824	10,928											21,752	20,386	1,366
BCCTP													-		0
Disabled													-		0
TANF Child	57,419	57,075											114,494	119,312	(4,818)
TANF Adult	40,518	40,260											80,778	82,556	(1,778)
LTC	2	1											3		3
MCE	114,819	115,585											230,404	220,740	9,664
WCM	1,360	1,341											2,701	2,781	(80)
Total	**224,942**	**225,190**											**450,132**	**445,775**	**4,357**
Fee for Service (Dual)															
SPD	82,253	82,742											164,995	165,720	(725)
BCCTP													-		0
Disabled													-		0
TANF Child	1	1											2		2
TANF Adult	1,675	1,712											3,387	3,692	(305)
LTC	2,894	2,874											5,768	5,972	(204)
MCE	6,480	6,749											13,229	12,064	1,165
WCM	20	18											38	30	8
Total	**93,323**	**94,096**											**187,419**	**187,478**	**(59)**
Fee for Service (Non-Dual - Total)															
SPD	11,984	12,003											23,987	22,290	1,697
BCCTP													-		0
Disabled													-		0
TANF Child	28,613	28,702											57,315	54,978	2,337
TANF Adult	32,830	33,442											66,272	65,822	450
LTC	360	364											724	662	62
MCE	63,450	64,657											128,107	114,024	14,083
WCM	1,096	1,094											2,190	1,958	232
Total	**138,333**	**140,262**											**278,595**	**259,734**	**18,861**
Grand Totals															
SPD	123,338	123,945											247,283	244,270	3,013
BCCTP													-		0
Disabled													-		0
TANF Child	303,384	303,015											606,399	613,610	(7,211)
TANF Adult	130,653	131,177											261,830	271,913	(10,083)
LTC	3,257	3,242											6,499	6,634	(135)
MCE	331,276	334,353											665,629	635,926	29,703
WCM	11,876	11,945											23,821	23,450	371
Total MediCal MM	**903,784**	**907,677**											**1,811,461**	**1,795,803**	**15,658**
OneCare Connect	**14,203**	**14,771**											**28,974**	**29,328**	**(354)**
OneCare	**2,764**	**2,874**											**5,638**	**5,256**	**382**
PACE	**435**	**434**											**869**	**904**	**(35)**
MSSP	**466**	**470**											**936**	**1,136**	**(200)**
Grand Total	**921,186**	**925,756**											**1,846,942**	**1,831,291**	**15,651**

*Note: Grand Total does not include MSSP

ENROLLMENT:

Overall, August enrollment was 925,756

- Favorable to budget 9,995 or 1.1%
- Increased 4,570 or 0.5% from Prior Month (PM) (July 2022)
- Increased 75,517 or 8.9% from Prior Year (PY) (August 2021)

Medi-Cal enrollment was 907,677

- Favorable to budget 9,676 or 1.1%
  - Medi-Cal Expansion (MCE) favorable 16,439
  - Seniors and Persons with Disabilities (SPD) favorable 1,675
  - Whole Child Model (WCM) favorable 211
  - Temporary Assistance for Needy Families (TANF) unfavorable 8,570
  - Long-Term Care (LTC) unfavorable 79
- Increased 3,893 from PM

OneCare Connect enrollment was 14,771

- Favorable to budget 106 or 0.7%
- Increased 568 from PM

OneCare enrollment was 2,874

- Favorable to budget 233 or 8.8%
- Increased 110 from PM

PACE enrollment was 434

- Unfavorable to budget 20 or 4.4%
- Increased 1 from PM

MSSP enrollment was 470

- Unfavorable to budget 98 or 17.3% due to MSSP currently being under-staffed. There is a staff to member ratio that must be met
- Increased 4 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
907,677	**898,001**	**9,676**	**1.1%**	**Member Months**	**1,811,461**	**1,795,803**	**15,658**	**0.9%**
				Revenues				
313,947,034	297,273,844	16,673,190	5.6%	Medi-Cal Capitation Revenue	600,042,874	594,390,201	5,652,673	1.0%
313,947,034	**297,273,844**	**16,673,190**	**5.6%**	**Total Operating Revenue**	**600,042,874**	**594,390,201**	**5,652,673**	**1.0%**
				Medical Expenses				
111,532,135	106,751,626	(4,780,509)	(4.5%)	Provider Capitation	213,232,798	213,487,131	254,333	0.1%
84,058,742	68,614,920	(15,443,822)	(22.5%)	Facilities Claims	152,218,112	137,036,105	(15,182,007)	(11.1%)
37,093,521	40,268,562	3,175,041	7.9%	Professional Claims	76,097,053	80,499,306	4,402,253	5.5%
56,984,288	50,271,149	(6,713,139)	(13.4%)	MLTSS	109,564,640	98,596,382	(10,968,258)	(11.1%)
(1,556,603)	-	1,556,603	0.0%	Prescription Drugs	(1,665,320)	-	1,665,320	0.0%
4,341,178	4,694,581	353,403	7.5%	Incentive Payments	8,679,714	9,388,769	709,055	7.6%
5,371,143	6,939,670	1,568,527	22.6%	Medical Management	9,965,933	13,688,844	3,722,911	27.2%
569,073	1,574,072	1,004,999	63.8%	Other Medical Expenses	1,718,146	3,148,144	1,429,998	45.4%
298,393,477	**279,114,580**	**(19,278,897)**	**(6.9%)**	**Total Medical Expenses**	**569,811,077**	**555,844,681**	**(13,966,396)**	**(2.5%)**
15,553,557	**18,159,264**	**(2,605,707)**	**(14.3%)**	**Gross Margin**	**30,231,797**	**38,545,520**	**(8,313,723)**	**(21.6%)**
				Administrative Expenses				
8,495,668	10,046,239	1,550,571	15.4%	Salaries, Wages & Employee Benefits	17,587,595	19,573,786	1,986,191	10.1%
349,543	855,823	506,280	59.2%	Professional Fees	814,740	1,696,283	881,543	52.0%
764,120	1,029,845	265,725	25.8%	Purchased Services	1,515,297	2,059,690	544,393	26.4%
235,761	383,818	148,057	38.6%	Printing & Postage	662,988	767,636	104,648	13.6%
385,759	525,000	139,241	26.5%	Depreciation & Amortization	736,236	1,050,000	313,764	29.9%
1,425,231	2,409,121	983,890	40.8%	Other Operating Expenses	3,122,861	4,818,242	1,695,381	35.2%
(369,887)	(325,660)	44,227	13.6%	Indirect Cost Allocation, Occupancy	(811,680)	(651,320)	160,360	24.6%
11,286,195	**14,924,186**	**3,637,991**	**24.4%**	**Total Administrative Expenses**	**23,628,037**	**29,314,317**	**5,686,280**	**19.4%**
				Operating Tax				
15,238,513	16,038,334	(799,821)	(5.0%)	Tax Revenue	30,476,549	32,073,120	(1,596,571)	(5.0%)
15,239,583	16,038,334	798,751	(5.0%)	Tax Expense	30,479,167	32,073,120	1,593,953	(5.0%)
(1,070)	**-**	**(1,070)**	**0.0%**	**Total Operating Tax**	**(2,618)**	**-**	**(2,618)**	**0.0%**
				Grant Income				
-	-	-	0.0%	Grant Revenue	-	-	-	0.0%
863,636	1,363,636	500,000	(36.7%)	Grant Expense	1,727,273	1,363,636	(363,637)	26.7%
(863,636)	**(1,363,636)**	**500,000**	**(36.7%)**	**Total Grant Income**	**(1,727,273)**	**(1,363,636)**	**(363,637)**	**26.7%**
7,500	**-**	**7,500**	**0.0%**	**Other Income**	**25,863**	**-**	**25,863**	**0.0%**
3,410,155	**1,871,442**	**1,538,713**	**82.2%**	**Change in Net Assets**	**4,899,733**	**7,867,567**	**(2,967,834)**	**(37.7%)**
95.0%	***93.9%***	***1.2%***		***Medical Loss Ratio***	***95.0%***	***93.5%***	***1.4%***	
3.6%	***5.0%***	***1.4%***		***Admin Loss Ratio***	***3.9%***	***4.9%***	***1.0%***	

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MEDI-CAL INCOME STATEMENT– AUGUST MONTH:

REVENUES of $313.9 million are favorable to budget $16.7 million driven by:

- Favorable volume related variance of $3.2 million
- Favorable price related variance of $13.5 million
  - $4.2 million due to prior year retroactive eligibility changes
  - $3.7 million due to COVID-19 Vaccination Incentive Program (VIP) payment
  - $4.3 million due to Proposition 56, COVID-19, and Enhanced Care Management (ECM) risk corridor reserves

MEDICAL EXPENSES of $298.4 million are unfavorable to budget $19.3 million driven by:

- Unfavorable volume related variance of $3.0 million
- Unfavorable price related variance of $16.3 million
  - Facilities Claims expense unfavorable variance of $14.7 million primarily due to Incurred But Not Reported (IBNR) claims
  - Managed Long-Term Services and Supports (MLTSS) expense unfavorable variance of $6.2 million due to IBNR claims
  - Provider Capitation expense unfavorable variance of $3.6 million due primarily to WCM program
  - Offset by:
  - Professional Claims expense favorable variance of $3.6 million
  - All other expenses favorable variance of $4.6 million

ADMINISTRATIVE EXPENSES of $11.3 million are favorable to budget $3.7 million driven by:

- Other Non-Salary expense favorable to budget $2.1 million
- Salaries & Benefit expense favorable to budget $1.6 million

CHANGE IN NET ASSETS is $3.4 million, favorable to budget $1.5 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Two Months Ending August 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,771	**14,665**	**106**	**0.7%**	**Member Months**	**28,974**	**29,328**	**(354)**	**(1.2%)**
				Revenues				
2,730,660	2,848,122	(117,462)	(4.1%)	Medi-Cal Revenue	5,470,985	5,704,828	(233,843)	(4.1%)
18,383,599	19,732,686	(1,349,087)	(6.8%)	Medicare Part C Revenue	36,408,294	39,538,902	(3,130,608)	(7.9%)
6,040,422	5,525,101	515,321	9.3%	Medicare Part D Revenue	12,786,187	11,051,009	1,735,178	15.7%
27,154,682	**28,105,909**	**(951,227)**	**(3.4%)**	**Total Operating Revenue**	**54,665,466**	**56,294,739**	**(1,629,273)**	**(2.9%)**
				Medical Expenses				
10,816,747	11,639,367	822,620	7.1%	Provider Capitation	22,477,175	23,320,771	843,596	3.6%
4,464,764	4,153,550	(311,214)	(7.5%)	Facilities Claims	8,424,829	8,295,854	(128,975)	(1.6%)
1,615,116	1,213,227	(401,889)	(33.1%)	Ancillary	2,924,080	2,421,949	(502,131)	(20.7%)
1,620,554	1,502,252	(118,302)	(7.9%)	MLTSS	3,238,439	3,001,725	(236,714)	(7.9%)
7,412,871	6,417,346	(995,525)	(15.5%)	Prescription Drugs	13,931,113	12,811,008	(1,120,105)	(8.7%)
489,861	550,115	60,254	11.0%	Incentive Payments	865,555	1,107,592	242,037	21.9%
1,026,718	1,306,245	279,527	21.4%	Medical Management	2,043,442	2,702,674	659,232	24.4%
27,446,633	**26,782,102**	**(664,531)**	**(2.5%)**	**Total Medical Expenses**	**53,904,634**	**53,661,573**	**(243,061)**	**(0.5%)**
(291,951)	**1,323,807**	**(1,615,758)**	**(122.1%)**	**Gross Margin**	**760,832**	**2,633,166**	**(1,872,334)**	**(71.1%)**
				Administrative Expenses				
705,250	952,951	247,701	26.0%	Salaries, Wages & Employee Benefits	1,338,120	1,865,830	527,710	28.3%
20,388	20,833	446	2.1%	Professional Fees	10,814	41,666	30,852	74.0%
89,639	109,606	19,967	18.2%	Purchased Services	193,020	219,212	26,192	11.9%
65,351	67,512	2,161	3.2%	Printing & Postage	93,949	135,024	41,075	30.4%
94	6,096	6,002	98.5%	Other Operating Expenses	271	12,192	11,921	97.8%
723,040	723,040	-	0.0%	Indirect Allocation, Occupancy	1,445,960	1,445,960	-	0.0%
1,603,761	**1,880,038**	**276,277**	**14.7%**	**Total Administrative Expenses**	**3,082,134**	**3,719,884**	**637,750**	**17.1%**
(1,895,712)	**(556,231)**	**(1,339,481)**	**240.8%**	**Change in Net Assets**	**(2,321,302)**	**(1,086,718)**	**(1,234,584)**	**113.6%**
101.1%	***95.3%***	***5.8%***		***Medical Loss Ratio***	***98.6%***	***95.3%***	***3.3%***	
5.9%	***6.7%***	***0.8%***		***Admin Loss Ratio***	***5.6%***	***6.6%***	***1.0%***	

ONECARE CONNECT INCOME STATEMENT– AUGUST MONTH:

REVENUES of $27.2 million are unfavorable to budget $1.0 million driven by:

- Favorable volume related variance of $0.2 million
- Unfavorable price related variance of $1.2 million

MEDICAL EXPENSES of $27.4 million are unfavorable to budget $0.7 million driven by:

- Unfavorable volume related variance of $0.2 million
- Unfavorable price related variance of $0.5 million
  - Prescription Drugs expense unfavorable variance of $0.9 million
  - Ancillary expense unfavorable variance of $0.4 million
  - Offset by:
  - Provider Capitation expense favorable variance of $0.9 million

ADMINISTRATIVE EXPENSES of $1.6 million are favorable to budget $0.3 million driven by:

- Salaries & Benefit expense favorable to budget $0.2 million
- Other Non-Salary expense favorable to budget $28,575

CHANGE IN NET ASSETS is ($1.9) million, unfavorable to budget $1.3 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
2,874	**2,641**	**233**	**8.8%**	**Member Months**	**5,638**	**5,256**	**382**	**7.3%**
				Revenues				
2,586,557	2,069,545	517,012	25.0%	Medicare Part C Revenue	4,765,767	4,120,443	645,324	15.7%
1,345,949	1,041,239	304,710	29.3%	Medicare Part D Revenue	2,610,877	2,073,970	536,907	25.9%
3,932,507	**3,110,784**	**821,723**	**26.4%**	**Total Operating Revenue**	**7,376,645**	**6,194,413**	**1,182,232**	**19.1%**
				Medical Expenses				
1,050,384	762,091	(288,293)	(37.8%)	Provider Capitation	1,938,216	1,517,309	(420,907)	(27.7%)
821,791	1,232,804	411,013	33.3%	Inpatient	1,585,351	2,451,499	866,148	35.3%
127,906	95,459	(32,447)	(34.0%)	Ancillary	319,924	189,956	(129,968)	(68.4%)
1,251,673	1,165,920	(85,753)	(7.4%)	Prescirption Drugs	2,218,473	2,316,580	98,107	4.2%
5,667	25,165	19,498	77.5%	Incentive Payments	(85)	50,089	50,174	100.2%
58,966	84,092	25,126	29.9%	Medical Management	90,700	192,443	101,743	52.9%
3,316,386	**3,365,531**	**49,145**	**1.5%**	**Total Medical Expenses**	**6,152,579**	**6,717,876**	**565,297**	**8.4%**
616,121	**(254,747)**	**870,868**	**341.9%**	**Gross Margin**	**1,224,066**	**(523,463)**	**1,747,529**	**333.8%**
				Administrative Expenses				
71,981	131,043	59,062	45.1%	Salaries, Wages & Employee Benefits	199,935	256,520	56,585	22.1%
9,054	24,583	15,529	63.2%	Professional Fees	62,839	49,166	(13,673)	(27.8%)
17,733	14,693	(3,040)	(20.7%)	Purchased Services	30,632	29,386	(1,246)	(4.2%)
7,176	41,767	34,591	82.8%	Printing & Postage	13,194	83,534	70,340	84.2%
-	-	-	0.0%	Other Operating Expenses	-	-	-	0.0%
109,710	109,710	-	0.0%	Indirect Allocation, Occupancy	218,370	218,370	-	0.0%
215,655	**321,796**	**106,141**	**33.0%**	**Total Administrative Expenses**	**524,970**	**636,976**	**112,006**	**17.6%**
400,466	**(576,543)**	**977,009**	**169.5%**	**Change in Net Assets**	**699,097**	**(1,160,439)**	**1,859,536**	**160.2%**
84.3%	***108.2%***	***(23.9%)***		***Medical Loss Ratio***	***83.4%***	***108.5%***	***(25.0%)***	
5.5%	***10.3%***	***4.9%***		***Admin Loss Ratio***	***7.1%***	***10.3%***	***3.2%***	

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
434	**454**	**(20)**	**(4.4%)**	**Member Months**	**869**	**904**	**(35)**	**-3.9%**
				Revenues				
2,781,335	2,881,493	(100,158)	(3.5%)	Medi-Cal Capitation Revenue	5,559,512	5,737,863	(178,351)	(3.1%)
678,571	683,708	(5,137)	(0.8%)	Medicare Part C Revenue	1,336,667	1,374,079	(37,412)	(2.7%)
205,531	193,136	12,395	6.4%	Medicare Part D Revenue	370,030	384,507	(14,477)	(3.8%)
3,665,437	**3,758,337**	**(92,900)**	**(2.5%)**	**Total Operating Revenue**	**7,266,209**	**7,496,449**	**(230,240)**	**(3.1%)**
				Medical Expenses				
884,187	1,146,681	262,494	22.9%	Medical Management	1,743,279	2,250,284	507,005	22.5%
895,305	902,886	7,581	0.8%	Facilities Claims	1,881,473	1,794,380	(87,093)	(4.9%)
886,027	907,392	21,365	2.4%	Professional Claims	1,595,160	1,803,178	208,018	11.5%
443,408	384,719	(58,689)	(15.3%)	Prescription Drugs	825,830	763,722	(62,108)	(8.1%)
52,618	65,925	13,307	20.2%	MLTSS	275,524	131,270	(144,254)	(109.9%)
183,248	187,527	4,279	2.3%	Patient Transportation	308,816	373,337	64,521	17.3%
5,425	5,780	355	6.1%	Incentive Payments	10,863	11,509	647	5.6%
3,350,219	**3,600,910**	**250,691**	**7.0%**	**Total Medical Expenses**	**6,640,945**	**7,127,680**	**486,735**	**6.8%**
315,218	**157,427**	**157,791**	**100.2%**	**Gross Margin**	**625,264**	**368,769**	**256,495**	**69.6%**
				Administrative Expenses				
146,423	183,045	36,622	20.0%	Salaries, Wages & Employee Benefits	284,976	357,493	72,517	20.3%
1,575	412	(1,163)	(282.3%)	Professional Fees	1,575	824	(751)	(91.1%)
5,842	43,680	37,838	86.6%	Purchased Services	56,124	87,360	31,236	35.8%
1,977	20,235	18,258	90.2%	Printing & Postage	7,375	40,469	33,094	81.8%
539	900	361	40.1%	Depreciation & Amortization	1,079	1,800	721	40.1%
4,791	10,072	5,281	52.4%	Other Operating Expenses	10,244	20,144	9,900	49.1%
13,006	12,539	(467)	(3.7%)	Indirect Cost Allocation, Occupancy	21,702	25,007	3,305	13.2%
174,154	**270,883**	**96,729**	**35.7%**	**Total Administrative Expenses**	**383,074**	**533,097**	**150,023**	**28.1%**
141,064	**(113,456)**	**254,520**	**(224.3%)**	**Change in Net Assets**	**242,190**	**(164,328)**	**406,518**	**(247.4%)**
91.4%	***95.8%***	***(4.4%)***		***Medical Loss Ratio***	***91.4%***	***95.1%***	***(3.7%)***	
4.8%	***7.2%***	***2.5%***		***Admin Loss Ratio***	***5.3%***	***7.1%***	***1.8%***	

CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
470	**568**	**(98)**	**(17.3%)**	**Member Months**	**936**	**1,136**	**(200)**	**(17.6%)**
				Revenues				
206,728	253,517	(46,789)	(18.5%)	Medi-Cal Revenue	473,673	507,034	(33,361)	(6.6%)
206,728	**253,517**	**(46,789)**	**(18.5%)**	**Total Operating Revenue**	**473,673**	**507,034**	**(33,361)**	**(6.6%)**
				Medical Expenses				
149,688	166,522	16,834	10.1%	Medical Management	294,564	333,044	38,480	11.6%
23,513	32,958	9,445	28.7%	Waived Services	47,299	65,916	18,617	28.2%
149,688	166,522	16,834	10.1%	Total Medical Management	294,564	333,044	38,480	11.6%
23,513	32,958	9,445	28.7%	Total Waived Services	47,299	65,916	18,617	28.2%
173,201	**199,480**	**26,279**	**13.2%**	**Total Program Expenses**	**341,863**	**398,960**	**57,097**	**14.3%**
33,527	**54,037**	**(20,510)**	**(38.0%)**	**Gross Margin**	**131,810**	**108,074**	**23,736**	**22.0%**
				Administrative Expenses				
76,269	83,260	6,991	8.4%	Salaries, Wages & Employee Benefits	157,016	162,581	5,565	3.4%
1,333	1,333	(0)	(0.0%)	Professional Fees	2,667	2,666	(1)	(0.0%)
5,935	9,148	3,213	35.1%	Other Operating Expenses	11,629	18,296	6,667	36.4%
6,550	6,550	-	0.0%	Indirect Allocation, Occupancy	13,100	13,100	-	0.0%
90,087	**100,291**	**10,204**	**10.2%**	**Total Administrative Expenses**	**184,412**	**196,643**	**12,231**	**6.2%**
(56,560)	**(46,254)**	**(10,306)**	**(22.3%)**	**Change in Net Assets**	**(52,602)**	**(88,569)**	**35,967**	**40.6%**
83.8%	***78.7%***	***5.1%***		***Medical Loss Ratio***	***72.2%***	***78.7%***	***(6.5%)***	
43.6%	***39.6%***	***(4.0%)***		***Admin Loss Ratio***	***38.9%***	***38.8%***	***(0.1%)***	

CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
38,832	55,650	16,818	30.2%	Purchased Service	77,167	111,300	34,133	30.7%
213,995	224,250	10,255	4.6%	Depreciation & Amortization	423,845	448,500	24,655	5.5%
20,875	22,500	1,625	7.2%	Insurance Expense	41,750	45,000	3,250	7.2%
131,918	138,755	6,837	4.9%	Repair & Maintenance	234,140	277,510	43,370	15.6%
82,095	48,405	(33,690)	(69.6%)	Other Operating Expense	172,648	96,810	(75,838)	(78.3%)
(487,715)	(489,560)	(1,845)	(0.4%)	Indirect Allocation, Occupancy	(949,550)	(979,120)	(29,570)	(3.0%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

CalOptima Health
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
159,097	172,500	(13,403)	-7.8%	Rental Income	376,890	345,000	31,890	9.2%
159,097	**172,500**	**(13,403)**	**(7.8%)**	**Total Operating Revenue**	**376,890**	**345,000**	**31,890**	**9.2%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
11,930	13,333	1,403	10.5%	Purchased Services	22,133	26,666	4,533	17.0%
-	-	-	0.0%	Deprecication & amoritzation	-	-	-	0.0%
-	2,733	2,733	100.0%	Insurance Expense	-	5,466	5,466	100.0%
31,480	25,666	(5,814)	-22.7%	Repair & Maintenance	72,262	51,332	(20,930)	-40.8%
28,882	39,933	11,051	27.7%	Other Operating Expense	70,430	79,866	9,436	11.8%
-	-	-	0.0%	Indirect Allocation, Ocucpancy	-	-	-	0.0%
72,292	**81,665**	**9,373**	**11.5%**	**Total Administrative Expenses**	**164,824**	**163,330**	**(1,494)**	**(0.9%)**
86,804	**90,835**	**(4,031)**	**(4.4%)**	**Change in Net Assets**	**212,066**	**181,670**	**30,396**	**16.7%**

OTHER INCOME STATEMENTS – AUGUST MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.4 million, favorable to budget $1.0 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.1 million, favorable to budget $0.3 million

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($56,560), unfavorable to budget $10,306

BUILDING 500 INCOME STATEMENT

CHANGE IN NET ASSETS is $0.1 million, unfavorable to budget $4,031

- Net of $0.2 million in rental income and $0.1 million in expenses for the month of August

CalOptima Health
Balance Sheet
August 31, 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$969,671,845	Accounts Payable	$40,538,777
Short-term Investments	932,034,481	Medical Claims liability	1,325,324,238
Capitation receivable	390,315,812	Accrued Payroll Liabilities	15,806,640
Receivables - Other	77,034,531	Deferred Revenue	8,002,226
Prepaid expenses	20,713,713	Deferred Lease Obligations	86,148
		Capitation and Withholds	203,246,618
Total Current Assets	**2,389,770,382**	**Total Current Liabilities**	**1,593,004,647**
Capital Assets			
Furniture & Equipment	48,861,260		
Building/Leasehold Improvements	5,059,408		
Construction in Progress	2,613,400		
505 City Parkway West	52,746,429		
500 City Parkway West	22,631,500		
	131,911,996		
Less: Accumulated Depreciation	(65,502,773)	**Other Liabilities**	
Capital assets, net	66,409,223	GASB 96 Subscription Liabilities	-
GASB 96 Capital Assets		Other (than pensions) post	
GASB 96 Subscription Assets	-	employment benefits liability	22,263,658
		Net Pension Liabilities	366,289
Less: GASB 96 Accumulated Depreciation	-	Bldg 505 Development Rights	-
GASB 96 Capital assets, net	-		
Total Capital Assets	66,409,223		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,615,634,594**
Homeless Health Reserve	40,636,739		
Board-designated assets:			
Cash and Cash Equivalents	8,650,853		
Investments	560,930,846	**Deferred Inflows**	
Total Board-designated Assets	569,581,699	Excess Earnings	686,563
		OPEB 75 Difference in Experience	4,822,000
		Change in Assumptions	1,909,305
Total Other Assets	610,518,438	OPEB Changes in Assumptions	3,389,000
		Diff in Projected vs Actual Earnings	20,982,636
		Net Position	
TOTAL ASSETS	**3,066,698,043**	TNE	105,225,526
		Funds in Excess of TNE	1,323,674,012
Deferred Outflows		**TOTAL NET POSITION**	1,428,899,538
Contributions	1,931,845		
Difference in Experience	2,353,671		
Excess Earning	-		
Changes in Assumptions	2,325,077		
OPEB 75 Changes in Assumptions	2,486,000		
Pension Contributions	529,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,076,323,636**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,076,323,636**

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CalOptima Health
Board Designated Reserve and TNE Analysis
as of August 31, 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	231,764,154				
	Tier 1 - MetLife	230,315,658				
Board-designated Reserve		462,079,812	342,746,317	534,734,250	119,333,495	(72,654,438)
	Tier 2 - Payden & Rygel	53,879,643				
	Tier 2 - MetLife	53,622,244				
TNE Requirement		107,501,887	105,225,526	105,225,526	2,276,361	2,276,361
	Consolidated:	**569,581,699**	**447,971,843**	**639,959,775**	**121,609,856**	**(70,378,077)**
	Current reserve level	*1.78*	*1.40*	*2.00*		

CalOptima Health
Statement of Cash Flows
August 31, 2022

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	2,212,350	9,430,770
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	214,354	424,204
Changes in assets and liabilities:		
Prepaid expenses and other	4,350,562	1,878,541
Catastrophic reserves		
Capitation receivable	(134,240,312)	9,514,242
Medical claims liability	150,486,070	47,308,889
Deferred revenue	(529,460)	(101,818)
Payable to health networks	9,717,133	10,031,989
Accounts payable	15,001,431	(11,778,111)
Accrued payroll	(4,324,853)	(3,886,806)
Other accrued liabilities	(3,018)	(6,023)
Net cash provided by/(used in) operating activities	42,884,258	62,815,877
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	2,253,593	82,426,022
Change in Property and Equipment	31,658	30,609
Change in Restricted Deposit & Other	-	51
Change in Board designated reserves	3,819,401	909,941
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	6,104,652	83,366,623
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	48,988,910	146,182,500
CASH AND CASH EQUIVALENTS, beginning of period	$920,682,935	823,489,344
CASH AND CASH EQUIVALENTS, end of period	**969,671,845**	**969,671,845**

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BALANCE SHEET – AUGUST MONTH:

ASSETS of $3.1 billion increased $172.6 million from July or 5.9%

- Operating Cash and Short-term Investments net increase of $46.7 million due primarily to:
  - Operating cash increased $49.0 million
  - Short-term Investments decreased $2.3 million
- Capitation Receivables increased $131.0 million due to the reclassification of Department of Health Care Services (DHCS) overpayments to claims liability

LIABILITIES of $1.6 billion increased $170.3 million from July or 11.8%

- Claims Liabilities increased $150.5 million due to timing of claim payments, changes in IBNR, and reclassification of DHCS payments received from capitation receivable
- Accounts Payable increased $15.0 million due to the timing of capitation premium tax payments
- Capitation and Withholds increased $9.7 million due to timing of capitation payments
- Accrued Payroll Liabilities decreased $4.5 million due to timing of pay period end dates

NET ASSETS of $1.4 billion, increased $2.2 million from July or 0.2%

CalOptima Health - Consolidated
Net Assets Analysis
For the Two Months Ended August 31, 2022

Category	Item Description	Amount (millions)	Spend to Date	%
	Total Net Position @ 08/31/2022:	**$1,428.9**		**100.0%**
Resources Assigned	Board Designated Reserve*	**$569.6**		**39.9%**
	Capital Assets, net of depreciation	**$66.4**		**4.6%**
Resources Allocated	Homeless Health Initiative**	$100.0	$34.6	7.0%
	Intergovernmental Transfers (IGT)	$111.7	$64.5	7.8%
	Mind OC Grant	$1.0	$1.0	0.1%
	CalFresh Outreach Strategy	$2.0	$0.4	0.1%
	Digital Transformation and Workplace Modernization	$100.0	$0.0	7.0%
	Coalition of Orange County Community Health Centers Grant	$50.0	$10.0	3.5%
	Subtotal:	**$364.7**	**$110.5**	**25.5%**
Resources Available for New Initiatives	Unallocated/Unassigned*	**$428.2**		**30.0%**

*Total of Board Designated reserve and unallocated reserve amount can support approximately 90 days of CalOptima Health's current operations
**See Summary of Homeless Health Initiatives and Allocated Funds for list of Board approved initiatives

CalOptima Health

Key Financial Indicators

As of Aug-2022

Income Statement

Item Name	Month-to-Date (August 2022) Actual	Budget	Variance	%		FY 2023 Year-to-Date (August 2022) Actual	Budget	Variance	%	
Member Months	925,756	915,761	9,995	1.1%		1,846,942	1,831,291	15,651	0.9%	
Operating Revenue	348,906,387	332,502,391	16,403,996	4.9%		669,824,867	664,882,836	4,942,031	0.7%	
Medical Expenses	332,679,915	313,062,603	(19,617,312)	(6.3%)		636,851,097	623,750,770	(13,100,327)	(2.1%)	
General and Administrative Expense	13,369,852	17,497,194	4,127,342	23.6%		27,802,626	34,400,917	6,598,291	19.2%	
Non-Operating Income/(Loss)	(644,270)	(772,801)	128,531	16.6%		4,259,627	(181,966)	4,441,593	2,440.9%	
Summary of Income & Expenses	2,212,350	1,169,793	1,042,557	89.1%		9,430,770	6,549,183	2,881,587	44.0%	

Ratios

Medical Loss Ratio (MLR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	95.3%	94.2%	1.2%		95.1%	93.8%	1.3%	

Administrative Loss Ratio (ALR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	3.8%	5.3%	1.4%		4.2%	5.2%	1.0%	

Investment

Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
@8/31/2022	1,487,825,728	1,492,742,358	(4,916,630)	(0.3%)

Unallocated/Unassigned Reserve Balance	Current Month @ August 2022	Fiscal Year Ending June 2022	Change	%
Consolidated	428,208,616	448,294,548	(20,085,932)	(4.5%)

Key:

> 0%	
> -20%, < 0%	
< -20%	

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Two Months Ending August 31, 2022

	FY 2022-23 Month-to-Date				FY 2022-23 Year-to-Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):								
Total Capital Assets	**-**	**6,712,000**	**6,712,000**	**100.0%**	**-**	**19,680,000**	**19,680,000**	**100.0%**
Operating Expenses:								
Salaries, Wages & Benefits	21,975	219,314	197,339	90.0%	21,975	383,795	361,820	94.3%
Professional Fees	-	186,041	186,041	100.0%	-	372,082	372,082	100.0%
Purchased Services	-	13,333	13,333	100.0%	-	26,666	26,666	100.0%
Depreciation Expenses	-	-	-	0.0%	-	-	-	0.0%
Other Expenses	-	274,365	274,365	100.0%	-	548,730	548,730	100.0%
Total Operating Expenses	**21,975**	**693,053**	**671,078**	**96.8%**	**21,975**	**1,331,273**	**1,309,298**	**98.3%**

Funding Balance Tracking:	**Actual Spend**	**Approved Budget**
Beginning Funding Balance	100,000,000	100,000,000
Less:		
FY2022-23	21,975	45,173,113
FY2023-24		
FY2024-25		
Ending Funding Balance	**99,978,025**	**54,826,887**

Summary of Homeless Health Initiatives and Allocated Funds
As of August 31, 2022

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,693,261		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,700,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Street Medicine	8,000,000		
Outreach and Engagement Team	7,000,000		
Funds Allocation Total		**$**	**59,363,261**
Program Commitment Balance, available for new initiatives*		**$**	**40,636,739**

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 August 2022

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	No budget reallocations for July					2022-23
August	Medi-Cal	Health Reward Incentive Fulfillment	Health Reward Incentive Fulfillment	$75,000	To reallocate funds from Pur Svcs – Health Reward Incentive Fulfillment to Incentive Budget for PHM Health Rewards.	2022-23

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
October 6, 2022

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima Health's Board of Directors including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima Health's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare and OneCare Connect

- 2021 Centers for Medicare & Medicaid Services (CMS) Program Audit/Independent Validation Audit (IVA) *(applicable to OneCare and OneCare Connect)*:

  - ***CalOptima Health is pending CMS' review and feedback on the IVA report.***

- Compliance Program Effectiveness (CPE) Audit (*applicable to OneCare*):

  - CMS (Medicare) requires CalOptima Health to undergo an independent audit of the effectiveness of its Compliance program on an annual basis.
  - As per the Medicare requirements, the results must be shared with the CalOptima Health Board of Directors.
  - CalOptima Health has engaged an independent consultant, BluePeak, to conduct the CPE audit.
  - The deliverables were submitted to BluePeak by the due date of September 2, 2022.
  - The virtual audit is scheduled to occur October 11-17, 2022.
  - The audit report is expected to be received in November 2022.

- 2022 Timeliness Monitoring Project (TMP) (*applicable to OneCare*):

  - By way of background, on April 5, 2022, CMS announced it will conduct an industry-wide monitoring project in the fall of 2022, collecting data to evaluate the timeliness of processing of One Care Part C reconsiderations. The TMP will include a retrospective collection and review of CY 2022 data.
  - CalOptima Health expects to receive the engagement notice in September or October of 2022. CalOptima Health is currently preparing the reconsiderations universes which will undergo review for this audit.

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2. Medi-Cal

- 2024 Managed Care Plan (MCP) Operational Readiness Contract:

  Update:

  - CalOptima Health submitted its first set of deliverables by the August 12, 2022, due date.
  - CalOptima Health is on-track to submit another set of deliverables by September 12, 2022.
  - On-track for all remaining deliverables.

  Background – FYI Only

  Throughout CY 2022 and CY 2023, MCPs, including CalOptima Health will be required to submit a series of contract readiness deliverables to the Department of Health Care Services (DHCS) for review and approval. Staff will implement the broad operational changes and contractual requirements outlined in the Operational Readiness agreement to ensure compliance with all requirements by the January 1, 2024, contract effective date.

- 2021 DHCS Medical Audit:

  Update: Draft report and exit conference pending.

  Background – FYI Only

  - Audit engagement notice received on October 7, 2021.
  - Review period was February 1, 2020, through December 31,2021.
  - Scope:
    - Non-Seniors and Persons with Disabilities and Seniors and Persons with Disabilities (SPD) members.
    - Utilization management, case management and coordination of care, member's rights, quality management, access & availability, and administrative and organizational capacity.
    - DHCS selected Kaiser, Prospect, and Family Choice Medical Group (FCMG) to participate in various capacities.
  - Exit conference: February 4, 2022. DHCS discussed preliminary observations.
    - ***In partnership with the business areas, the Office of Compliance has worked to address preliminary observations, as appropriate***.

- 2022 Managed Care Entity (MCE) Program Integrity (PI) Review:

  Update: CMS & DHCS have requested CalOptima Health's participation in virtual meetings to discuss the internal PI efforts in place to ensure adequate oversight, as well as to deter and address fraud, waste, and abuse. Virtual meetings are expected between October 24-28, 2022; however, specific dates and times are forthcoming.

Background – FYI Only

- April 13, 2022, the DHCS notified CalOptima Health that it had been selected to provide feedback to CMS in respect to CalOptima Health's internal PI efforts that are in place to ensure adequate oversight as well as to deter and address FWA.
- Review period was the preceding 3 Federal Fiscal Year (FFYs).
- Focused on CalOptima Health's Medi-Cal program. DHCS requested that CalOptima Health respond to a series of questions within the CMS Template and submit responses and supporting documentation to DHCS, which DHCS would then submit to CMS.
- May 4, 2022, CalOptima Health provided its timely response to DHCS.

B. Regulatory Notices of Non-Compliance

- CalOptima Health did not receive any notices of non-compliance from its regulators for the month of August 2022.

C. Updates on Internal and Health Network Monitoring and Audits

- Internal Monitoring Dashboard:

  - As part of its monitoring process, CalOptima Health's Audit & Oversight department, in collaboration with business areas, maintains a dashboard to monitor key performance indicators (KPI's) for internal and external operations on a monthly basis. Dashboard results are presented to CalOptima Health's Audit & Oversight Committee and Compliance Committee for oversight.
    - CalOptima Health's Utilization Management (UM) department recently updated previously reported UM Concurrent Review timeliness KPI's as they determined there were issues with the reporting logic. Based on the updates the previously reported metrics appeared to fall below the compliance threshold. The issue was escalated to the Medi-Cal Regulatory Affairs & Compliance (RAC) team and is currently under investigation. As of the time of this report, the data was still being researched to understand the actual performance for prior time periods, and a sample of cases is under review to confirm they were processed appropriately. Prospectively, from the date the issue was identified, UM Management processes were adjusted to further assure cases were being managed timely.

- Health Network Audits:

  - CalOptima Health's Audit and Oversight (A&O) department completed annual audits on the following delegated health networks to assess their capabilities and performance with delegated activities:

    - AMVI Prospect – July 1, 2021 – April 30, 2022
    - United Care Medical Group- July 1, 2021 – April 30, 2022
    - Prospect Medical Group- July 1, 2021- May 31, 2022
    - AMVI Care Medical Group- July 1, 2021- May 31, 2022

- Audit tools and elements were derived from accrediting, regulatory and CalOptima Health contractual standards. For areas that scored below the 100% threshold, A&O issued a corrective action plan (CAP) request and is actively working with each health network to remediate findings.

Non-Clinical Policy Review

Delegated Entity	Access Availability	Claims	Compliance	Cultural & Linguistics	Customer Service	Provider Network Contracting	Provider Relations	Sub-Contractual
AMVI Care	100%	100%	100%	100%	100%	98%	100%	96%
AMVI Prospect	100%	1100%	100%	100%	100%	100%	100%	95%
Prospect	100%	100%	100%	100%	100%	100%	100%	96%
UCMG	100%	100%	100%	100%	100%	100%	100%	96%

Non-Clinical File Review

Delegated Entity	Claims, Approved	Claims, Denied	PDR's	Customer Service	Initial Provider Training		Annual Provider Training		Initial Staff Training		Annual Staff Training	
					TAT	CT	TAT	CT	TAT	CT	TAT	CT
AMVI Care	99%	100%	100%	96%	100%	100%	20%	20%	100%	0%	10%	10%
AMVI Prospect	87%	96%	100%	90%	10%	90%	9%	9%	0%	0%	0%	0%
Prospect	95%	98%	99%	100%	30%	40%	40%	40%	100%	0%	10%	10%
UCMG	100%	98%	100%	96%	0%	100%	70%	70%	82%	0%	0%	0%

TAT* Turnaround Time
CT* Completed Training

Clinical Policy Review

Delegated Entity	Case Management	Case Management, Whole Child Model	Medi-Cal Addendum	Utilization Management
AMVI Care	100%	100%	100%	100%
AMVI Prospect	100%	N/A	100%	100%
Prospect	100%	100%	100%	100%
UCMG	100%	100%	100%	100%

Clinical File Review

Delegated Entity	Blood Lead Screening (MC)	Case Management	Community Support(s) (MC)	Expedited (MC)	SARAG (OCC)	NEMT (MC)	NOMNC	ODAG (OC)	PSA (MC)	Standard (MC)
AMVI Care	100%	94%	83%	98%	66%	100%	67%	N/A	76%	93%%
AMVI Prospect	N/A	83%	N/A	N/A	N/A	N/A	100%	67%	N/A	N/A
Prospect	100%	95%	88%	98%	71%	88%	70%	N/A	79%	NTR
UCMG	77%	75%	75%	77%	66%	100%	83%	69%	88%	NTR

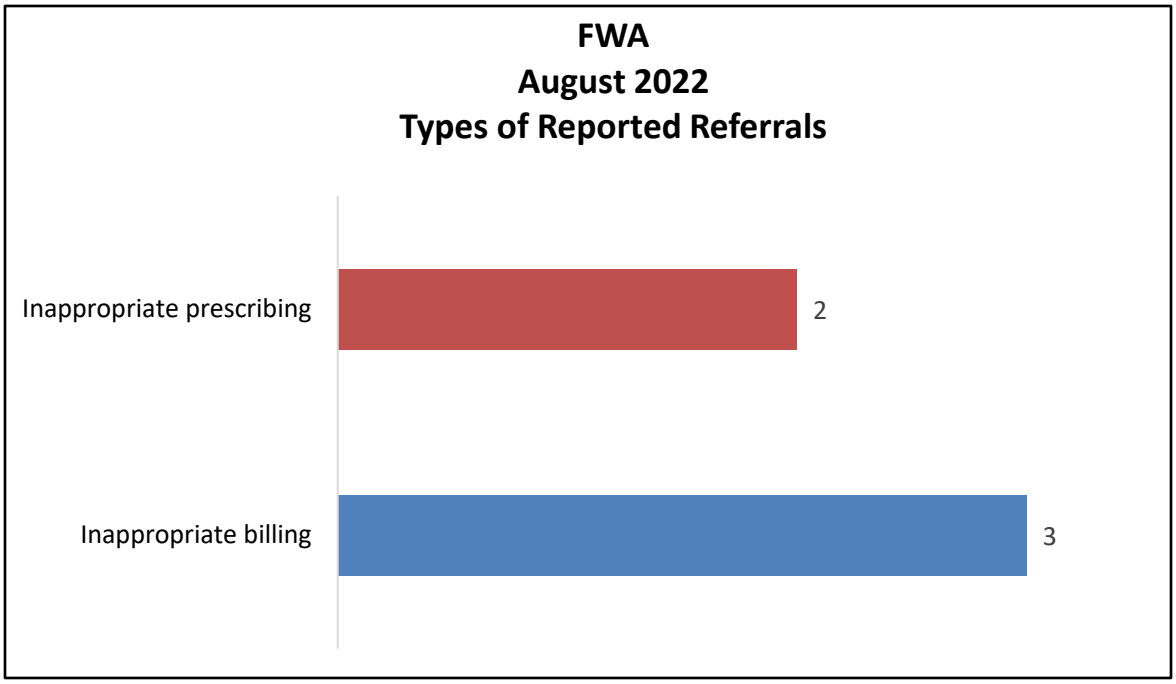
Credentialing and Recredentialing Policy

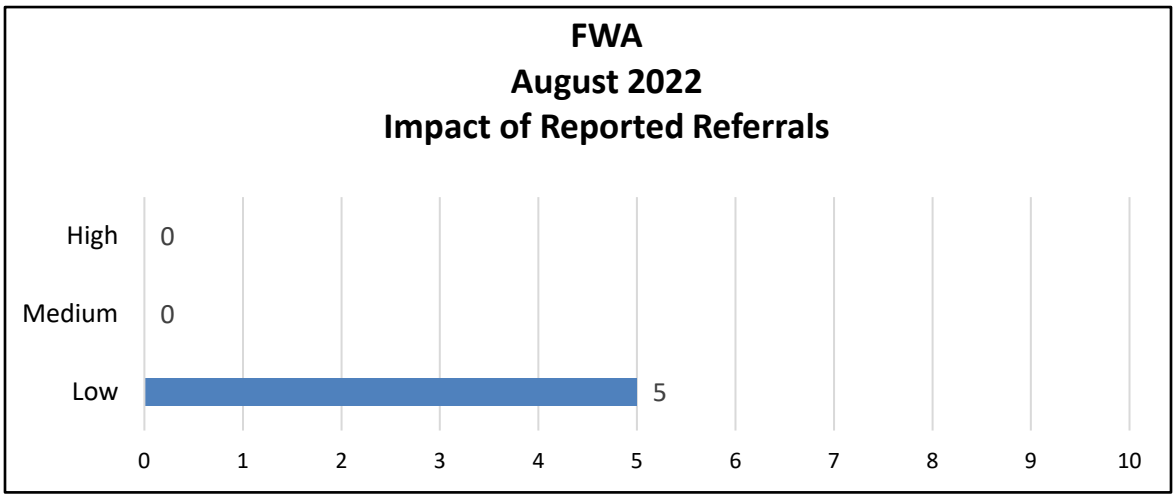
Delegated Entity	Policy Review
AMVI Care	98%
AMVI Prospect	98%
Prospect	98%
UCMG	98%

Delegated Entity	Initial Credentialing File Review	Recredentialing File Review
AMVI Care	95%	98%
AMVI Prospect	95%	98%
Prospect	98%	98%
UCMG	95%	95%

Delegated Entity	Organizational Providers Initial File Review	Organizational Providers Recredentialing File Review
AMVI Care	85%	88%
AMVI Prospect	88%	92%
Prospect	85%	88%
UCMG	100%	NTR

D. Fraud, Waste & Abuse (FWA) Investigations (August 2022)

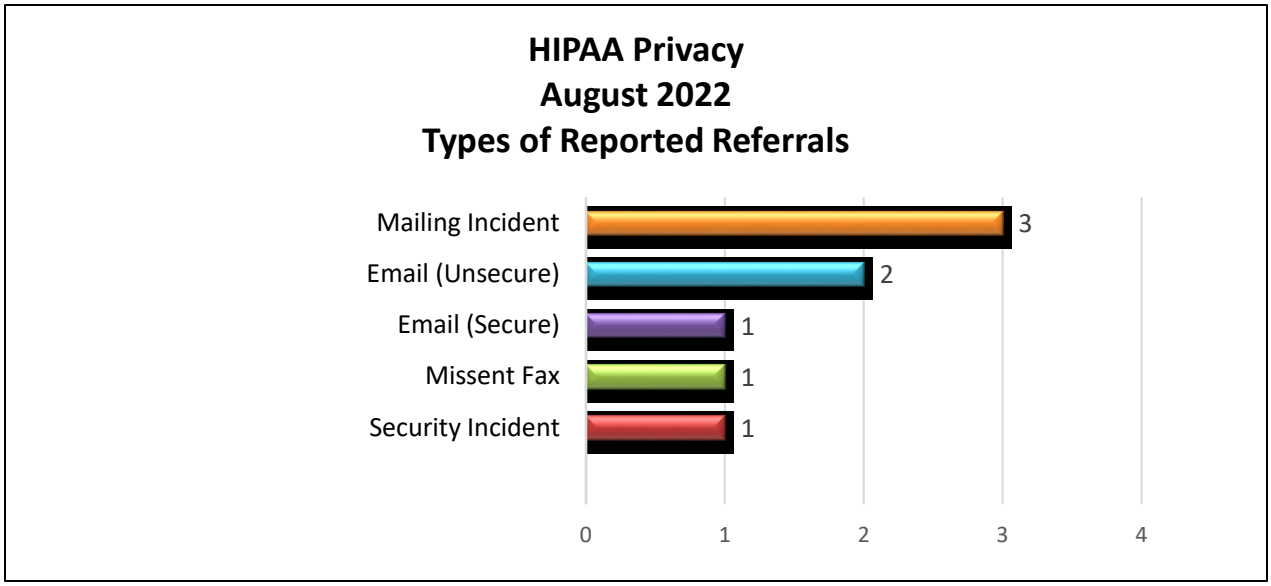


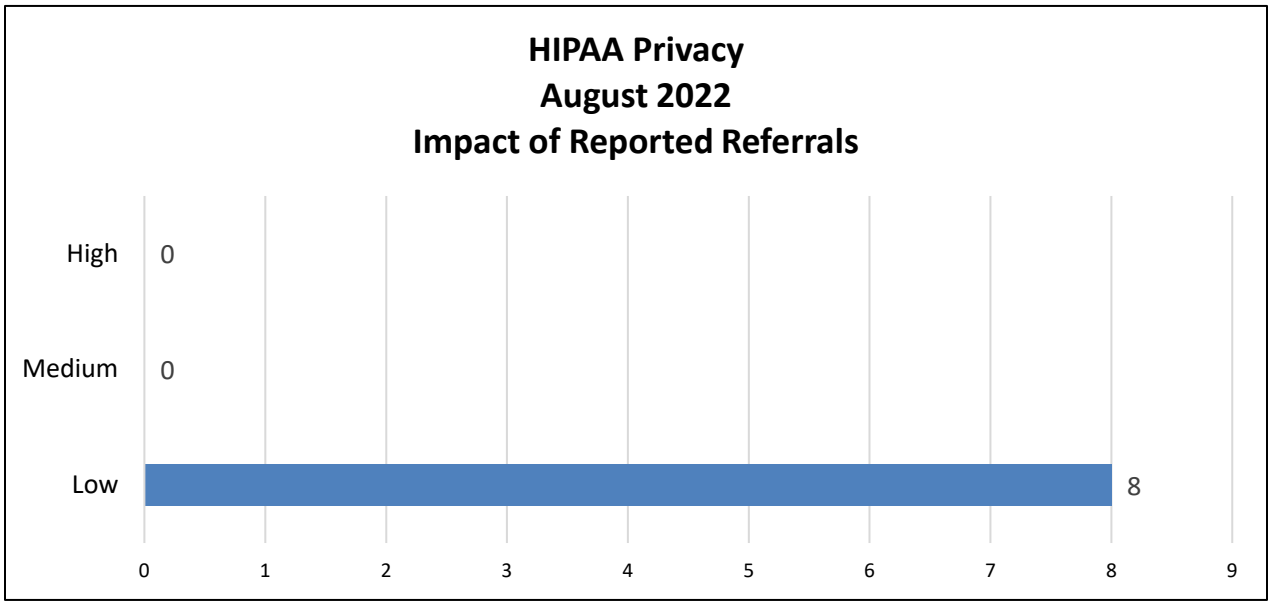


Total Number of New Cases Referred to DHCS (State)	5
Total Number of New Cases Referred to DHCS and CMS*	3
Total Number of Referrals (Subjects) Reported to Regulatory Agencies	8

*Effective January 1, 2022, CMS implemented a new portal to report suspicious FWA. Any potential FWA *with impact to Medicare* is reported to both DHCS and CMS at the start of an investigation.

E. Privacy Update: (August 2022)





Total Number of Referrals Reported to DHCS (State)	8
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

M E M O R A N D U M

September 9, 2022

To: CalOptima Health

From: Potomac Partners DC & Strategic Health Care

Re: September Board of Directors Report

FY23 Appropriations & Likely Continuing Resolution

The House has introduced and passed some of their Fiscal Year 2023 (FY23) appropriations bills as of the start of September, but the Senate's bills have yet to be negotiated and by all accounts are serving as a placeholder for negotiations. As a result, a Continuing Resolution to extend government spending at FY22 levels is expected to be considered before the end of the fiscal year on September 30th. A Continuing Resolution (CR) would avert a government shutdown and give Congress more time to negotiate on topline spending accounts.

Both parties have publicly stated they would like to avoid a shutdown just before the elections, but a $22.4 billion supplemental funding request from the White House is receiving opposition from Republicans who would rather repurpose existing unallocated funds. Senator Manchin (D-WV) is also proposing to attach pipeline permitting legislation to the CR, which is opposed by progressive Democrats. However, if the current timeline is followed, the CR would last until December 16th giving Congress about a month to finalize an omnibus or series of smaller spending packages called "minibuses" before the start of the 118th Session of Congress on January 3rd, 2023.

Proposed Rule Aims to Make Medicaid and CHIP Enrollment Easier

On August 31st, CMS released a Notice of Proposed Rulemaking (NPRM) that seeks to reduce red tape and simplify the application and verification process for individuals and families seeking to take advantage of Medicaid and CHIP. This rule, if finalized, would standardize commonsense eligibility and enrollment policies, such as limiting renewals to once every 12 months, allowing applicants 30 days to respond to information requests, requiring prepopulated renewal forms, and establishing clear, consistent renewal processes across states. A factsheet can be found here. The full NPRM can be found here.

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PUBLIC HEALTH EMERGENCY (PHE) TIMELINE

HHS has finally released a plan for unraveling the waivers at the end of the PHE. CMS' "*Roadmap for the End of the COVID-19 Public Health Emergency*" details how it plans to terminate many of the waivers and flexibilities that providers utilized during the pandemic. It is important to note that we have also passed the 60-day mark for the current PHE, which more than likely means that it will be renewed in October and continue into mid-January. In a helpful blog post from CMS, the agency details what will happen as the country moves past the PHE with many helpful links for documents that give guidance for providers, insurers, and states. Click here for the blog. The blog also includes links to waivers and other flexibilities listed by provider type. Click here for a 47-page CMS document of all its waivers that was updated last week.

BEHAVIORAL HEALTH

Health systems across the country are grappling with an increase of behavioral health cases and a lack of providers, as half of the counties in the U.S. do not have a psychiatrist or an addiction medicine specialist. New data from George Washington University shows that the shortages also have disproportionately affected low-income consumers, as nearly 1 of 4 behavioral health providers did not see any Medicaid beneficiaries in 2020. HHS awarded $40.2 million in youth mental health grants in August and has allotted $47.6 million for new school-based mental health grants, including $5.3 million from American Rescue Plan Act funding, intended to address pandemic-related stressors that have increased mental health conditions among youth. More information on these funds can be found here.

ROE V. WADE

On August 26th, HHS announced a plan of action in response to the *Dobbs v. Jackson Woman's Health Organization* Supreme Court decision on abortion. Both actions further support President Biden's Executive Order 14076, *Protecting Access to Reproductive Health Care* (here), and Executive Order 14079, *Securing Access to Reproductive Health Care* (here). The full announcement can be found here. Earlier this month, the U.S. government filed a lawsuit alleging that Idaho's anti-abortion law, which went into effect this week, directly conflicts with the federal *Emergency Medical Treatment and Labor Act* (EMTALA) in those situations. Last month, HHS issued guidance (here) affirming EMTALA's requirements, and Secretary Becerra sent a letter (here) to providers reminding them of their obligations to provide access to abortion in emergency situations.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate Bridget E. McGowan Associate

September 15, 2022

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

General Update

The Legislature adjourned for final recess late on August 31, marking the end of the 2021-22 Legislative Session. Legislators will return to their districts for the remainder of the year, aside from the day new legislators are sworn in on December 5.

The Legislature spent the last days of session on the Senate and Assembly Floor working through final budget bills as well as hundreds of policy bills that needed floor votes and concurrence votes to pass out of the Legislature. Much of the end of session was dominated by the Governor's climate package that included bills relating to state emissions reduction goals, oil drilling, clean energy and the extension of the Diablo Canyon power plant.

The Governor will have until September 30 to act upon the bills put on his desk at the end of session.

Legislation of Interest

AB 498 (Quirk-Silva) - CalOptima Health Board of Directors. This bill locks the CalOptima Health board positions into state statute. The measure also prohibits the County Supervisors and the lawyer/accountant board members from working at CalOptima Health or any entity that received money from CalOptima Health in the previous five years. This prohibition remains in place for one year after these board members leave their board positions.

The bill was amended in late August to clarify that funds spent on routine administrative expenditures will not trigger the third-party "employment" prohibition.

AB 498 passed out of the Legislature on the last night of session. The bill is now on the Governor's desk.

SB 1338 (Umberg) - CARE Court. SB 1338 establishes the Community Assistance, Recovery, and Empowerment (CARE) Court Program to provide comprehensive treatment, housing and support services to Californians with complex behavioral health care needs. This measure remains controversial with some because it allows homeless individuals to be confined against their will while they are evaluated to determine whether they would benefit from various social services.

As anticipated, the Governor signed SB 1338. He held a press conference in Santa Clara County this week to announce the signing.

SB 1342 (Bates) - Older Adult Care Coordination. This bill would authorize counties to create a Multi-Disciplinary Team (MDT) for older adults that would allow county departments and aging services providers to exchange information to improve interagency care coordination and service delivery for older adults and their caregivers.

CalOptima Health submitted a support letter for this bill, which is sponsored by the County of Orange. It is currently on the Governor's desk.

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2021–22 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
COVID-19 (Coronavirus)			
H.R. 4735 Axne (IA) **S. 2493** Bennet (CO)	**Provider Relief Fund Deadline Extension Act:** Would delay the deadline by which providers must spend any funds received from the Provider Relief Fund (PRF) — created in response to the COVID-19 pandemic — until the end of 2021 or the end of the COVID-19 public health emergency (PHE), whichever occurs later. Funds that are unspent by any deadline must be repaid to the U.S. Department of Health and Human Services (HHS). ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted providers.	**07/28/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 5963 Spanberger (VA) **S. 3611** Shaheen (NH)	**Provider Relief Fund Improvement Act**: Would delay the deadline by which providers must spend any funds received from the PRF until the end of the COVID-19 PHE. Would also direct HHS to distribute any funds remaining in the PRF by March 31, 2022. Finally, would allow workplace safety improvements as an allowable use of PRF dollars. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted providers.	**11/12/2021** Introduced; referred to committees	CalOptima Health: Watch
SB 1473 Pan	**COVID-19 Therapeutics Coverage:** Effective immediately, would require a health plan to cover COVID-19 therapeutics provided by an in-network or out-of-network provider, without cost sharing or prior authorization requirements. Out-of-network claims must be reimbursed at the prevailing market rate, as set by future guidance. ***Potential CalOptima Health Impact:*** Reimbursement for all in-network and out-of-network medical claims for COVID-19 therapeutics without utilization management controls.	**08/31/2022** Passed Legislature; pending action by the Governor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
H.R. 8542 Porter (CA) **S. 515** Warren (MA)	**Mental Health Justice Act:** Would require HHS to award grants to state, tribal and local governments to hire, train and dispatch mental health professionals instead of law enforcement personnel to respond to behavioral health crises. ***Potential CalOptima Health Impact:*** Increased access to behavioral health services for CalOptima Health members; decreased rates of arrest and incarceration.	**02/25/2021** Introduced; referred to committees	CalOptima Health: Watch County of Orange: Support
H.R. 1914 DeFazio (OR) **S. 764** Wyden (OR)	**Crisis Assistance Helping Out On The Streets (CAHOOTS) Act:** Would increase the Federal Medical Assistance Percentage (FMAP) for states to cover 24/7 community-based mobile crisis intervention services for those experiencing a mental health or substance use disorder (SUD) crisis from 85% to 95% for three years. Would also require HHS to issue an additional $25 million in planning and evaluation grants to states. ***Potential CalOptima Health Impact:*** Increased behavioral health and SUD services to CalOptima Health Medi-Cal members.	**03/16/2021** Introduced; referred to committees	**08/05/2021** CalOptima Health: Support
AB 552 Quirk-Silva	**Integrated School-Based Behavioral Health Partnership Program:** Would have established the Integrated School-Based Behavioral Health Partnership Program to expand prevention and early intervention behavioral health services for students. This would have allowed a county mental health agency and local education agency to develop a formal partnership whereby county mental health professionals would have delivered brief school-based services to any student who has, or is at risk of developing, a behavioral health condition or SUD. ***Potential CalOptima Health Impact*:** Increased coordination with the Orange County Health Care Agency and school districts to ensure non-duplication of other school-based behavioral health services and initiatives.	**09/19/2022** Vetoed	CalOptima Health: Watch
SB 1019 Gonzalez	**Mental Health Benefit Outreach and Education:** Starting no later than January 1, 2025, would require a Medi-Cal managed care plan (MCP) to conduct annual outreach and education to beneficiaries and primary care physicians regarding covered mental health benefits while incorporating best practices in stigma reduction. The California Department of Health Care Services (DHCS) must review an MCP's outreach and engagement plan for approval. Every three years, DHCS would conduct an assessment of Medi-Cal beneficiaries' experience with mental health services. ***Potential CalOptima Health Impact:*** Additional member and provider outreach activities by CalOptima Health staff.	**08/30/2022** Passed Legislature; pending action by the Governor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 1338 Umberg	**Community Assistance, Recovery, and Empowerment (CARE) Court Program:** No later than October 1, 2023, in Orange County, establishes the CARE Court Program to facilitate delivery of mental health and SUD services to individuals with schizophrenia spectrum or other psychotic disorders who are unable to survive safely in the community. The program will connect a person in crisis with a court-ordered care plan for up to 12 months, with the option to extend an additional 12 months, as a diversion from homelessness, incarceration or conservatorship. Care plans may include court-ordered stabilization medications, wellness and recovery supports, and connection to social services and housing resources. Eligible individuals may be referred by family members, counties, behavioral health providers or first responders among others. ***Potential CalOptima Health Impact:*** Increased behavioral health and SUD services for eligible CalOptima Health members.	**09/14/2022** Signed into law	CalOptima Health: Watch CAHP: Concern

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Budget			
H.R. 2471 DeLauro (CT)	**Consolidated Appropriations Act, 2022**: Appropriates $1.5 trillion to fund the United States federal government through September 30, 2022, including earmarks for the following projects in Orange County: • Children's Hospital of Orange County: $325,000 to expand capacity for mental health treatment services and programs in response to the COVID-19 pandemic • City of Huntington Beach: $500,000 to establish a mobile crisis response program • County of Orange: $2 million to develop a second Be Well Orange County campus in the City of Irvine • County of Orange: $5 million to develop a Coordinated Reentry Center to help justice-involved individuals with mental health conditions or SUDs reintegrate into the community • North Orange County Public Safety Task Force: $5 million to expand homeless outreach and housing placement services In addition, extends all current telehealth flexibilities in the Medicare program until approximately five months following the termination of the COVID-19 PHE. ***Potential CalOptima Health Impact:*** Increased coordination with the County of Orange and other community partners to support implementation of projects that benefit CalOptima Health members; continuation of all current telehealth flexibilities for CalOptima Health OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE).	**03/15/2022** Signed into law	CalOptima Health: Watch
AB 178 Ting **SB 154** Skinner	**Budget Act of 2022:** Makes appropriations for the government of the State of California for Fiscal Year (FY) 2022–23. Total spending is just over $300 billion, of which $234.4 billion is from the General Fund. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed Analysis of the Enacted Budget.	**06/30/2022** Signed into law	CalOptima Health: Watch
AB 186 Committee on Budget	**Skilled Nursing Facility (SNF) Financing Reform Trailer Bill:** Enacts budget trailer bill language containing the policy changes needed to implement FY 2022–23 budget expenditures regarding SNF financing. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed Analysis of the Enacted Budget.	**06/30/2022** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 204 Committee on Budget	**Health Trailer Bill II:** Would require DHCS to issue retention payments of up to $1,000 each to employees of Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and other qualified community clinics. ***Potential CalOptima Health Impact:*** Increased workforce stabilization and less employee turnover at contracted FQHCs and other community clinics.	**08/31/2022** Passed Legislature; pending action by the Governor	CalOptima Health: Watch
SB 184 Committee on Budget and Fiscal Review	**Health Trailer Bill I:** Consolidates and enacts budget trailer bill language containing the policy changes needed to implement most health-related expenditures in the FY 2022–23 state budget. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed Analysis of the Enacted Budget.	**06/30/2022** Signed into law	CalOptima Health: Watch
Covered Benefits			
H.R. 56 Biggs (AZ)	**Patient Access to Medical Foods Act:** Would expand the federal definition of medical foods to include food prescribed as a therapeutic option when traditional therapies have been exhausted or may cause adverse outcomes. Effective January 1, 2022, medical foods, as defined, would be covered by private health insurance providers and federal public health programs, including Medicare, TRICARE, Children's Health Insurance Program (CHIP) and Medicaid, as a mandatory benefit. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health's lines of business.	**01/04/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 1118 Dingell (MI)	**Medicare Hearing Aid Coverage Act of 2021:** Effective January 1, 2022, would require Medicare Part B coverage of hearing aids and related examinations. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health OneCare, OneCare Connect and PACE.	**02/18/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 4187 Schrier (WA)	**Medicare Vision Act of 2021:** Effective January 1, 2024, would require Medicare Part B coverage of vision services, including eyeglasses, contact lenses, routine eye examinations and fittings. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health OneCare and PACE.	**06/25/2021** Introduced; referred to committees	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4311 Doggett (TX) **S. 2618** Casey (PA)	**Medicare Dental, Vision, and Hearing Benefit Act of 2021:** Effective no sooner than January 1, 2022, would require Medicare Part B coverage of the following benefits: • Dental: Routine dental cleanings and examinations, basic and major dental services, emergency dental care, and dentures • Vision: Routine eye examinations, eyeglasses, contact lenses and low vision devices • Hearing: Routine hearing examinations, hearing aids and related examinations The Senate version would also increase the Medicaid FMAP for hearing, vision and dental services to 90%. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health OneCare, OneCare Connect and PACE; higher federal funding rate for current Medi-Cal benefits.	**07/01/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 4650 Kelly (IL)	**Medicare Dental Coverage Act of 2021**: Effective January 1, 2025, would require Medicare Part B coverage of dental and oral health services, including routine dental cleanings and examinations, basic and major dental treatments, and dentures. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health OneCare and PACE.	**07/22/2021** Introduced; referred to committees	CalOptima Health: Watch
AB 1929 Gabriel	**Medi-Cal Violence Preventive Services:** Adds violence prevention services as a covered Medi-Cal benefit to reduce the rate of violent injury and trauma as well as promote recovery, stabilization and improved health outcomes. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**08/22/2022** Signed into law	CalOptima Health: Watch
AB 1930 Arambula	**Medi-Cal Perinatal Services:** Would require Medi-Cal coverage of additional perinatal assessments and services as developed by the California Department of Public Health and additional stakeholders for beneficiaries up to one year postpartum. A nonlicensed perinatal worker could deliver such services if supervised by an enrolled Medi-Cal provider or a non-enrolled community-based organization (CBO) if a Medi-Cal provider is available for billing. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members up to one-year postpartum.	**08/25/2022** Passed Legislature; pending action by the Governor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2697 Aguiar-Curry	**Medi-Cal Community Health Workers (CHWs) and Promotores:** Would add preventive services provided by CHWs and promotores as a Medi-Cal covered benefit with the goal of preventing disease, prolonging life and promoting physical and behavioral health. Would require Medi-Cal MCPs to conduct outreach and education to beneficiaries regarding the CHW benefit, eligibility and lists of referral sources and authorized providers. MCPs must also notify all providers about the CHW benefit. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members; additional member and provider outreach activities; additional network adequacy analyses.	**08/30/2022** Passed Legislature; pending action by the Governor	CalOptima Health: Watch
SB 245 Gonzalez	**Medi-Cal Abortion Services:** Prohibits a health plan from imposing Medi-Cal cost-sharing on all abortion services, including any pre-abortion or follow-up care, no sooner than January 1, 2023. In addition, a health plan and its delegated entities may not require a prior authorization or impose an annual or lifetime limit on such coverage. ***Potential CalOptima Health Impact:*** Modified Utilization Management (UM) procedures for a covered Medi-Cal benefit.	**03/22/2022** Signed into law	CalOptima Health: Watch CAHP: Oppose
SB 912 Limón	**Medi-Cal Biomarker Testing:** No later than July 1, 2023, would add biomarker testing, including whole genome sequencing, as a Medi-Cal covered benefit to diagnose, treat or monitor a disease. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**08/30/2022** Passed Legislature; pending action by the Governor	CalOptima Health: Watch CAHP: Oppose Unless Amended
Medi-Cal Eligibility and Enrollment			
H.R. 1738 Dingell (MI) **S. 646** Brown (OH)	**Stabilize Medicaid and CHIP Coverage Act of 2021:** Would provide 12 months of continuous eligibility and coverage for any Medicaid or CHIP beneficiary. ***Potential CalOptima Health Impact:*** Increased number of CalOptima Health Medi-Cal members.	**03/10/2021** Introduced; referred to committees	CalOptima Health: Watch ACAP: Support
H.R. 5610 Bera (CA) **S. 3001** Van Hollen (MD)	**Easy Enrollment in Health Care Act:** To streamline and increase enrollment into public health insurance programs, would allow taxpayers to request their federal income tax returns include a determination of eligibility for Medicaid, CHIP or advance premium tax credits to purchase insurance through a health plan exchange. Taxpayers could also consent to be automatically enrolled into any such program or plan if they would be subject to a zero net premium. ***Potential CalOptima Health Impact:*** Increased number of CalOptima Health Medi-Cal members.	**10/19/2021** Introduced; referred to committees	CalOptima Health: Watch ACAP: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 6636 Trone (MD) **S. 2697** Cassidy (LA)	**Due Process Continuity of Care Act:** Would allow states to extend Medicaid coverage to inmates who are awaiting trial and have not been convicted of a crime. ***Potential CalOptima Health Impact*:** If DHCS exercises option and requires enrollment into managed care, increased number of CalOptima Health Medi-Cal members.	**08/10/2021** Introduced; referred to committees	CalOptima Health: Watch
AB 2680 Arambula	**Community Health Navigator Program:** Would require DHCS to create the Community Health Navigator Program, starting January 1, 2023, to issue direct grants to qualified CBOs to conduct targeted outreach, enrollment and access activities for Medi-Cal-eligible individuals and families. ***Potential CalOptima Health Impact:*** Increased number of CalOptima Health Medi-Cal members.	**08/31/2022** Died on Senate floor	CalOptima Health: Watch
Medi-Cal Operations and Administration			
AB 498 Quirk-Silva	**CalOptima Health Board of Directors:** Makes permanent the current structure of the CalOptima Health Board of Directors (Board), including all designated seats. In addition, effective January 1, 2023, enacts the following prohibitions for one year following a Director's term: • Prohibits Directors in all seats from lobbying CalOptima Health • Prohibits Directors in the Supervisorial and accounting/legal seats from being employed by CalOptima Health or any third-party entity that has received funds from CalOptima Health within the previous five years (not including routine administrative expenses) • Prohibits Directors in a Supervisorial seat from being appointed to any other Board ***Potential CalOptima Health Impact:*** Permanent continuation of the current Board structure; new employment restrictions for one year following a Director's Board term.	**09/19/2022** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1400 Kalra, Lee, Santiago	**California Guaranteed Health Care for All:** Would create the California Guaranteed Health Care for All program (CalCare) to provide a comprehensive universal single-payer health care benefit for all California residents. Would require CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of CHIP, Medi-Cal, Medicare, the Knox-Keene Act, and ancillary health care or social services covered by regional centers for people with developmental disabilities. ***Potential CalOptima Health Impact***: Unknown but potentially significant impacts to the Medi-Cal delivery system and MCPs, including changes to administration, covered benefits, eligibility, enrollment, financing and organization.	**01/31/2022** Died on Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 1937 Patterson	**Out-of-Pocket Pregnancy Costs:** No later than July 1, 2023, would require DHCS to reimburse pregnant Medi-Cal beneficiaries up to $1,250 for out-of-pocket pregnancy costs, including birth and infant care classes, midwife and doula services, lactation support, prenatal vitamins, lab tests or screenings, prenatal acupuncture or acupressure, and medical transportation. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health Medi-Cal members who are currently or were recently pregnant.	**04/29/2022** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1944 Lee	**Brown Act Flexibilities:** Would extend certain Brown Act flexibilities, temporarily enacted in response to the COVID-19 PHE, until January 1, 2030, regardless of the existence of a PHE. Specifically, teleconferencing locations for any members of a legislative body would not need to be identified or publicly accessible. If exercising these flexibilities, a legislative body must comply with the following requirements: • A quorum of members must participate in person at a single location identified on the agenda and publicly accessible. • The agenda must identify which members are teleconferencing. • Members of the public must have access to a video stream of the primary meeting location. • Members of the public must be able to provide public comment via in-person, audio-visual or call-in options. ***Potential CalOptima Health Impact:*** Continued ability for members of the Board and advisory committees to participate in meetings by teleconference; modified posting and noticing requirements for the Clerk of the Board.	**07/01/2022** Died in Senate Governance and Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1995 Arambula	**Medi-Cal Premium and Copayment Elimination:** Would eliminate Medi-Cal premiums for low-income children whose family income exceeds 160% federal poverty level (FPL), working disabled persons with incomes less than 250% FPL and pregnant women and infants enrolled in the Medi-Cal Access Program. Would also eliminate copayments for all Medi-Cal beneficiaries. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health Medi-Cal members.	**08/12/2022** Died in Senate Appropriations Committee	CalOptima Health: Watch LHPC: Support
AB 2077 Calderon	**Medi-Cal Personal Needs Allowance:** No later than July 1, 2024, would increase the monthly income that a Medi-Cal beneficiary residing in a long-term care (LTC) facility or receiving PACE services is allowed to retain from $35 to $80. Beneficiaries must contribute remaining income as a share of cost to the facility before Medi-Cal pays remaining expenses. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health PACE participants and CalOptima Health Medi-Cal members residing in LTC facilities with a share of cost.	**08/24/2022** Passed Legislature; pending action by the Governor	CalOptima Health: Watch CalPACE: Support LHPC: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2449 Rubio, B.	**Brown Act Flexibilities:** Extends and modifies current Brown Act flexibilities *after* the termination of the COVID-19 PHE until January 1, 2026. Specifically, teleconferencing locations for any members of a legislative body will still not need to be publicly accessible or identified on the meeting agenda. However, if exercising these flexibilities after the COVID-19 PHE, a legislative body must comply with the following requirements: • A quorum of members must participate in person at a single location identified on the agenda and publicly accessible. • Teleconferencing members must participate through audio and visual technology. • Members of the public must be able to provide public comment via in-person, two-way audiovisual platform or two-way telephonic service with a live meeting webcast. • Members may only teleconference due to a medical emergency for themselves or their family, or, at no more than two meetings per calendar year, another "just cause" for remote participation, such as a caregiving need, contagious illness, disability or travel while on official business. Does not impact current Brown Act flexibilities while the COVID-19 PHE remains in effect. ***Potential CalOptima Health Impact:*** Continued ability for Board and advisory committee members to participate in meetings by teleconference after the COVID-19 PHE; modified meeting streaming capabilities by Information Technology Services; modified recordkeeping by the Clerk of the Board.	**09/13/2022** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2724 Arambula	**Alternate Health Care Service Plan**: No sooner than January 1, 2024, authorizes DHCS to contract directly with an Alternate Health Care Service Plan (AHCSP) as a Medi-Cal MCP in any county. An AHCSP is a nonprofit health plan with at least four million enrollees statewide that owns or operates pharmacies and provides medical services through an exclusive contract with a single medical group in each region. Currently, Kaiser Permanente (Kaiser) is the only AHCSP. Enrollment into Kaiser will be limited to the following Medi-Cal beneficiaries: • Previous AHCSP enrollees and their immediate family members • Dually eligible for Medi-Cal and Medicare benefits • Foster youth • A share of default enrollments when a Medi-Cal MCP is not selected ***Potential CalOptima Health Impact:*** *De facto* termination of the COHS model; Kaiser as an additional Medi-Cal MCP in Orange County; increased coordination with Kaiser on various Medi-Cal and community initiatives; decreased number of CalOptima Health Medi-Cal members; increased percentage of CalOptima Health members who are high-risk.	**06/30/2022** Signed into law	**04/07/2022** CalOptima Health: Oppose Unless Amended LHPC: Oppose
SB 250 Pan	**Prior Authorization "Deemed Approved" Status:** Beginning January 1, 2024, would require a health plan to review a provider's prior authorization requests to determine eligibility for "deemed approved" status, which would exempt the provider from prior authorization requirements for any plan benefit for one year. A provider would qualify if the health plan approved at least 90% of their prior authorization requests for the same service within the past year. ***Potential CalOptima Health Impact:*** Implementation of new UM procedures to assess provider appeals rates and exempt certain providers from UM requirements.	**08/12/2022** Died in Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
SB 858 Wiener	**Health Plan Civil Penalties:** Would increase the civil penalty amount that DMHC could levy on a health plan from no more than $2,500 per violation to no more than $25,000 per violation. Would also increase several administrative penalty amounts. All amounts would be adjusted every five years, beginning January 1, 2028. ***Potential CalOptima Health Impact:*** Increased financial penalties for CalOptima Health OneCare and PACE.	**08/25/2022** Passed Legislature; pending action by the Governor	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 923 Wiener	**TGI Inclusive Care Act:** No later than March 1, 2025, would require Medi-Cal MCP, PACE organization and delegated entity staff in direct contact with beneficiaries to complete cultural competency training to help provide inclusive health care services for individuals who identify as transgender, gender diverse or intersex (TGI). In addition, would require a Medi-Cal MCP and PACE organization to identify in its provider directory any in-network providers who share that they offer gender-affirming services. Finally, no later than March 1, 2024, would require the California Health and Human Services Agency to implement a quality standard that measures patient experience with TGI cultural competency. ***Potential CalOptima Health Impact:*** Additional training requirement for member-facing CalOptima Health employees; additional requirement for provider directory publication.	**08/25/2022** Passed Legislature; pending action by the Governor	CalOptima Health: Watch
Older Adult Services			
H.R. 3173 DelBene (WA) **S. 3018** Marshall (KS)	**Improving Seniors' Timely Access to Care Act:** Would require Medicare Advantage (MA) plans to issue real-time decisions for routine prior authorization requests. HHS would determine and biennially update the definitions of "real-time" and "routine." In addition, HHS would establish electronic prior authorization transmission standards for MA plans. ***Potential CalOptima Health Impact:*** Modified UM procedures and timelines for CalOptima Health OneCare.	**09/14/2022** Passed House floor; referred to Senate	CalOptima Health: Watch
H.R. 4131 Dingell (MI) **S. 2210** Casey (PA)	**Better Care Better Jobs Act:** Would make permanent the enhanced 10% FMAP for Medicaid home- and community-based services (HCBS) enacted by the American Rescue Plan Act of 2021. Would also provide states with $100 million in planning grants to develop HCBS infrastructure and workforces. Additionally, would make permanent spousal impoverishment protections for those receiving HCBS. ***Potential CalOptima Health Impact:*** Continuation of current federal funding rate for HCBS; expansion of HCBS opportunities.	**06/24/2021** Introduced; referred to committees	CalOptima Health: Watch NPA: Support
H.R. 4941 Blumenauer (OR)	**PACE Part D Choice Act of 2021:** Would allow a Medicare-only PACE participant to opt out of drug coverage provided by the PACE program and instead enroll in a standalone Medicare Part D prescription drug plan that results in equal or lesser out-of-pocket costs. PACE programs would be required to educate their participants about this option. ***Potential CalOptima Health Impact****:* Increased enrollment into CalOptima Health PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.	**08/06/2021** Introduced; referred to committees	CalOptima Health: Watch NPA: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 6770 Dingell (MI) **S. 1162** Casey (PA)	**PACE Plus Act:** Would increase the number of PACE programs nationally by making it easier for states to adopt PACE as a model of care and providing grants to organizations to start PACE centers or expand existing PACE centers. Would incentivize states to expand the number of seniors and people with disabilities eligible to receive PACE services beyond those deemed to require a nursing home level of care. Would provide states a 90% FMAP to cover the expanded eligibility. ***Potential CalOptima Health Impact:*** Subject to further DHCS authorization, expanded eligibility for CalOptima Health PACE; additional federal funding to expand the size and/or service area of a current PACE center or to establish a new PACE center(s).	**04/15/2021** Introduced; referred to committees	CalOptima Health: Watch NPA: Support
H.R. 6823 Brownley (CA) **S. 3854** Moran (KS)	**Elizabeth Dole Home and Community Based Services for Veterans and Caregivers Act:** Would require Veterans Affairs (VA) medical centers to establish partnerships with PACE organizations to enable veterans to access PACE services through their VA benefits. ***Potential CalOptima Health Impact:*** Increased number of CalOptima Health PACE participants; increased care coordination for CalOptima Health PACE participants who are veterans.	**07/19/2022** Passed House Committee on Veterans' Affairs; referred to House floor	CalOptima Health: Watch NPA: Support
S. 3626 Casey	**PACE Expanded Act:** To increase access to and the affordability of PACE, would allow PACE organizations to set premiums individually for Medicare-only beneficiaries consistent with their health status. Would also allow individuals to enroll in PACE at any time during the month. In addition, would simplify and expedite the process for organizations to apply for the following: • New PACE program • New centers for an existing PACE program • Expanded service area for an existing PACE center Finally, would allow pilot programs to test the PACE model of care with new populations not currently eligible to participate in PACE. ***Potential CalOptima Health Impact****:* Increased number of CalOptima Health PACE participants; expanded eligibility criteria; new premium development procedure; simplified process to establish new PACE centers.	**02/10/2022** Introduced; referred to committee	CalOptima Health: Watch NPA: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 1342 Bates	**Older Adult Care Coordination:** Would allow a county and/or an Area Agency on Aging to create a multi-disciplinary team (MDT) for county departments and aging service providers to exchange information about older adults to better address their health and social needs. By eliminating data silos, MDTs could develop coordinated case plans for wraparound services, provide support to caregivers and improve service delivery. ***Potential CalOptima Health Impact:*** Participation in Orange County's MDT; improved care coordination for CalOptima Health's older adult members.	**08/31/2022** Passed Legislature; pending action by the Governor	**03/29/2022** CalOptima Health: Support County of Orange: Sponsor/Support
Pharmacy			
SB 853 Wiener	**Medication Access Act:** Effective January 1, 2023, would require a health plan to cover a prescribed medication for the duration of any internal and external appeals if the drug was previously covered for the beneficiary by any health plan. ***Potential CalOptima Health Impact:*** Modified UM and Grievance and Appeals requirements for prescribed drugs covered by CalOptima Health; increased CalOptima Health costs for drug coverage.	**08/12/2022** Died in Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
SB 958 Limón	**Medication and Patient Safety Act of 2022:** Would prohibit health plans from arranging for "brown bagging" or "white bagging," as follows, except under certain limited conditions: • "Brown bagging" involves specialty pharmacies dispensing an infused or injected medication directly to a patient who transports it to a provider for administration. • "White bagging" involves specialty pharmacies distributing such medications to a provider ahead of a patient's visit. ***Potential CalOptima Health Impacts:*** Increased CalOptima Health costs and decreased member access for certain physician-administered drugs covered by CalOptima Health.	**07/01/2022** Died in Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose Unless Amended
Providers			
AB 2581 Salas	**Behavioral Health Provider Credentialing:** Effective January 1, 2023, would require health plans to process credentialing applications from mental health and SUD providers within 60 days of receipt. ***Potential CalOptima Health Impact:*** Modified provider credentialing processes for Quality Improvement staff.	**08/24/2022** Passed Legislature; pending action by the Governor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2659 Patterson	**Midwife Access:** Would require a Medi-Cal MCP to include at least one licensed midwife (LM), certified-nurse midwife (CNM) and alternative birth center specialty clinic in each county within its provider network. An MCP would be exempt if such providers or centers are not located within the county or do not accept Medi-Cal payments. An MCP must reimburse an out-of-network provider who accepts the Medi-Cal fee-for-service rate. ***Potential CalOptima Health Impact:*** Additional provider contracting and credentialing; increased access to midwifery services for CalOptima Health Medi-Cal members.	**04/29/2022** Died in Assembly Health Committee	CalOptima Health: Watch
SB 966 Limón	**Clinic Providers:** Effective 60 days following the termination of the COVID-19 PHE, would allow FQHCs and RHCs to be reimbursed for visits with an associate clinical social worker or associate marriage and family therapist when supervised by a licensed behavioral health practitioner. ***Potential CalOptima Health Impact:*** Increased member access to behavioral health providers at contracted FQHCs.	**08/31/2022** Passed Legislature; pending action by the Governor	CalOptima Health: Watch LHPC: Support
SB 987 Portantino	**California Cancer Care Equity Act**: Would require a Medi-Cal MCP to make a good faith effort to contract directly with at least one National Cancer Institute Designated Cancer Center in each county — where one exists — within the MCP's service area. In addition, an MCP must inform a beneficiary with a complex cancer diagnosis of their right to request a referral to a Cancer Center. An MCP must refrain from arbitrarily denying such referrals. ***Potential CalOptima Health Impact:*** Modified UM procedures for CalOptima Health Medi-Cal members referred to the UCI Health Chao Family Comprehensive Cancer Center; increased access to cancer care.	**08/31/2022** Passed Legislature; pending action by the Governor	CalOptima Health: Watch
Reimbursement Rates			
AB 1892 Flora	**California Orthotic and Prosthetic Patient Access and Fairness Act:** Would require reimbursement for prosthetic and orthotic appliances and durable medical equipment (DME) to be at least 80% of the lowest maximum allowance for California established by the federal Medicare program. ***Potential CalOptima Health Impact***: Increased cost to CalOptima Health Medi-Cal due to higher reimbursement to DME providers; adjustment to DHCS capitation rates.	**08/12/2022** Died in Senate Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2458 Weber	**Whole Child Model (WCM) Reimbursement Rates:** Effective January 1, 2023, would increase provider reimbursement rates for WCM services by 25% if provided at a medical practice in which at least 30% of pediatric patients are Medi-Cal beneficiaries. ***Potential CalOptima Health Impact:*** Increased cost to CalOptima Health Medi-Cal due to higher reimbursement to WCM providers; adjustment to DHCS capitation rates.	**05/20/2022** Died in Assembly Appropriations Committee	CalOptima Health: Watch
Social Determinants of Health			
H.R. 379 Barragan (CA) **S. 104** Smith (MN)	**Improving Social Determinants of Health Act of 2021:** Would require the Centers for Disease Control and Prevention (CDC) to establish a social determinants of health (SDOH) program to coordinate activities to improve health outcomes and reduce health inequities. CDC would be required to consider SDOH in all relevant grant awards and other activities as well as issue new grants of up to $50 million to health agencies, nonprofit organizations and/or institutions of higher education to address or study SDOH. ***Potential CalOptima Health Impact:*** Increased availability of federal grants to address SDOH.	**01/21/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 943 McBath (GA) **S. 851** Blumenthal (CT)	**Social Determinants for Moms Act:** Would require HHS to convene a task force to coordinate federal efforts on social determinants of maternal health as well as award grants to address SDOH, eliminate disparities in maternal health and expand access to free childcare during pregnancy-related appointments. Would also extend postpartum eligibility for the Special Supplemental Nutrition Program for Women, Infants, and Children from six months postpartum to two years postpartum. ***Potential CalOptima Health Impact:*** Additional federal guidance or requirements as well as increased availability of federal grants to address social factors affecting maternal health.	**02/08/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 2503 Bustos (IL) **S. 3039** Young (IN)	**Social Determinants Accelerator Act of 2021:** Would establish the Social Determinants Accelerator Interagency Council to award state and local health agencies up to 25 competitive grants totaling no more than $25 million (House version) or $10 million (Senate version) as well as provide technical assistance to improve coordination of medical and non-medical services to a targeted population of high-need Medicaid beneficiaries. ***Potential CalOptima Health Impact:*** Increased availability of federal grants to address the SDOH of members with complex needs.	**07/15/2021** Passed Subcommittee on Health of the House Committee on Energy and Commerce; referred to full Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 3894 Blunt Rochester (DE)	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2021:** Would require the Centers for Medicare & Medicaid Services (CMS) to update guidance at least once every three years to help states address SDOH in Medicaid and CHIP programs. ***Potential CalOptima Health Impact:*** Increased opportunities for CalOptima Health to address SDOH.	**12/08/2021** Passed House floor; referred to Senate Committee on Finance	CalOptima Health: Watch
H.R. 4026 Burgess (TX)	**Social Determinants of Health Data Analysis Act of 2021:** Would require the Comptroller General of the United States to submit a report to Congress outlining the actions taken by HHS to address SDOH. The report would include an analysis of interagency efforts, barriers and potential duplication of efforts as well as recommendations on how to foster private-public partnerships to address SDOH. ***Potential CalOptima Health Impact:*** Increased opportunities for CalOptima Health to address SDOH.	**11/30/2021** Passed House floor; referred to Senate Committee on Health, Education, Labor, and Pensions	CalOptima Health: Watch
SB 17 Pan	**Racial Equity Advisory and Accountability Commission:** Would establish the Racial Equity Commission (REC) to develop a Racial Equity Framework containing resources, best practices and tools for advancing racial equity across the state government by April 1, 2025.The REC would also provide technical assistance upon request by state and local agencies as well as issue annual reports, starting December 1, 2025, with recommendations to address issues related to racial equity. ***Potential CalOptima Health Impact:*** Increased reporting requirements to DHCS.	**08/31/2022** Died on Assembly floor	CalOptima Health: Watch
Telehealth			
H.R. 366 Thompson (CA)	**Protecting Access to Post-COVID-19 Telehealth Act of 2021:** Would allow HHS to waive or modify any telehealth service requirements in the Medicare program during a national disaster or PHE and for 90 days after one is terminated. Would also permit Medicare reimbursement for telehealth services provided by an FQHC or RHC as well as allow patients to receive telehealth services in the home without restrictions. ***Potential CalOptima Health Impact:*** Continuation and expansion of certain telehealth flexibilities allowed during the COVID-19 pandemic for CalOptima Health OneCare, OneCare Connect and PACE.	**01/19/2021** Introduced; referred to committees	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 1332 Carter (GA) **S. 368** Scott (SC)	**Telehealth Modernization Act of 2021:** Would permanently extend certain current Medicare telehealth flexibilities enacted temporarily in response to the COVID-19 pandemic. Specifically, would permanently allow the following: • FQHCs and RHCs may serve as the site of a telehealth provider • Beneficiaries may receive all telehealth services at any location, including their own homes • CMS may retain and expand the list of covered telehealth services • CMS may expand the types of providers eligible to provide telehealth services ***Potential CalOptima Health Impact:*** Continuation of certain telehealth flexibilities allowed during the COVID-19 pandemic for CalOptima Health OneCare, OneCare Connect and PACE.	**02/23/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 2166 Sewell (AL)	**Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021:** Would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for MA and PACE plans during the COVID-19 PHE. ***Potential CalOptima Health Impact:*** For CalOptima Health OneCare, OneCare Connect and PACE, members' risk scores and risk adjustment payments would accurately reflect diagnoses.	**03/23/2021** Introduced; referred to committees	**08/05/2021** CalOptima Health: Support ACAP: Support NPA: Support
H.R. 2903 Thompson (CA) **S. 1512** Schatz (HI)	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021:** Would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Specifically, would: • Remove all geographic restrictions for telehealth services • Allow beneficiaries to receive telehealth in their own homes, in addition to other locations determined by HHS • Remove restrictions on the use of telehealth in emergency medical care • Allow FQHCs and RHCs to provide telehealth services ***Potential CalOptima Health Impact:*** Continuation and expansion of telehealth flexibilities for CalOptima Health OneCare, OneCare Connect and PACE.	**04/28/2021** Introduced; referred to committees	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 3447 Smith (MO)	**Permanency for Audio-Only Telehealth Act:** Would permanently extend the following current flexibilities, which have been temporarily authorized by CMS during the COVID-19 PHE: • Medicare providers may be reimbursed for providing certain services via audio-only telehealth, including evaluation and management, behavioral health and SUD services, or any other service specified by HHS. • Medicare beneficiaries may receive telehealth services at any location, including their homes. ***Potential CalOptima Health Impact:*** Permanent continuation of certain telehealth flexibilities for CalOptima Health OneCare, OneCare Connect and PACE.	**05/20/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 4058 Matsui (CA) **S. 2061** Cassidy (LA)	**Telemental Health Care Access Act of 2021:** Would remove the requirement that Medicare beneficiaries be seen in-person within six months of being treated for behavioral health services via telehealth. ***Potential CalOptima Health Impact:*** For CalOptima Health OneCare and OneCare Connect, decreased in-person behavioral health encounters and increased telehealth behavioral health encounters.	**06/22/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 7573 Axne (IA) **S. 3593** Cortez Masto (NV)	**Telehealth Extension and Evaluation Act**: Would extend current Medicare telehealth payments authorized temporarily in response to the COVID-19 pandemic for two additional years following the termination of the PHE. Would require HHS to study the impact of telehealth flexibilities and report its recommendations for permanent telehealth policies to Congress. ***Potential CalOptima Health Impact:*** Continuation of telehealth flexibilities for CalOptima Health OneCare, OneCare Connect and PACE.	**02/08/2022** Introduced; referred to committee	CalOptima Health: Watch
S. 150 Cortez Masto (NV)	**Ensuring Parity in MA for Audio-Only Telehealth Act of 2021:** Would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for MA plans during the COVID-19 PHE. ***Potential CalOptima Health Impact:*** For CalOptima Health OneCare and OneCare Connect, members' risk scores and risk adjustment payments would accurately reflect diagnoses.	**02/02/2021** Introduced; referred to committee	CalOptima Health: Watch ACAP: Support NPA: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 32 Aguiar-Curry	**Medi-Cal Telehealth Payment and Flexibilities:** Would modify the permanent Medi-Cal telehealth policy recently implemented by SB 184, the Health Trailer Bill for the FY 2022–23 Enacted State Budget. Specifically, Medi-Cal providers, including FQHCs and RHCs, may establish a new patient using audio-only telehealth when the visit is related to sensitive services or when the patient requests audio-only telehealth or does not have access to video. ***Potential CalOptima Health Impact:*** Continuation and modification of certain telehealth flexibilities for CalOptima Health Medi-Cal and PACE.	**08/31/2022** Passed Legislature; pending action by the Governor	CalOptima Health: Watch CAHP: Concern
Youth Services			
H.R. 66 Buchanan (FL)	**Comprehensive Access to Robust Insurance Now Guaranteed (CARING) for Kids Act:** Would permanently extend authorization and funding of CHIP and associated programs, including the Medicaid and CHIP express lane eligibility option, which enables states to expedite eligibility determinations by referencing enrollment in other public programs. ***Potential CalOptima Health Impact:*** Continuation of current federal funding and eligibility requirements for CalOptima Health Medi-Cal members eligible under CHIP.	**01/04/2021** Introduced; referred to committee	CalOptima Health: Watch
H.R. 1390 Wild (PA) **S. 453** Casey (PA)	**Children's Health Insurance Program Pandemic Enhancement and Relief (CHIPPER) Act:** Would retroactively extend CHIP's temporary 11.5% FMAP increase, enacted by the HEALTHY KIDS Act (2018), from September 30, 2020, until September 30, 2022, to meet increased health care needs during the COVID-19 PHE. ***Potential CalOptima Health Impact:*** Increased federal funds for CalOptima Health Medi-Cal members eligible under CHIP.	**02/25/2021** Introduced; referred to committees	CalOptima Health: Watch

2021 Signed Bills

- H.R. 1868 (Yarmuth [KY])
- AB 128 (Ting)
- AB 133 (Committee on Budget)
- AB 161 (Ting)
- AB 164 (Ting)
- AB 361 (Rivas)
- AB 1082 (Waldron)
- SB 48 (Limón)
- SB 65 (Skinner)
- SB 129 (Skinner)
- SB 171 (Committee on Budget and Fiscal Review)
- SB 221 (Wiener)
- SB 306 (Pan)
- SB 510 (Pan)

2021 Vetoed Bills

- AB 369 (Kamlager)
- AB 523 (Nazarian)
- SB 365 (Caballero)
- SB 682 (Rubio)

Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: September 19, 2022

2022 Federal Legislative Dates

January 3	117th Congress, Second Session convenes
April 11–2	Spring recess
August 1–12	Summer recess for House
August 8–September 5	Summer recess for Senate
December 10	Second Session adjourns

2022 State Legislative Dates

January 3	Legislature reconvenes
January 14	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2021
January 21	Last day for any committee to hear and report to the floor any bill introduced in that house in 2021
January 31	Last day for each house to pass bills introduced in that house in 2021
February 18	Last day for legislation to be introduced
April 7–18	Spring recess
April 29	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2022
May 6	Last day for policy committees to hear and report to the floor any non-fiscal bills introduced in that house in 2022
May 20	Last day for fiscal committees to hear and report to the floor any bills introduced in that house in 2022
May 23–27	Floor session only
May 27	Last day for each house to pass bills introduced in that house in 2022
June 15	Budget bill must be passed by midnight
July 1	Last day for policy committees to hear and report bills in their second house to fiscal committees or the floor
July 1–August 1	Summer recess
August 12	Last day for fiscal committees to report bills in their second house to the floor
August 15–31	Floor session only
August 25	Last day to amend bills on the floor
August 31	Last day for each house to pass bills; final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2022 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima Health

CalOptima Health is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to serve member health with excellence and dignity, respecting the value and needs of each person. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan) and the Program of All-Inclusive Care for the Elderly (PACE).

FY 2022–23 California State Budget: Analysis of the Enacted Budget

Table of Contents

Background

On January 10, 2022, Gov. Gavin Newsom released the Fiscal Year (FY) 2022–23 Proposed State Budget with total spending at $286.4 billion, including $213.1 billion General Fund (GF). The proposed budget also estimated a $45.7 billion surplus and proposed $34.6 billion in budget reserves, which could be attributed to federal COVID-19 stimulus funding and higher than expected tax receipts.

On May 13, 2022, Gov. Newsom released the FY 2022–23 Revised Budget Proposal (May Revise) at a total of $300.7 billion, including $227.4 billion in GF spending, representing an increase of $14.3 billion compared to the January Proposed Budget due to further revenue growth. The May Revise included an even larger $49.2 billion discretionary surplus and $37.1 billion in budget reserves.

To meet the constitutionally obligated deadline to pass a balanced budget, on June 14, 2022, the Senate and Assembly passed Senate Bill (SB) 154, the Budget Act of 2022, a preliminary state budget representing the Legislature's counterproposal to the May Revise. The Legislature's Budget included a spending plan of $300 billion, including $235.5 billion GF.

Following negotiations with the Legislature, Gov. Newsom signed into law the preliminary state budget (SB 154) on June 27 and the final budget revisions (Assembly Bill [AB] 178) on June 30. On the same day, he signed the consolidated Health Trailer Bill (SB 184) and the Skilled Nursing Facility (SNF) Financing Reform Trailer Bill (AB 186) containing the statutory policy changes needed to implement health-related budget expenditures. Together, these bills represent the Enacted Budget for FY 2022–23, effective July 1, 2022.

Overview

In summary, the enacted budget appropriates a total of just over $300 billion, of which $234.4 billion is from the GF. This represents an increase of $37.4 billion compared with the FY 2021–22 enacted budget. Specifically, the budget includes $135.5 billion ($36.6 billion GF) in Medi-Cal spending, an 11.2% increase from the current FY, with an assumption that Medi-Cal caseload will increase by 0.6% to 14.5 million beneficiaries as redeterminations resume this FY following termination of the COVID-19 public health emergency (PHE). Based on a record-high budget surplus, the budget allocates 93% towards one-time spending initiatives and $37.2 billion for reserves. Major components included in the enacted budget that may impact CalOptima are discussed below.

Behavioral Health

The Enacted Budget includes significant investments in behavioral health, particularly for children and youth. As expected, there is ongoing funding towards implementing the Children and Youth Behavioral Health Initiative (CYBHI), including the following components in FY 2022–23:

- Dyadic services as a new Medi-Cal benefit, as discussed later
- Evidence-based behavioral health practices
- School behavioral health partnerships and capacity
- Statewide behavioral health services platform and related e-consult service and provider training

While some CYBHI initiatives are directly managed by DHCS, CalOptima's Behavioral Health Integration department may still be involved in guiding certain programs or coordinating member access.

In addition, the budget includes an extra $290 million in one-time funding over three years to address urgent needs and emergent issues in children's behavioral health through the following initiatives:

- Wellness and mindfulness programs
- Parent training and education
- Digital supports for remote assessment and intervention
- School-based crisis response pilots to prevent youth suicide
- Peer-to-peer support programs

A total of $8 million in one-time finding is also allocated for National Suicide Prevention Lifeline crisis centers to prepare for the implementation of the 9-8-8 calling code on July 16, 2022.

Finally, to address the immediate housing and treatment needs of those with serious behavioral health conditions, the budget also includes $1.5 billion over two years to purchase and install tiny homes for immediate behavioral health bridge housing.

California Advancing and Innovating Medi-Cal (CalAIM)

The Enacted Budget includes $3.1 billion ($1.2 billion GF) in FY 2022–23 to implement CalAIM. CalAIM initiatives being implemented in FY 2022–23 continue to include:

- Discontinuation of the Cal MediConnect pilot program and transition to exclusively aligned Dual Eligible Special Needs Plans (D-SNPs)
- Population Health Management (PHM) program
- Pre-release Medi-Cal eligibility screenings and 90+ days of targeted in-reach services
- Providing Access and Transforming Health (PATH) initiative

Updates include the identification of additional aid codes that will transition from Medi-Cal fee-for-service (FFS) to managed care starting January 1, 2023, expanding in-reach services for justice-involved individuals to include full-scope Medi-Cal pharmacy benefits and delaying the launch of statewide PHM service from January 1, 2023, until July 1, 2023.

In addition to $1.8 billion of previously allocated PATH funding, the budget provides an additional $50 million ($16 million GF) for counties and correctional entities to support capacity building, technical assistance, collaboration and planning. While plans are not eligible for this funding, CalOptima is expected to coordinate PATH and CalAIM Incentive Payment Program investments with the County of Orange.

COVID-19

As the COVID-19 pandemic enters its endemic phase, the budget allocates $1.9 billion to ensure ongoing pandemic response and preparedness for potential future surges of additional COVID-19 variants. This includes investments towards vaccinations (including boosters), rapid and school-based testing, enhanced surveillance, test to treat therapeutics and medical surge staffing.

In addition, with the PHE expected to terminate in the coming months, the budget includes funding to ensure continuity of Medi-Cal coverage as eligibility redeterminations resume. Funding supports additional county workloads, Health Enrollment Navigators expansion and media and outreach campaigns to collect updated member contact information. CalOptima is separately executing its own member communication strategies.

Finally, the budget permanently extends certain COVID-19 flexibilities that have proven to be beneficial to Medi-Cal beneficiaries regardless of the existence of a pandemic. These include the following, though additional flexibilities may be identified at a later date:

- Separate payments to Federally Qualified Health Centers (FQHCs) for COVID-19 vaccinations
- 10% rate increase for Intermediate Care Facilities for Developmentally Disabled (ICF-DD)
- Medicare reimbursement rates for the COVID-19 vaccine, COVID-19 lab services and oxygen and respiratory durable medical equipment
- Presumptive Medi-Cal eligibility for older adults and individuals with disabilities

Housing and Homelessness

Building off a $12 billion multiyear investment to address homelessness as part of last year's enacted budget, this year's budget includes an additional $2 billion multiyear affordable housing package, including investments in the Multifamily Housing Program, Housing Accelerator Program, Farmworker Housing Program, Accessory Dwelling Unit financing and Veterans Housing and Homelessness Prevention Program. The budget also includes $700 million over two years for local jurisdictions to address encampments through short- and long-term rehousing strategies.

Contingent on passage of implementing legislation (SB 1338), the budget sets aside funding for the governor's proposed Community Assistance, Recovery, and Empowerment (CARE) Court. CARE Court would facilitate delivery of mental health and substance use disorder services to individuals with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capabilities. The program would connect a person in crisis with a court-ordered care plan for up to 24 months as a diversion from homelessness, incarceration or conservatorship. Care plans could include court-ordered stabilization medications, wellness and recovery supports, and connection to social services and a housing plan. It is not yet known how Medi-Cal managed care plans (MCPs) may be involved in the delivery or coordination of care to their members.

Inflation Relief

In an effort to provide direct relief for rising costs due to inflation, the budget includes a $17 billion relief package, which includes the following elements:

- $1.3 billion for retention payments of up to $1,500 each for hospital and SNF workers
- Permanent extension of the State Premium Subsidy Program to provide financial assistance for individuals purchasing health care coverage through Covered California

These are expected to result in direct positive impacts to CalOptima's health networks and providers as well as members who churn on and off of Medi-Cal eligibility.

Kaiser Medi-Cal Contract

As part of the budget packet, Gov. Newsom also signed into law AB 2724, which authorizes DHCS to enter into a direct, statewide contract with Kaiser Permanente to provide Medi-Cal services in any county, starting January 1, 2024. If the Centers for Medicare and Medicaid Services approves DHCS' waiver request, the contract is expected to result in significant negative impacts to CalOptima and its members and providers as well as the broader safety net health system. CalOptima and the County of Orange adopted positions of Oppose Unless Amended to prohibit a direct contract in counties with County Organized Health Systems (COHS), but the final bill still applies to COHS counties.

Medi-Cal Benefits

The Enacted Budget includes additional funding for several new Medi-Cal benefits.

As referenced earlier, the budget funds the implementation of dyadic services, effective January 1, 2023. Similar to Parent-Child Interaction Therapy, currently managed by the Orange County Health Care Agency (HCA), dyadic care provides integrated physical and behavioral health screening and services to the whole family. The goal of providing dyadic care is to improve access to preventive and coordinated care for children, rates of immunization completion, social-emotional health services, developmentally appropriate parenting and maternal mental health.

In addition, 24/7 mobile crisis intervention services will become a Medi-Cal benefit implemented through county behavioral health systems as soon as January 1, 2023. It is expected that HCA may operate this benefit out of the Be Well OC campus. While not provided by MCPs, this new benefit may still require increased coordination and follow-up care by CalOptima and its contracted providers.

The budget also delays implementation of the doula benefit from July 1, 2022, until January 1, 2023, and provides funding to increase the maximum reimbursement rate from an average of $450 to $1,094 per birth for doula services. Lastly, effective July 1, 2022, annual cognitive health assessments become a Medi-Cal benefit for beneficiaries ages 65 years and older if they are ineligible under Medicare.

Medi-Cal Eligibility

Notably, the budget expands full-scope Medi-Cal benefits to income-eligible adults ages 26–49 regardless of immigration status no later than January 1, 2024. This will extend eligibility to include all ages following prior action to expand coverage for those under age 26 as of January 1, 2020, and those ages 50 and older as of May 1, 2022. Along with the latter expansion, this proposal could increase CalOptima's membership by approximately 75,000–80,000 individuals.

The budget also continues to include $53 million ($19 million GF) funding to eliminate Medi-Cal premiums for approximately 500,000 higher-income pregnant women,

children and disabled working adults covered under the Children's Health Insurance Program (CHIP), Medi-Cal Access Program (MCAP) and 250% Working Disabled Program.

Additionally, trailer bill language authorizes continuous Medi-Cal eligibility for children up to 5 years of age, beginning January 1, 2025, preventing disenrollment regardless of changes in family income. DHCS will also expand the Children's Presumptive Eligibility Program by allowing all Medi-Cal providers to enroll children under 19 years of age into Medi-Cal through the presumptive eligibility process.

No sooner than January 1, 2025, seniors and persons with disabilities who qualify for Medi-Cal under Medically Needy criteria will have reduced share of cost requirements by increasing the Medi-Cal Maintenance Need Income Level to match the income eligibility limit for Medi-Cal without a share of cost. As a result of CalAIM, these share of cost beneficiaries are currently covered under Medi-Cal FFS, as of January 1, 2022.

Provider Payments

The Enacted Budget includes $700 million over five years for Equity and Practice Transformation Payments, which are one-time provider payments focused on advancing equity, reducing COVID-19-driven care gaps, supporting upstream interventions to address social determinants of health and improving quality in maternity, children's preventive and integrated behavioral health care. It is anticipated that some if not all of these payments will flow through Medi-Cal MCPs, though key details on implementation have not been shared.

A new Workforce and Quality Incentive Program will provide $280 million in directed payments to SNFs that meet quality benchmarks or who have demonstrated substantial improvement. Medi-Cal MCPs will coordinate program implementation and issue payments. Other changes to SNF payments include:

- New reimbursement rate structure, beginning January 1, 2023
- Average 4% annual rate increase
- One-year extension of the temporary 10% rate increase effective during the COVID-19 PHE

The budget continues nearly all Proposition 56 supplemental payment programs, with several transferring to the GF to allow for ongoing funding regardless of fluctuations in Proposition 56 revenues. However, the Value Based Payment program still sunsetted on June 30, 2022, and the Behavioral Health Integration program is still set to sunset on December 31, 2022. The budget made permanent the Medi-Cal Physician and Dentist Loan Repayment Program, also funded through Proposition 56, and provided additional funds from the GF for FY 2022–23.

The Enacted Budget also eliminates most remaining Great Recession-era ("AB 97") Medi-Cal rate cuts for 35 additional provider types and services, effective either July 1, 2022, or January 1, 2023.

Telehealth

To build off telehealth flexibilities adopted during the COVID-19 pandemic, the budget authorizes a permanent telehealth policy that allows Medi-Cal providers, including FQHCs, to be reimbursed for both video and audio-only telehealth encounters at the same rate as an in-person visit. Providers must still provide an option for in-person visits. However, a new Medi-Cal patient relationship may not be established via audio-only telehealth.

Miscellaneous

The Enacted Budget also includes the following provisions that may impact CalOptima:

- $351.6 million over four years for workforce development, including:
  - $200 million for the behavioral health workforce
  - $76 million for the primary care, clinic and reproductive health workforce
  - $75.6 million for the public health workforce
- $350 million over three years to recruit, train and certify 25,000 new community health workers by 2025, with specialized training to work with those who are justice-involved, unhoused, older adults or disabled
- $200 million to improve access to reproductive health services
- $101 million to expand medication-assisted treatment to help address the opioid crisis
- $100 million for the CalRX Biosimilar Insulin Initiative to create public-private partnerships to increase generic insulin manufacturing and lower insulin costs
- $50 million over two years for technical assistance grants and capacity development programs for small and under-resourced providers to improve data exchange capabilities
- Development of an Alternative Payment Model for FQHCs, optionally allowing them to transition from a volume-based to value-based reimbursement methodology, no sooner than January 1, 2024
- Reclassification of diabetic products, including continuous glucose monitors, as pharmacy benefits covered under Medi-Cal Rx, effective July 1, 2022

Next Steps

The Legislature will continue to advance budget trailer bills and policy bills through the legislative process. Bills with funding allocated in the Enacted Budget are likely to be passed and signed into law. The Legislature has until August 31 to pass legislation, and Gov. Newsom has until September 30 to either sign or veto that legislation. Additionally, state agencies will begin implementing the policies enacted through the budget. Staff will continue to monitor these polices and provide updates regarding issues that have a significant impact to CalOptima.

About CalOptima

CalOptima, a county organized health system (COHS), is the single plan providing guaranteed access to Medi-Cal for all eligible individuals in Orange County and is responsible for almost all medical acute services, including custodial long-term care. CalOptima is governed by a locally appointed Board of Directors, which represents the diverse interests that impact Medi-Cal.

If you have any questions, please contact GA@caloptima.org.

Board of Directors Meeting
October 6, 2022

CalOptima Health Community Outreach Summary — September and October 2022

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To this end, our team attends community coalitions, collaborative meetings and advisory groups, and supports our community partners' public activities.

CalOptima Health's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima Health program
- Community awareness of CalOptima Health
- Partnerships that increase positive visibility and relationships with community organizations

We continue to participate in public activities virtually in most instances, with limited in-person attendance. Participation includes providing Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima Health-branded items.

Community Outreach Highlight

Our Community Relations team hosted InfoSeries events to bring awareness to the topic of homelessness and the different populations it affects. Homelessness is an issue that affects not only our members, but the community at large. The first InfoSeries event took place in March and focused on dispelling common myths about homelessness and the California Advancing and Innovating Medi-Cal (CalAIM) services that support members experiencing homelessness. June's event focused on Transitional Age Youth (TAY), and August's event focused on family homelessness at the national and local level. Lastly, the InfoSeries will wrap up with an emphasis on older adults experiencing homelessness.

Summary of Public Activities

As of September 7, CalOptima Health plans to participate in, organize or convene 52 public activities in September and October. In September, there will be 27 public activities that include 14 virtual community/collaborative meetings, two community-based presentations, 10 community events and one Health Network Forum. In October, there will be 25 public activities that include 16 virtual community/collaborative meetings, one community-based presentation, six community events, one Health Network Forum and one Cafecito. A summary of the Agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided three endorsements since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

1. Provided use of CalOptima Health name or logo for YMCA of Orange County to promote the CalFresh program with the goal of increasing access and the visibility of CalFresh to our members and the community at large
2. Letter of support for Charitable Ventures to help reduce prenatal substance exposure and provide services and supports to pregnant and parenting women with substance use disorders and their families
3. Letter of support for MindOC for the Behavioral Health Continuum Infrastructure Program (BHCIP) Round 4 application

For additional information or questions, contact CalOptima Health Community Relations Manager Tiffany Kaaiakamanu at 657-235-6872 or tkaaiakamanu@caloptima.org.

Updated 2022-09-07

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List of community events hosted by CalOptima Health and community partners in September and October 2022:

September 2022			
9/8 1:30–3 p.m.	**InfoSeries: California Master Plan for Aging, Orange County Efforts and Services for Older Adults*** Virtual	At least five staff members attended.	• Forum • Open to health and human service providers; registration required
9/9 8 a.m.–3:15 p.m.	**Annual SoCal Alzheimer's Disease Research Conference hosted by UCI MIND†** Irvine Marriott 18000 Von Karman Ave, Irvine	At least one staff member attended (in-person). Sponsorship fee: $1,000; included resource table, four general admission tickets, logo and link on event website and logo on signage during break.	• Health/resource fair • Open to the public
9/10 10 a.m.–1 p.m.	**Fall Health & Resource Fair hosted by the City of Anaheim†** Downtown Anaheim Community Center 250 E. Center St., Anaheim	At least one staff member attended (in-person). Registration fee: $125; included a resource booth.	• Health/resource fair • Open to the public
9/10 9 a.m.–Noon	**Out of the Darkness Community Walk hosted by the American Foundation for Suicide Prevention†** UC Irvine-Aldrich Park	At least one staff member attended (in-person). Sponsorship fee: $1,000; included a resource table at the walk, placement of agency's logo on the event's t-shirts and website, and agency's name in event host's newsletter.	• Health/resource fair • Open to the public
9/12 9–10 a.m.	**CalOptima Health Medi-Cal Overview Presentation in Spanish** Whitten Community Center 900 S. Melrose St., Placentia	At least one staff member presented (in-person).	• Community-based organization presentation • Open to members only
9/14 1–2 p.m.	**CalOptima Health Medi-Cal Overview Presentation in English** Key Elementary 2000 W. Ball Rd., Anaheim	At least two staff members presented (in-person).	• Community-based organization presentation • Open to members only
9/15 9–11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members attended.	• Forum • Open to health and human service providers
9/16 9 a.m.–1 p.m.	**Orange County's 6th Regional Conference hosted by Vision y Compromiso†** Wesley Village 10861 Acacia Pkwy., Garden Grove	At least one staff member attended (in-person). Sponsorship fee: $600 included a five-minute speaking opportunity during the conference and logo displayed on the conference PowerPoint presentation.	• Forum • Open to health and human service providers
9/17 10 a.m.–1 p.m.	**Active Living Expo hosted by the Huntington Beach Council on Aging†** Senior Center in Central Park 18041 Goldenwest St., Huntington Beach	At least one staff member attended (in-person). Sponsorship fee: $1,000; included a resource table at the event, agency's name listed on the event banner, a half-page ad in the event program, a link to agency's website from the host website for six months, placement of agency's name/logo on banner at senior center, logo on event's	• Health/resource fair • Open to the public

* CalOptima Hosted
† Exhibitor/Attendee

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		Passport to Health, agency's banner displayed in prominent area of the center the week before the event, recognition of sponsorship from main stage during event and in the Surf City Break, a press release from City of Huntington Beach distributed to county and local press, and a healthy living hospitality basket.	
9/17 9 a.m.–1 p.m.	**Vaccine Event hosted by CalOptima Health, Anaheim Elementary School District, CHOC and OC Health Care Agency*** Key Elementary School 2000 W. Ball Rd., Anaheim	At least 10 staff members attended (in-person).	• Health/resource fair • Open to the public
9/21 2– 6 p.m.	**Vaccine Event hosted by CalOptima Health, Santa Ana Unified School District, CHOC and OC Health Care Agency*** Pio Pico Elementary School 931 W. Highland St., Santa Ana	At least 10 staff members attended (in-person).	• Health/resource fair • Open to the public
9/24 11 a.m.–2 p.m.	**Celebration Recovery Picnic hosted by the Mental Health Association Orange County†** Hart Park 701 S. Glassell St., Orange	At least one staff member attended (in-person). Sponsorship fee: $250; included a resource booth and agency's logo/name on event flyers.	• Health/resource fair • Open to the public
9/28 10 a.m.–1 p.m.	**Knowledge and Health Fair hosted by the Costa Mesa Senior Center†** Costa Mesa Senior Center 695 W. 19th St., Costa Mesa	At least one staff member attended (in-person). Registration fee: $200; included resource table at event, table sign displaying organization's name and placement of organization's name on the Knowledge and Health Fair expo passport.	• Health/resource fair • Open to the public
October 2022			
10/1 5–8 p.m.	**Walk to End Alzheimer's Resource Fair hosted by the Alzheimer's Association†** Mike Ward Community Park 20 Lake Rd., Irvine	At least two staff members attended (in-person). Sponsorship fee: $1,500; included a resource table at the event, name listing on event t-shirts, logo with a link back to the agency on the event website and feature in the event welcome packet.	• Health/resource fair • Open to the public
10/1 8:30 a.m.–12:30 p.m.	**Together4Teens hosted by the Wellness & Prevention Center†** Capistrano Valley High School 26301 Via Escolar, Mission Viejo	At least one staff member attended (in-person). Sponsorship fee: $500; included a resource table at event, mention in e-newsletter and social media, logo on event flyer, opportunity to place own promotional items in resource bag and quarter-page digital program ad.	• Health/resource fair • Open to the public
10/6 8 a.m.–6 p.m.	**Breaking Barriers Summit hosted by the OC Grantmakers†** Orange Coast College 2701 Fairview Rd., Costa Mesa	At least two staff members to attend (in-person). Sponsorship fee: $2,500; includes two event tickets, placement of agency's logo and link on event website and all event e-communications, Gold Sponsor social media promotion, inclusion on sponsor page of event app, and recognition as a sponsor at the beginning and end of the event.	• Forum • Open to community stakeholders; register required

* CalOptima Hosted
† Exhibitor/Attendee

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10/8 9 a.m. – 1p.m	**Vaccine Event hosted by CalOptima Health, Santa Ana Unified School District, CHOC and OC Health Care Agency*** Villa Fundamental Intermediate School 1441 E. Chestnut Ave., Santa Ana	At least 10 staff members to attend (in-person).	• Health/resource fair • Open to the public
10/12 9–10 a.m.	**CalOptima Health Medi-Cal Overview Presentation in English** Cypress Senior Center 9031 Grindlay St., Cypress	At least one staff member to present (in-person).	• Community-based organization presentation • Open to members only
10/15 9 a.m.–Noon	**Mujeres Empowerment and Civic Engagement Virtual Conference hosted by the Center for Healthy Neighborhoods†** Hybrid	At least one staff member to attend (in-person). Sponsorship fee: $1,000; includes company name and logo display on website and on-screen during conference, and an opportunity to host a resource table at a local viewing.	• Forum • Open to the public
10/20 9–11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members to attend.	• Forum • Open to health and human service providers
10/22 8:30 a.m.–2 p.m.	**Annual Alzheimer's Latino Conference hosted by Alzheimer's Orange County†** Templo Calvario Church 2501 W. 5th St., Santa Ana	At least one staff member to attend (in-person). Sponsorship fee: $2,000; includes recognition at the event during opening ceremonies, acknowledgment in press releases, advertisements one month prior to conference (radio, magazine, website, and newspaper), agency's logo placement at conference as well as on event agenda and looping acknowledgment video, agency's information in event goody bag, a resource table at the event, lunch for two attendees, and certificate of recognition.	• Conference • Open to the public
10/25 9–10:30 a.m.	**Cafecito Meeting*** Virtual	At least five staff members to attend.	• Steering committee meeting • Open to collaborative members

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

* CalOptima Hosted
† Exhibitor/Attendee

Updated 2022-09-07

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CalOptima Health Board Action Agenda Referral

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

14. Authorize a General Awareness and Brand Development Campaign to Increase Visibility and Understanding of CalOptima Health in Orange County

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Deanne Thompson, Executive Director, Marketing & Communications, (714) 954-2141

Recommended Actions

1. Upon approval of marketing materials, including printed materials, from the California Department of Health Care Services, authorize the Executive Director, Marketing and Communications, to implement a comprehensive CalOptima Health General Awareness and Brand Development Campaign that includes multichannel outreach to Orange County residents and CalOptima Health's members, prospective members, providers, and partners.
2. Authorize unbudgeted expenditures in an amount not to exceed $2.7 million from existing reserves for the General Awareness and Brand Development Campaign.

Background

In August 2022, the CalOptima Board of Directors approved a new name for the agency, CalOptima Health, and a new logo mark. The goal of the rebranding effort was to closely associate the agency with its core function and mission to serve member health and to introduce a logo that reflects desired brand attributes, including connection, community, and diversity among other concepts. With CalOptima Health now appropriately branded, the next step is to raise general awareness about the agency through a comprehensive marketing, advertising, and outreach campaign.

Based on the strategic direction of past leadership teams, CalOptima Health's Communications department routinely budgeted only for campaigns focused on competitive programs (OneCare Connect, Program of All-Inclusive Care for the Elderly, etc.) or general health messages (quality/preventive care, COVID-19, etc.). However, CalOptima Health now provides health coverage for 28% of all Orange County residents, and increased awareness of the agency's pivotal role in the community will improve recognition by the general population and promote engagement among affiliated members, providers, and partners.

Discussion

With the adoption of a new mission and five-year strategic vision, CalOptima Health is poised to increase awareness and strengthen perceptions of the agency's purpose, services, and programs. This will improve the effectiveness and outcomes of strategic priorities by boosting understanding in the marketplace and enhancing the agency's value to members and community stakeholders. The proposed General Awareness and Brand Development Campaign allows for expanded brand recognition, which promotes access to care and follows the investment parameters of other neighboring public health plans.

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In addition, the timing of this campaign reflects important external drivers for increasing awareness of CalOptima Health's Medi-Cal plan, including the upcoming Medi-Cal member redetermination effort at the end of the public health emergency, the expansion of Medi-Cal coverage to additional populations (i.e., undocumented adults age 26–49), and the potential impact of the Kaiser Permanente direct Medi-Cal contract.

This spring, CalOptima Health conducted a request for proposal to identify vendors for outside advertising agency services. CalOptima Health engaged Maricich Health to explore the launch of a General Awareness and Brand Development Campaign. Maricich Health has many years of experience working with L.A. Care Health Plan and Inland Empire Health Plan and offered an outline of the campaign's components and estimated expenses as follows:

- Brand Platform Development and Consulting: Research, strategy, brand messaging and design platforms, brand concept, and guidelines — $250,000
- Campaign Creation and Execution: Media plan, campaign development, and campaign production — $450,000
- Campaign Media Costs: Media costs, monitoring, and reporting — $2 million

The proposed campaign would be developed during the next four to five months, for a debut in the first quarter of 2023.

Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $2.7 million from existing reserves will fund this action.

Rationale for Recommendation
Implementing a CalOptima Health General Awareness and Brand Development Campaign will support enhanced recognition of the agency's key role in the community, improve understanding of our values and vision, and contribute to the strategic priority of promoting CalOptima Health's voice and influence.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Maricich Health General Awareness and Brand Development Campaign Overview
2. Entities Covered by this Recommended Board Action

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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CalOptima Health

General Awareness and Brand Development Campaign Overview

maricich health

BRANDING | ADVERTISING | COMMUNICATIONS

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CalOptima Health: General Awareness and Brand Development – Budget Overview

Dear CalOptima Health Team,

It's been a pleasure working with you in the development of the new CalOptima Health logo. Per your request, we developed a high-level budget overview for raising awareness and launching the CalOptima Health brand across our diverse Orange County community.

Maricich Health is pleased to bring deep experience in working with public health plans, including L.A. Care Health Plan and Inland Empire Health Plan. Back in 2010, when we started working with L.A. Care specifically, the organization was relatively unknown. Maricich Health transformed the L.A. Care brand, drove awareness, supported significant growth and elevated the brand into one recognized as the nation's leading publicly operated health plan. There are many similarities between L.A. Care and CalOptima Health, and our recommendations are based upon leveraging these key insights for success.

The budget numbers contained within have been developed objectively, to develop and launch the new brand within the many communities you serve, communicating CalOptima Health's strategic objectives, and breaking through the clutter with a captivating message of leadership in a competitive media market. We're excited about what's in store for the CalOptima Health brand and are looking forward to this next phase of the brand journey.

Sincerely,

Mark Maricich, CEO

David Maricich, President

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Executive Summary

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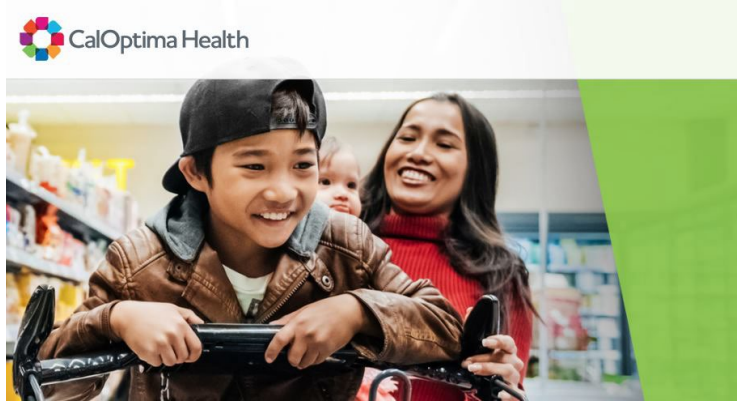
EXECUTIVE SUMMARY

To support CalOptima Health's 5-Year Strategic Plan to transcend regulatory changes and anticipated market shifts by optimizing its role in providing health care access to the community, the organization is considering a foundational investment to boost its brand awareness and perception.



Increased awareness and perception of CalOptima Health's purpose, services and products will increase the effectiveness and outcomes of all strategic priorities by reducing confusion in the marketplace and enhancing the organization's perceived value to members and community stakeholders.

The need for a strong brand is clear and further supported by a 2021 public opinion survey showing that nearly 40% of Orange County residents are not familiar with CalOptima Health and of those who are, more than 50% are either unsure or misinformed about what the organization provides to the community.

To turn the tide, this document serves to outline the recommended brand development investment parameters and options based on comparable data from the neighboring public health plans L.A. Care and IEHP.

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Recommended Brand Development Budget Parameters

	Phase/Deliverables	Recommended Budget
CalOptima Health	**Brand Platform Development & Consulting** Research, Strategy, Brand Messaging and Design Platforms, Brand Concept, Guidelines	$250,000*
	Brand Campaign Creation & Execution Media Plan, Campaign Development, Campaign Production	$450,000
	Brand Campaign Media Costs Media Costs, Monitoring & Reporting	$2,000,000
		$2,700,000 TOTAL

*$75,000 due at project start with remaining balance billed at monthly milestones.

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Background & Budget Rationale

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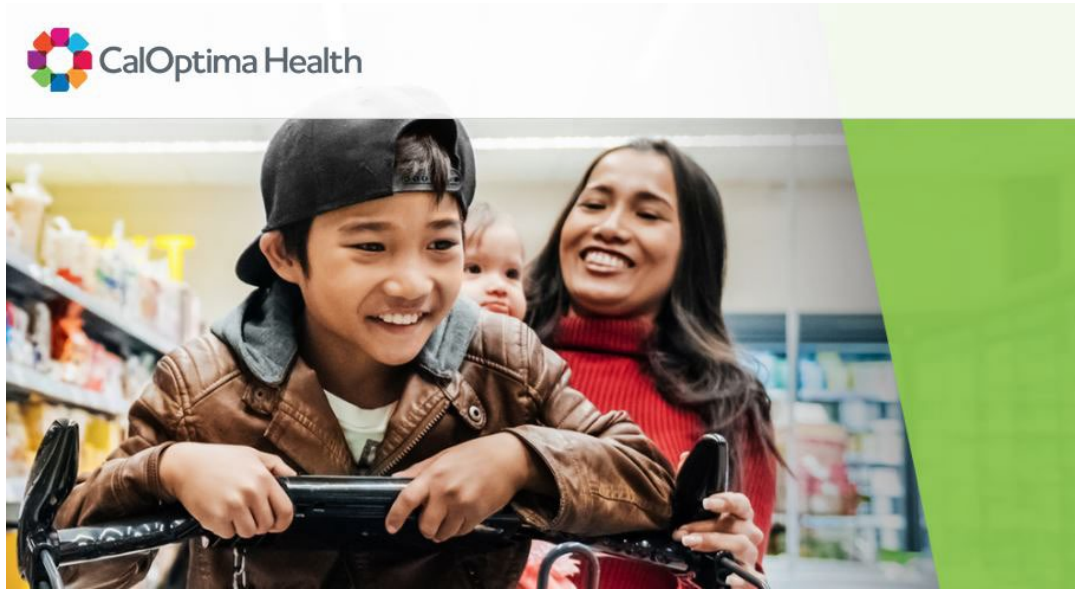
CALOPTIMA HEALTH: BRAND & STRATEGIC OBJECTIVES

Strategic Compass for the Brand:

- Mission: To serve member health with excellence and dignity, respecting the value and needs of each person.
- Vision: By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.
- Core Strategy: The "inter-agency" co-creation of services and programs, together with our delegated networks, providers and community partners, to support the mission and vision.
- Strategic & Tactical Priorities: (all center around)
  - Overcoming Health Disparities
  - Future Growth
  - Organizational, Operational Leadership



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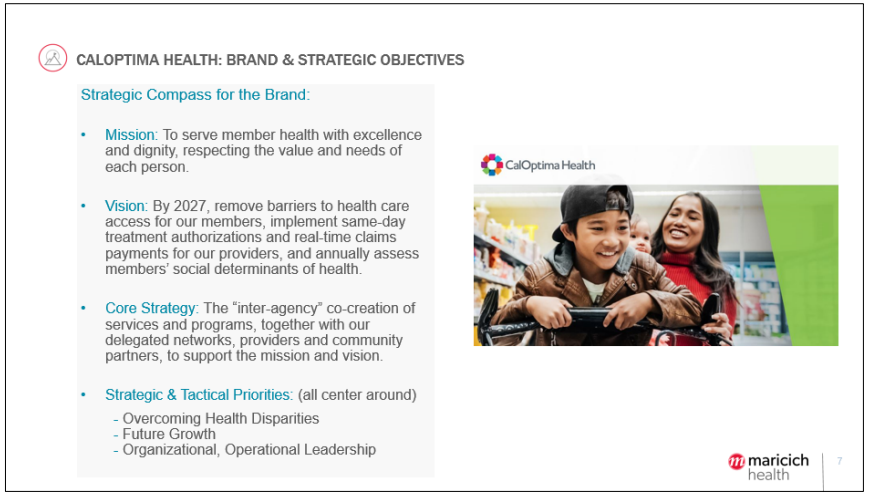
CALOPTIMA HEALTH: BRAND & STRATEGIC OBJECTIVES



Key Takeaway:

An authentic brand strategy will be based on discovery, insights and engagement with stakeholders, regarding CalOptima Health's true brand differentiators, mission, vision, core strategy, strategic and tactical priorities.

A successful brand message will be rooted in consensus of these insights, serving as the driving inspiration behind the brand position/personality, reasons-to-believe and resulting big idea.

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MARKET RESEARCH RECOMMENDATIONS

Verbatim recommendations from market research:
(Final launch details TBD, based on CalOptima input.)

- **Recommendation 1**: **Continue to raise awareness of the CalOptima name and its primary mission**. Although 61% of residents overall reported that they had heard of CalOptima, fewer than half the residents familiar with CalOptima were aware that it provides health insurance. Name recognition and brand understanding were particularly low among white, English-speaking and college-educated residents.

- **Recommendation 2**: Explore opportunities to **educate the public about CalOptima's services and value** to Orange County as a whole, including work to address homelessness and other brand attributes that extend beyond CalOptima's direct role as a Medi-Cal provider.

- **Recommendation 3**: In addition to general outreach, consider **developing communication strategies** specifically tailored to white, college-educated audiences about CalOptima's value and activities. These residents had lower awareness levels and lower favorability ratings.

- **Recommendation 4**: Consider **conducting stakeholder interviews with influencers and community leaders** to better understand brand perceptions surrounding CalOptima and to identify opportunities to expand the organization's role and partnerships.

Source: Final Report — 2021 CalOptima Public Opinion Survey, October 2021
Study conducted by Public Values Research/Westbound Communications

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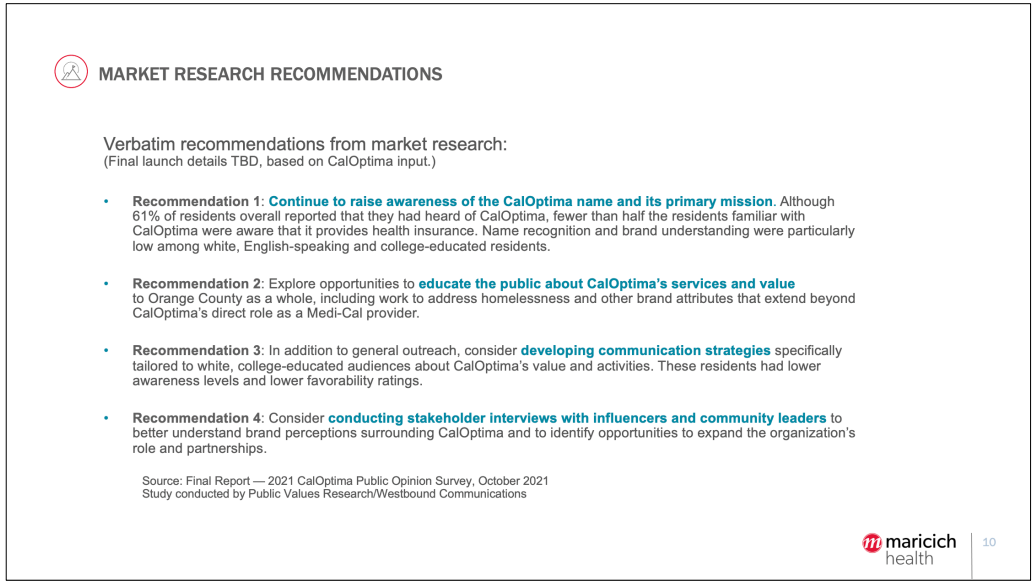
MARKET RESEARCH RECOMMENDATIONS



Key Takeaway:

Research shows that CalOptima Health needs to raise its brand awareness. Since there is a correlation between increased brand awareness and utilization of health care services, CalOptima Health will take steps to achieve its 2027 vision and implement strategic objectives to “remove barriers to care” by communicating in a broad branding campaign that reaches all community members in multiple languages.

A successful brand message will be rooted in consensus of these insights, serving as the driving inspiration behind the brand position, personality, reasons-to-believe and resulting big idea.

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CALOPTIMA HEALTH COMPETITIVE AD SPENDING

Brand	Branding / Marketing Local Campaign Region	2021 Local Advertising Media Spend (entire year)	2022 Local Advertising Media Spend (Q1 – Q2 only)	Notes
Kaiser Permanente	LA/OC	$14,369,941	$1,811,875	Most ad spending is in Q3 - Q4.
OC Health Care Agency	**OC**	**$7,613,200***	**$3,806,900**	***Based on County agenda reports for sports sponsorships. Other sources report this as $9.25M**
AltaMed	LA/OC	$8,685,190	$6,491,083	
Providence	LA/OC	$5,849,993	$145,248	Most ad spending is in Q3 - Q4.
L.A. Care Health Plan	**LA**	**$3,688,288**	**$1,946,493**	**L.A. Care Covered reported spending is at $1.7M, but is most likely higher**
IEHP	**IE**	**$1,855,911**	**$612,611**	
UCI Health	OC	$1,449,129	$2,213,825	
City of Hope	LA/OC	$1,306,058	$653,461	May not include big campaign push that is currently in OC market.
Hoag	OC	$660,598	$557,272	Does not include new campaign that has just launched in OC market.
Molina	LA	$570,619	$209,808	
CalOptima Health	**OC**	**$151,007**	**$264,483**	**Reported ad data only, will not include entire budget.**

Source: Nielsen

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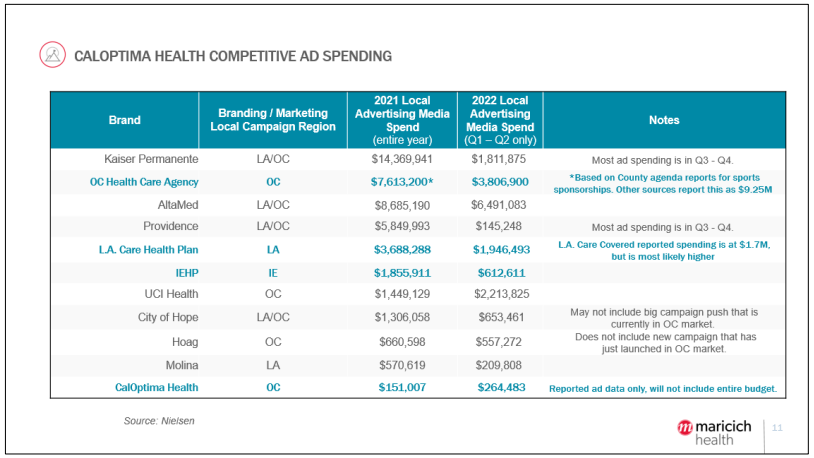
CALOPTIMA HEALTH COMPETITIVE AD SPENDING



CALOPTIMA HEALTH COMPETITIVE AD SPENDING

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Molina	LA	$570,619	$209,808	
CalOptima Health	OC	$151,007	$264,483	Reported ad data only, will not include entire budget.

Source: Nielsen

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Key Takeaway:

CalOptima Health needs to increase its media budget, especially for a branding campaign.

The leading health care organizations validate substantially larger media budgets based on the effect of supporting access to care in the communities they serve.

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OUR STRATEGIC & CREATIVE PROCESS

1

DISCOVER

Stakeholder Discovery / Insights

Target Audience Discovery / Insights

Competitive Review / Insights

2

PRESCRIBE

Directional Brand Strategy

Directional Brand Positioning

Directional Brand Messaging

3

DEVELOP

Brand Strategy Refinement

Brand Anthem Concept (Big Idea) Mood Board

Creative Campaign Concepts & Review

3 – 4 months

4

EXECUTE

Tactical, Digital & Media Consulting

Creative Campaign Production and Style Guide

Launch Internal, External Campaign

5

ANALYZE

Marketing Performance Dashboard Setup

Collect Data Review KPIs & Insights

Ongoing Campaign Reporting, Evolve & Reapply

3 – 9 months

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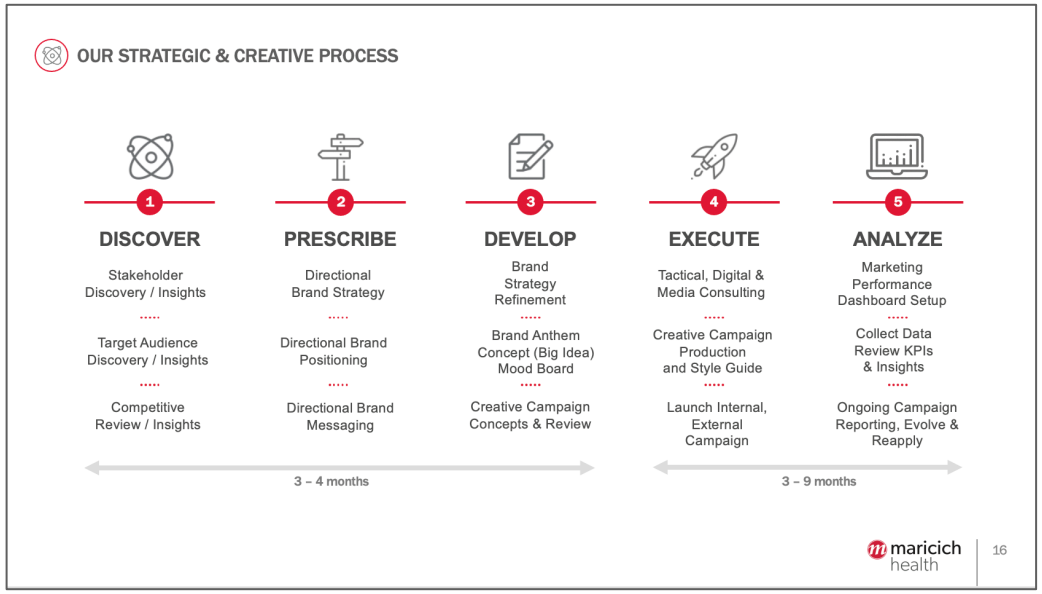
OUR STRATEGIC & CREATIVE PROCESS



Key Takeaway:

The strategic and creative process that Maricich Health will use with CalOptima Health follows the same steps that we have taken with successful branding initiatives for both L.A. Care and IEHP.

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CALOPTIMA HEALTH BRANDING INITIATIVE TIMELINE

	CalOptima Health Branding Initiative Work Plan & Schedule	Oct	Nov	Dec	Jan 2023	Feb	Mar	Apr thru Feb 2024
DISCOVER	Stakeholder Interviews/Research, Target Audience Review, Competitive Review, CalOptima Health Brand Discovery Insights	→						
PRESCRIBE	CalOptima Health Directional Brand Strategy, Directional Positioning, and Directional Messaging Development	→						
DEVELOP	Brand Strategy Refinement, Brand Anthem/Big Idea/ Mood Board, Creative Campaign Concepting for CalOptima Health Brand Launch		→					
	Creative Review: Internal Socialization/External Stakeholder Input				→			
EXECUTE	Tactical, Digital & Media Consulting, Creative Campaign Production, Finalize Media Plan, Develop Brand Style Guide				→			
	Phased Campaign Internal/External Rollout & Media Consulting						→	
ANALYZE	Marketing Performance Dashboard Setup, Support, Ongoing Campaign Reporting & Account Management					→		

Estimated Budget: $2,700,000

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Maricich Health	18201 McDurmott W., Suite A	Irvine	CA	92614

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CalOptima Health Board Action Agenda Referral

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item
15. Accept and Receive and File Fiscal Year 2021-22 CalOptima Health Audited Financial Statements

Contact
Nancy Huang, Chief Financial Officer (657) 235-6935

Recommended Action
Accept and receive and file the Fiscal Year (FY) 2021-22 CalOptima Health consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP (Moss-Adams).

Background
CalOptima Health has contracted with financial auditors Moss-Adams to complete CalOptima Health's annual financial audit. At the May 19, 2022, meeting of the CalOptima Health Finance and Audit Committee, Moss-Adams presented the FY 2021-22 Audit Plan. The plan includes performing the mandatory annual consolidated financial statement audit and review of relevant internal controls and compliance for CalOptima Health's major programs.

Discussion
Moss-Adams conducted the interim audit beginning May 23, 2022, and the year-end audit during July to August of 2022. This year's significant audit areas that Moss-Adams reviewed included:

- Medical claims liability and claims expense;
- Capitation revenue and receivables; and
- Amounts due to the State of California or the California Department of Health Care Services.

Results from CalOptima Health's FY 2021-22 Audit were positive. The auditor:

- Made no changes in CalOptima Health's approach to applying critical accounting policies;
- Did not report any significant difficulties during the audit; and
- Identified no material misstatements nor control deficiencies.

As such, management recommends that the Board accept the CalOptima Health FY 2021-22 audited financial statements, as presented.

Fiscal Impact
There is no fiscal impact related to this recommended action.

Concurrence
Troy Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Finance and Audit Committee

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Attachments

1. FY 2021-22 CalOptima Health Audited Financial Statements
2. Presentation by Moss-Adams, LLP

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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REPORT OF INDEPENDENT AUDITORS
AND FINANCIAL STATEMENTS WITH
SUPPLEMENTARY INFORMATION

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

June 30, 2022 and 2021

MOSSADAMS

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Orange County Health Authority, a Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Management's Discussion and Analysis

The intent of management's discussion and analysis of CalOptima Health's financial performance is to provide readers with an overview of the agency's financial activities for the fiscal years ended June 30, 2022, 2021, and 2020. Readers should review this summation in conjunction with CalOptima Health's financial statements and accompanying notes to the financial statements to enhance their understanding of CalOptima Health's financial performance.

Key Operating Indicators

The table below compares key operating indicators for CalOptima Health for the fiscal years ended June 30, 2022, 2021, and 2020:

Key Operating Indicators	2022	2021	2020
Members (at end of fiscal period)			
Medi-Cal program	897,134	825,076	742,769
OneCare	2,668	1,934	1,452
OneCare Connect	14,415	14,833	14,358
PACE	429	398	391
Average member months			
Medi-Cal program	859,290	793,023	724,049
OneCare	2,342	1,669	1,463
OneCare Connect	14,682	14,704	14,144
PACE	417	389	380
Operating revenues (in millions)	$ 4,227	$ 4,148	$ 3,833
Operating expenses (in millions)			
Medical expenses	3,946	3,729	3,644
Administrative expenses	150	141	142
Operating income (in millions)	$ 131	$ 278	$ 47
Operating revenues PMPM (per member per month)	$ 402	$ 427	$ 432
Operating expenses PMPM			
Medical expenses PMPM	375	384	410
Administrative expenses PMPM	14	15	16
Operating income PMPM	$ 13	$ 28	$ 6
Medical loss ratio	93%	90%	95%
Administrative expenses ratio	3.6%	3.4%	3.7%
Premium tax revenue and expenses not included above			
Operating revenues (in millions)	$ 168	$ 154	$ 67
Administrative expenses (in millions)	$ 166	$ 150	$ 75

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Overview of the Financial Statements

This annual report consists of financial statements and notes to those statements, which reflect CalOptima Health's financial position as of June 30, 2022, 2021, and 2020, and the results of its operations for the fiscal years ended June 30, 2022, 2021, and 2020. The financial statements of CalOptima Health, including the statements of net position, statements of revenues, expenses, and changes in net position, and statements of cash flows, represent the accounts and transactions of the five (5) lines of business – Medi-Cal, OneCare, OneCare Connect, Program of All-Inclusive Care for the Elderly (PACE), and Multipurpose Senior Services Program (MSSP).

- The statements of net position include all of CalOptima Health's assets, deferred outflows of resources, liabilities, and deferred inflows of resources, using the accrual basis of accounting, as well as an indication about which assets and deferred outflows of resources are utilized to fund obligations to providers and which are restricted as a matter of the Board of Directors' policy.

- The statements of revenues, expenses, and changes in net position present the results of operating activities during the fiscal years and the resulting increase or decrease in net position.

- The statements of cash flows report the net cash provided by or used in operating activities, as well as other sources and uses of cash from investing, capital, and related financing activities.

The following discussion and analysis addresses CalOptima Health's overall program activities. CalOptima Health's Medi-Cal program accounted for 90.0 percent, 90.2 percent, and 90.3 percent of its annual revenues during fiscal years 2022, 2021, and 2020, respectively. CalOptima Health's OneCare program accounted for 0.9 percent, 0.6 percent, and 0.4 percent of its annual revenues during fiscal years 2022, 2021, and 2020, respectively. CalOptima Health's OneCare Connect program accounted for 8.1 percent, 8.3 percent, and 8.3 percent of its annual revenues during fiscal years 2022, 2021, and 2020, respectively. All other programs in aggregate accounted for 1.0 percent, 0.9 percent, and 1.0 percent of CalOptima Health's annual revenues during fiscal years 2022, 2021, and 2020, respectively.

2022 and 2021 Financial Highlights

As of June 30, 2022 and 2021, total assets and deferred outflows of resources were approximately $3,025.3 million and $2,540.8 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $1,419.5 million and $1,308.8 million, respectively.

Net position increased by approximately $110.7 million, or 8.5 percent, during fiscal year 2022 and increased by approximately $283.7 million, or 27.7 percent, during fiscal year 2021.

Table 1a: Condensed Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2022	2021	Change from 2021 Amount	Change from 2021 Percentage
ASSETS				
Current assets	$ 2,337,407	$ 1,834,119	$ 503,288	27.4%
Board-designated assets and restricted cash	611,428	645,979	(34,551)	-5.3%
Capital assets, net	66,864	45,728	21,136	46.2%
Total assets	3,015,699	2,525,826	489,873	19.4%
DEFERRED OUTFLOWS OF RESOURCES	9,626	14,992	(5,366)	-35.8%
Total assets and deferred outflows of resources	$ 3,025,325	$ 2,540,818	$ 484,507	19.1%
LIABILITIES				
Current liabilities	$ 1,551,310	$ 1,165,444	$ 385,866	33.1%
Other liabilities	22,756	62,230	(39,474)	-63.4%
Total liabilities	1,574,066	1,227,674	346,392	28.2%
DEFERRED INFLOWS OF RESOURCES	31,790	4,363	27,427	628.6%
NET POSITION				
Net investment in capital assets	66,772	45,601	21,171	46.4%
Restricted by legislative authority	107,346	101,509	5,837	5.8%
Unrestricted	1,245,351	1,161,671	83,680	7.2%
Total net position	1,419,469	1,308,781	110,688	8.5%
Total liabilities, deferred inflows of resources, and net position	$ 3,025,325	$ 2,540,818	$ 484,507	19.1%

2022 and 2021 Financial Highlights (continued)

Current assets increased $503.3 million from $1,834.1 million in 2021 to $2,337.4 million in 2022, primarily in cash and investments. Cash and investments had a net increase of $490.7 million primarily from increased enrollment and premium capitation rates. Current liabilities increased $385.9 million from $1,165.4 million in 2021 to $1,551.3 million in 2022 driven primarily by payables due to the State of California (the "State") for the COVID-19 (previously called Gross Medical Expense (GME)) Risk Corridor for the period of July 1, 2019 through June 30, 2022, the Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) risk corridors for the period of July 1, 2019 through June 30, 2022, and the Enhanced Care Management (ECM) risk corridor for the period of January 1, 2022 through June 30, 2022.

Board-designated assets and restricted cash decreased by $34.6 million and increased by $3.6 million in fiscal years 2022 and 2021, respectively, primarily driven by a portfolio valuation change. In addition to the existing Board-designated reserve, the Board of Directors designated $100.0 million in total funding for homeless health initiatives on April 4, 2019. As of June 30, 2022, the balance of the homeless health reserve was $40.6 million.

The Board of Directors' policy is to augment the rest of Board-designated assets to provide a desired level of funds between 1.4 months and 2.0 months in consolidated capitation revenue to meet future contingencies. CalOptima Health's reserve level of Tier One and Tier Two investment portfolios as of June 30, 2022, is at 1.75 times the monthly average consolidated capitation revenue.

CalOptima Health is also required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act").

2021 and 2020 Financial Highlights

As of June 30, 2021 and 2020, total assets and deferred outflows of resources were approximately $2,540.8 million and $2,256.8 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $1,308.8 million and $1,025.1 million, respectively.

Net position increased by approximately $283.7 million, or 27.7 percent, during fiscal year 2021 and increased by approximately $89.6 million, or 9.6 percent, during fiscal year 2020.

2021 and 2020 Financial Highlights (continued)

Table 1b: Condensed Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2021	2020	Change from 2020 Amount	Change from 2020 Percentage
ASSETS				
Current assets	$ 1,834,119	$ 1,556,053	$ 278,066	17.9%
Board-designated assets and restricted cash	645,979	642,383	3,596	0.6%
Capital assets, net	45,728	46,654	(926)	-2.0%
Total assets	2,525,826	2,245,090	280,736	12.5%
DEFERRED OUTFLOWS OF RESOURCES	14,992	11,661	3,331	28.6%
Total assets and deferred outflows of resources	$ 2,540,818	$ 2,256,751	$ 284,067	12.6%
LIABILITIES				
Current liabilities	$ 1,165,444	$ 1,171,996	$ (6,552)	-0.6%
Other liabilities	62,230	52,947	9,283	17.5%
Total liabilities	1,227,674	1,224,943	2,731	0.2%
DEFERRED INFLOWS OF RESOURCES	4,363	6,677	(2,314)	-34.7%
NET POSITION				
Net investment in capital assets	45,601	46,493	(892)	-1.9%
Restricted by legislative authority	101,509	100,574	935	0.9%
Unrestricted	1,161,671	878,064	283,607	32.3%
Total net position	1,308,781	1,025,131	283,650	27.7%
Total liabilities, deferred inflows of resources, and net position	$ 2,540,818	$ 2,256,751	$ 284,067	12.6%

Current assets increased $278.1 million from $1,556.1 million in 2020 to $1,834.1 million in 2021, primarily in cash, investments, and premium receivables. Cash and investments had a net increase of $244.3 million from deferred capitation payments from the State and Intergovernmental Transfers (IGT). The increase in premium receivables is primarily due to delays in payment of updated premium capitation rates from the State. Current liabilities decreased $6.6 million from $1,172.0 million in 2020 to $1,165.4 million in 2021 due to the release of the In-Home Supportive Services (IHSS) liability accrual offset by an increase in payables due to the State for the GME risk corridor for the period of July 1, 2019 through December 31, 2020 (i.e., Bridge Period), and the Proposition 56 risk corridors for fiscal years 2020 and 2021.

Board-designated assets and restricted cash increased by $3.6 million and $22.0 million in fiscal years 2021 and 2020, respectively. In addition to the existing Board-designated reserve, the Board of Directors designated $100.0 million in total funding for homeless health initiatives. As of June 30, 2021, the balance of the homeless health reserve was $56.8 million.

2021 and 2020 Financial Highlights (continued)

The Board of Directors' policy is to augment the rest of Board-designated assets to provide a desired level of funds between 1.4 months and 2.0 months of consolidated capitation revenue to meet future contingencies. CalOptima Health's reserve level of Tier One and Tier Two investment portfolios as of June 30, 2021, was at 1.80 times of monthly average consolidated capitation revenue.

CalOptima Health is also required to maintain a $300,000 restricted deposit as a part of the Act.

2022 and 2021 Results of Operations

CalOptima Health's fiscal year 2022 operating and non-operating revenues resulted in a $110.7 million increase in net position, $173.0 million less compared to a $283.7 million increase in fiscal year 2021. The following table reflects the changes in revenues and expenses for 2022 compared to 2021:

Table 2a: Revenues, Expenses, and Changes in Net Position for
Fiscal Years Ended June 30,
(Dollars in Thousands)

Results of Operations	2022	2021	Change from 2021 Amount	Change from 2021 Percentage
PREMIUM REVENUES	$ 4,227,259	$ 4,148,336	$ 78,923	1.9%
Total operating revenues	4,227,259	4,148,336	78,923	1.9%
MEDICAL EXPENSES	3,945,849	3,729,469	216,380	5.8%
ADMINISTRATIVE EXPENSES	150,443	141,166	9,277	6.6%
Total operating expenses	4,096,292	3,870,635	225,657	5.8%
OPERATING INCOME	130,967	277,701	(146,734)	-52.8%
NONOPERATING REVENUES AND EXPENSES	(20,279)	5,949	(26,228)	-440.9%
Increase in net position	110,688	283,650	(172,962)	-61.0%
NET POSITION, beginning of year	1,308,781	1,025,131	283,650	27.7%
NET POSITION, end of year	$ 1,419,469	$ 1,308,781	$ 110,688	8.5%

2022 and 2021 Operating Revenues

The increase in operating revenues of $78.9 million in fiscal year 2022 is primarily attributable to an increase in enrollment of 8.6 percent which resulted in additional revenue of $162.0 million and increases in premium capitation rates for new programs, such as ECM, Community Supports, and COVID-19 testing and treatment services. The increase in revenue is offset by additional payables due to the State for the COVID-19, Proposition 56, and ECM risk corridor estimates.

2022 and 2021 Medical Expenses

Provider capitation, comprised of capitation payments to CalOptima Health's contracted health networks, increased by 6.5 percent from fiscal year 2021 to fiscal year 2022. Capitated member enrollment accounted for approximately 75.0 percent of CalOptima Health's enrollment, averaging 644,579 members during fiscal year 2022, and 75.0 percent of CalOptima Health's enrollment, averaging 595,103 members during fiscal year 2021. Included in the capitated environment are 212,078 or 32.9 percent and 192,076 or 32.3 percent members in a shared risk network for fiscal years 2022 and 2021, respectively. Shared risk networks receive capitation for professional services and are claims-based for hospital services.

Provider capitation expenses totaled $1,261.4 million in fiscal year 2022, compared to $1,184.9 million in fiscal year 2021. The increase reflects additional capitation expenses primarily due to increases in enrollment as the State pauses redetermination of eligibility during the public health emergency.

Claims expense to providers and facilities, including long-term care (LTC) services, increased by 24.9 percent from fiscal year 2021 to fiscal year 2022 due to the release of IHSS estimates in fiscal year 2021 and increased utilization from higher enrollment.

Prescription drug costs decreased by 45.0 percent in fiscal year 2022 compared to fiscal year 2021, primarily due to the State's transition of pharmacy benefits to Fee-for-Service beginning January 1, 2022.

In addition to items mentioned above, total quality assurance fee (QAF) payments received and passed through to hospitals decreased from $209.1 million to $146.4 million from fiscal year 2021 to fiscal year 2022. These receipts and payments are not included in the statements of revenues, expenses, and changes in net position.

2022 and 2021 Administrative Expenses

Total administrative expenses were $150.4 million in 2022 compared to $141.2 million in 2021. Overall administrative expenses increased by 6.6 percent or $9.2 million, primarily due to non-salary and wages expense categories. In fiscal years 2022 and 2021, CalOptima Health's administrative expenses were 3.6 percent and 3.4 percent of total operating revenues, respectively.

2021 and 2020 Results of Operations

CalOptima Health's fiscal year 2021 operating and non-operating revenues resulted in a $283.7 million increase in net position, $194.1 million more compared to a $89.6 million increase in fiscal year 2020. The following table reflects the changes in revenues and expenses for 2021 compared to 2020:

Table 2b: Revenues, Expenses, and Changes in Net Position for
Fiscal Years Ended June 30,
(Dollars in Thousands)

Results of Operations	2021	2020	Change from 2020 Amount	Change from 2020 Percentage
PREMIUM REVENUES	$ 4,148,336	$ 3,833,145	$ 315,191	8.2%
Total operating revenues	4,148,336	3,833,145	315,191	8.2%
MEDICAL EXPENSES	3,729,469	3,644,419	85,050	2.3%
ADMINISTRATIVE EXPENSES	141,166	142,142	(976)	-0.7%
Total operating expenses	3,870,635	3,786,561	84,074	2.2%
OPERATING INCOME	277,701	46,584	231,117	496.1%
NONOPERATING REVENUES AND EXPENSES	5,949	43,004	(37,055)	-86.2%
Increase in net position	283,650	89,588	194,062	216.6%
NET POSITION, beginning of year	1,025,131	935,543	89,588	9.6%
NET POSITION, end of year	$ 1,308,781	$ 1,025,131	$ 283,650	27.7%

2021 and 2020 Operating Revenues

The increase in operating revenues of $315.2 million in fiscal year 2021 is primarily attributable to an increase in enrollment of 9.4 percent resulting in additional revenue of approximately $356.5 million from fiscal year 2020. The increase in revenue is offset by an increase to payables due to the State for the GME and Proposition 56 risk corridors.

2021 and 2020 Medical Expenses

Provider capitation, comprised of capitation payments to CalOptima Health's contracted health networks, increased by 4.6 percent from fiscal year 2020 to fiscal year 2021. Capitated member enrollment accounted for approximately 75.0 percent of CalOptima Health's enrollment, averaging 595,103 members during fiscal year 2021, and 74.9 percent of CalOptima Health's enrollment, averaging 542,204 members during fiscal year 2020. Included in the capitated environment are 192,076 or 32.3 percent and 175,704 or 32.4 percent members in a shared risk network for fiscal years 2021 and 2020, respectively. Shared risk networks receive capitation for professional services and are claims-based for hospital services.

2021 and 2020 Medical Expenses (continued)

Provider capitation expenses totaled $1,184.9 million in fiscal year 2021, compared to $1,133.1 million in fiscal year 2020. The increase reflects additional capitation expenses primarily due to the increase in CalOptima Health's enrollment.

Claims expense to providers and facilities, including LTC services, decreased by 6.0 percent from fiscal year 2020 to fiscal year 2021 primarily driven by decreased utilization trends due to the COVID-19 pandemic.

Prescription drug costs increased by 12.0 percent in fiscal year 2021 compared to fiscal year 2020 due primarily to an 18.5% unit cost increase from fiscal year 2020.

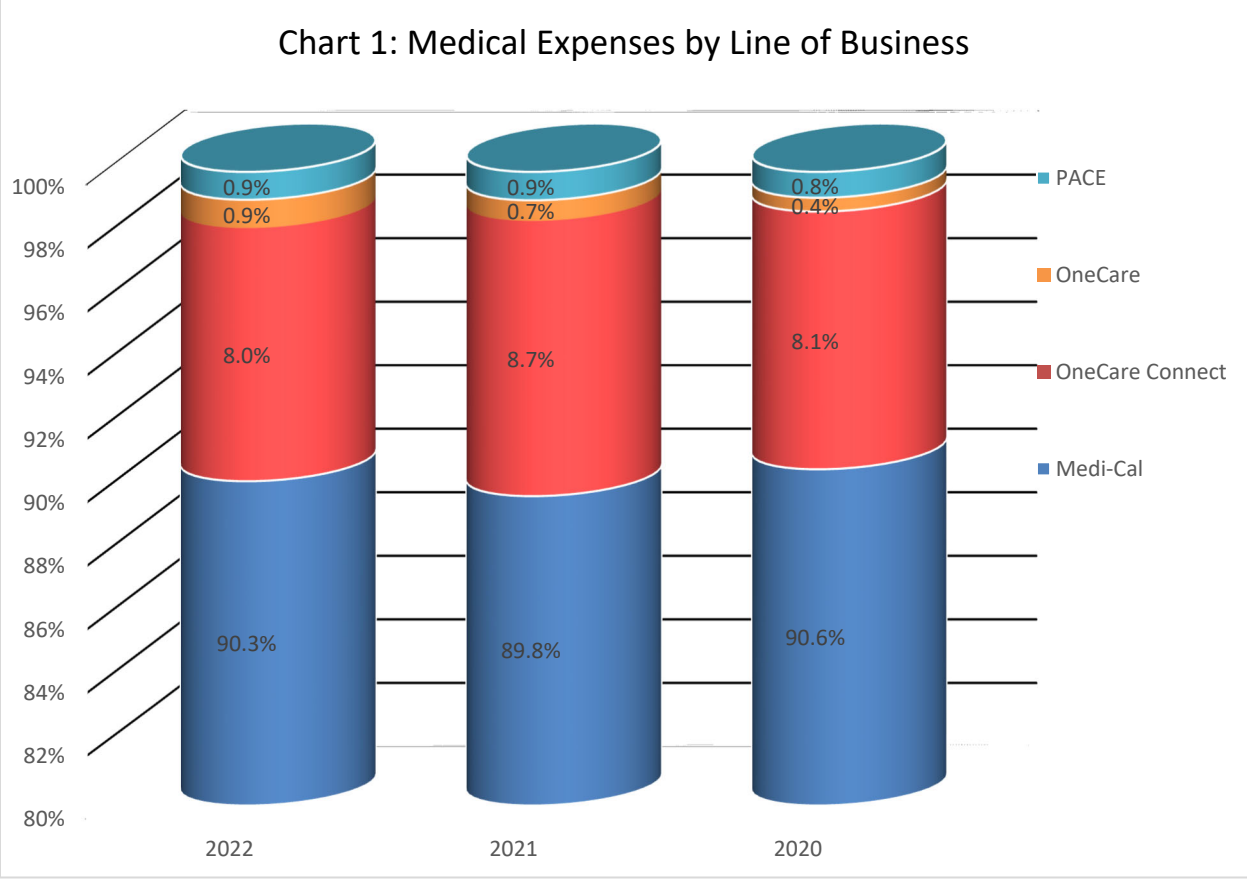
In addition to items mentioned above, total QAF payments received and passed through to hospitals increased from $154.6 million to $209.1 million from fiscal year 2020 to fiscal year 2021. These receipts and payments are not included in the statements of revenues, expenses, and changes in net position.

2021 and 2020 Administrative Expenses

Total administrative expenses were $141.2 million in 2021 compared to $142.1 million in 2020. Overall administrative expenses decreased by 0.7 percent or $1 million, spread across all expense categories. During fiscal years 2021 and 2020, CalOptima Health's administrative expenses were 3.4 percent and 3.7 percent of total operating revenues, respectively.

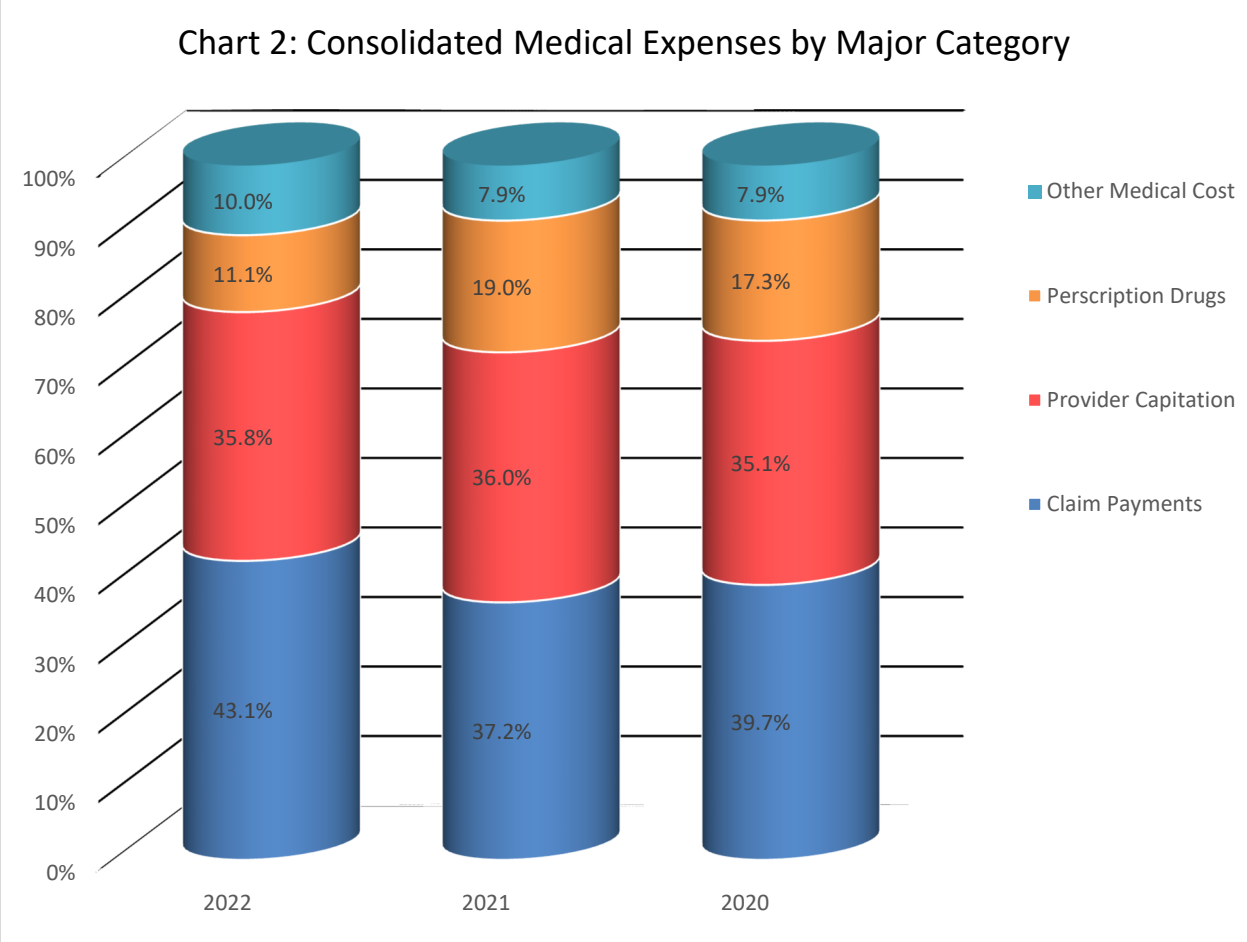
2022, 2021, and 2020 Medical Expenses by Line of Business

Below is a comparison chart of total medical expenses by line of business and their respective percentages of the overall medical expenditures by fiscal year.



2022, 2021, and 2020 Medical Expenses by Major Category

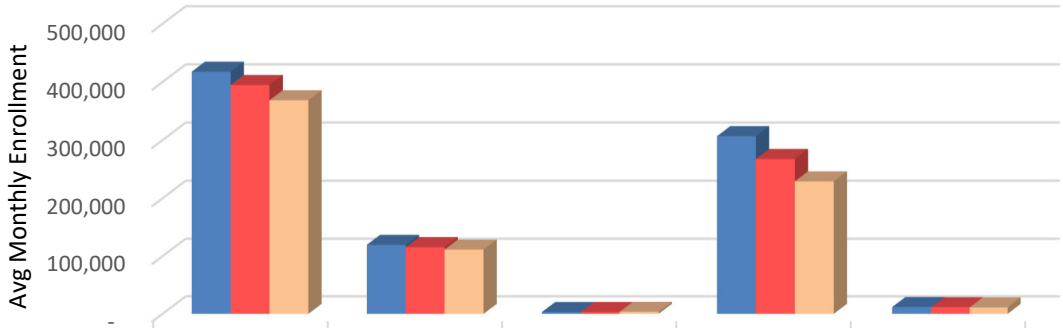
Below is a comparison chart of medical expenses by major category and their respective percentages of the overall medical expenditures by fiscal year.



2022, 2021, and 2020 Enrollment

During fiscal year 2022, CalOptima Health served an average of 859,290 Medi-Cal members per month compared to an average of 793,023 members per month in 2021 and 724,049 members per month in 2020. The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2022, 2021, and 2020:

Chart 3: Medi-Cal Membership by Aid Category
(Shown as Average Member Months)



	TANF	Disabled/ Aged	LTC	MCE	WCM
2022	417,709	119,679	3,149	306,910	11,843
2021	394,819	115,711	3,158	267,700	11,634
2020	368,614	111,496	3,493	229,196	11,250

Significant aid categories are defined as follows:

Temporary Assistance to Needy Families (TANF) includes families, children, and poverty-level members who qualify for the TANF federal welfare program, which provides cash aid and job-search assistance to poor families. TANF also includes members who migrated from CalOptima Health, Health Net, and Kaiser Healthy Family programs.

Disabled and Aged includes individuals who have met the criteria for disability set by the Social Security Administration, and individuals of 65 years of age and older who receive supplemental security income (SSI) checks, or are medically needy, or have an income of 100 percent or less of the federal poverty level.

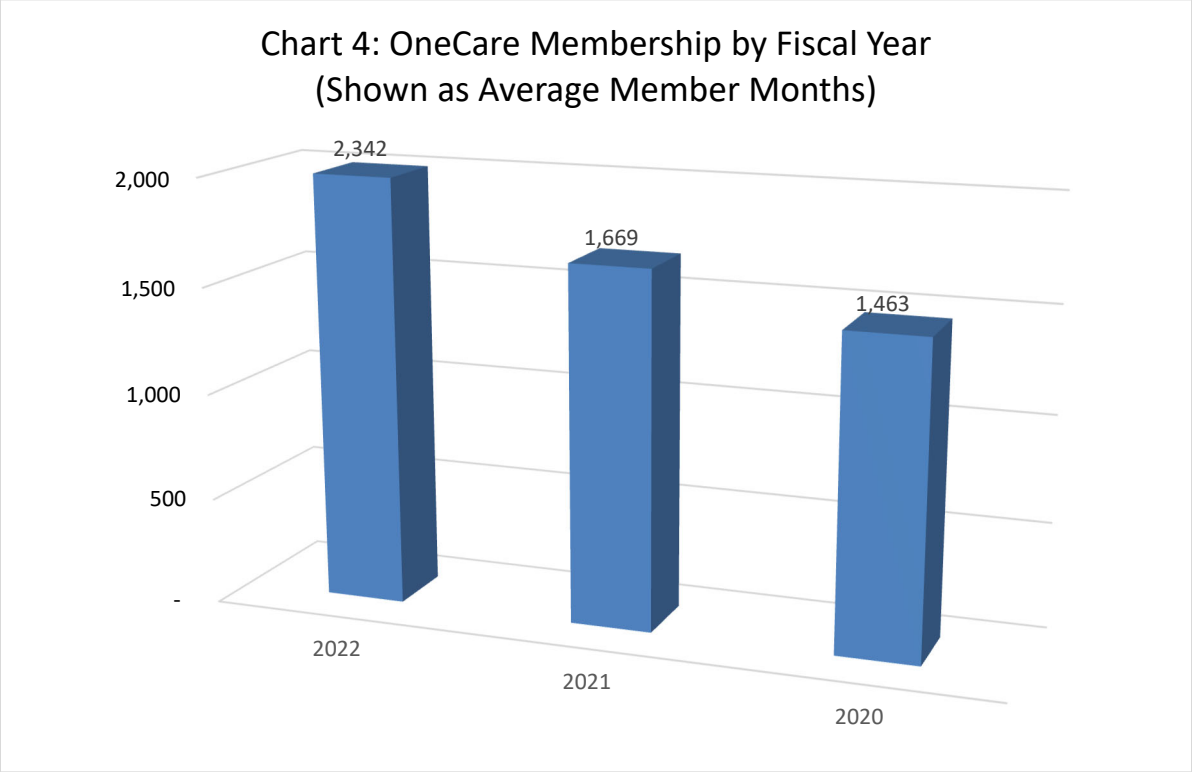
LTC includes frail elderly adults, nonelderly adults with disabilities, and children with developmental disabilities and other disabling conditions requiring long-term care services.

2022, 2021, and 2020 Enrollment (continued)

Medi-Cal Expansion (MCE) program includes adults without children, ages 19–64, qualified based upon income, as required by the Patient Protection and Affordable Care Act (ACA).

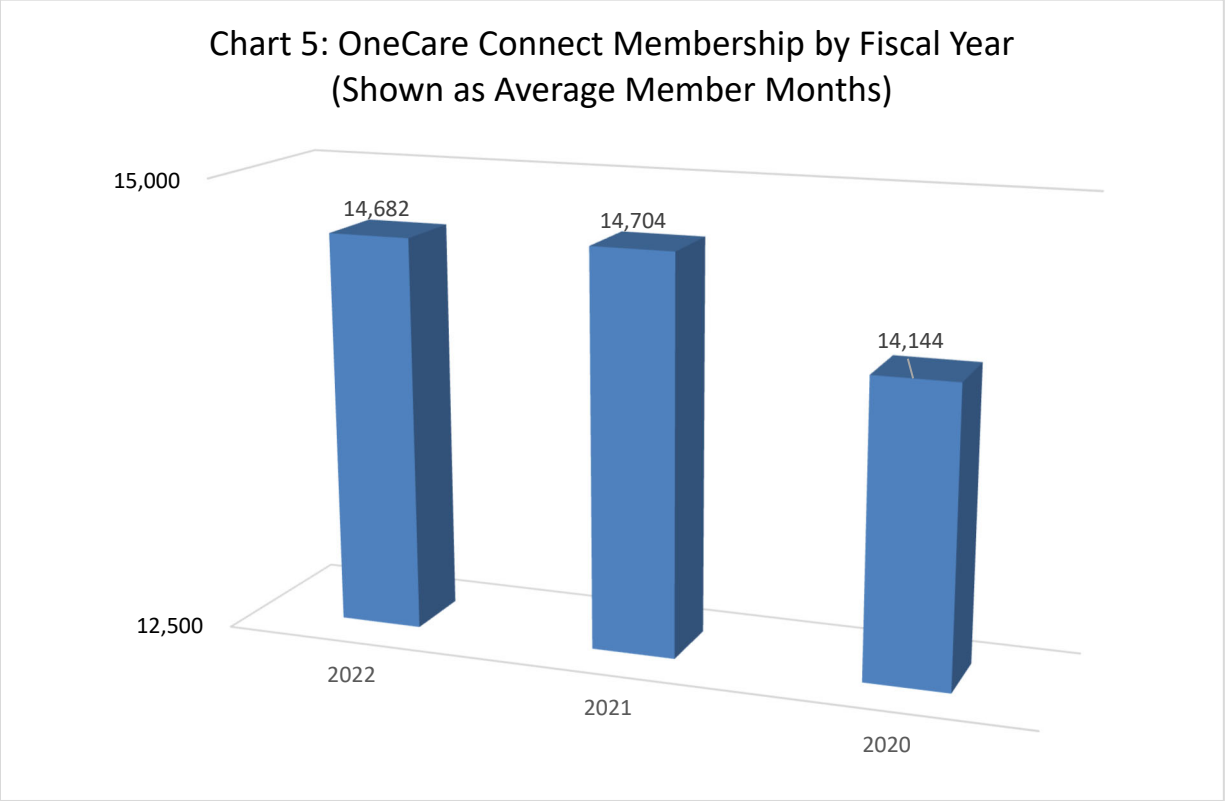
CalOptima Health's Whole Child Model (WCM) program includes children who are California Children's Services (CCS) eligible. These members are receiving their CCS services and non-CCS services under the WCM program.

OneCare was introduced in October 2005 as a Medicare Advantage Special Needs Plan. It provides a full range of health care services to average member months of 2,342, 1,669, and 1,463 for the years ended June 30, 2022, 2021, and 2020, respectively. Members are eligible for both the Medicare and Medi-Cal programs (i.e., dual eligible). The chart below displays the average member months for the past three years.



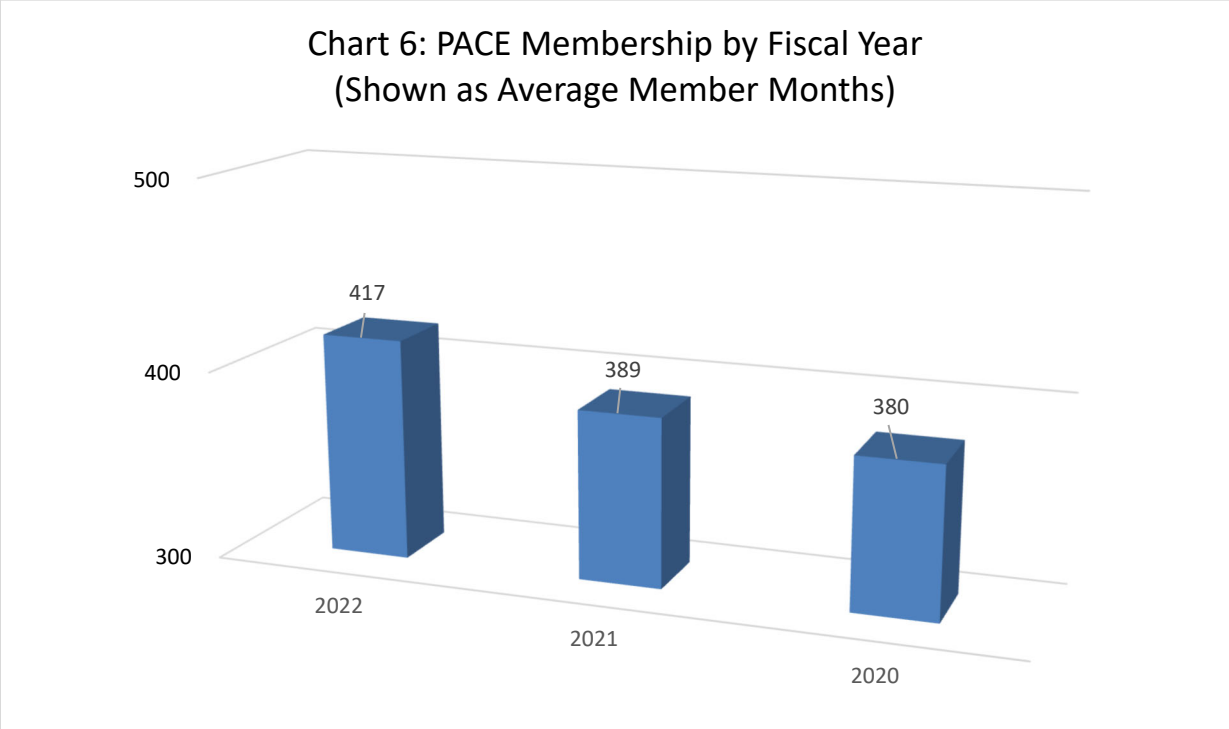
2022, 2021, and 2020 Enrollment (continued)

CalOptima Health launched the OneCare Connect program to serve dual eligible members in Orange County in July 2015. This program combines members' Medicare and Medi-Cal coverage and adds other benefits and supports. The average member months were 14,682, 14,704, and 14,144 for the years ended June 30, 2022, 2021, and 2020, respectively. The chart below displays the average member months for the past three years.



2022, 2021, and 2020 Enrollment (continued)

PACE began operations in October 2013. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them to continue living independently in the community. The average member months were 417, 389, and 380 for the years ended June 30, 2022, 2021, and 2020, respectively. The chart below displays the average member months for the past three years.



Economic Factors and the State's Fiscal Year 2022-21 Budget

On June 30, 2022, Governor Gavin Newsom signed the fiscal year 2022-23 state budget. The budget includes broad-based relief to address rising prices, investments to address homelessness and behavioral health, and a commitment to strengthen the State's infrastructure. It prioritizes one-time spending of discretionary funds, while building reserves and prepaying debt obligations.

General Fund spending in the budget package was $234.4 billion, a decrease of $8.6 billion or 3.5 percent from fiscal year 2021-22. The budget included $137.9 billion in Total Fund spending ($36.4 billion in General Fund spending) for the Medi-Cal program. It projected an average monthly caseload of 14.8 million beneficiaries in fiscal year 2022-23, an increase of 3.0 percent from fiscal year 2021-22. Major Medi-Cal program changes adopted in the budget include:

- Continued implementation of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative;
- Expansion of eligibility to undocumented adults aged 26 through 49, beginning no later than January 1, 2024;
- Addition of qualifying community-based mobile crisis intervention services as a Medi-Cal benefit no sooner than January 1, 2023;
- Elimination of various Assembly Bill (AB) 97 provider rate reductions from 2011; and
- Implementation of equity and practice transformation provider payments to managed care plans or providers.

The budget projected $219.7 billion in General Fund revenues and transfers in fiscal year 2022-23, a decrease of $7.4 billion or 3.2 percent compared to fiscal year 2021-22. The three largest General Fund taxes (i.e., personal income tax, sales and use tax, corporation tax) were projected to decrease by 2.6 percent. The State is projected to end fiscal year 2022-23 with $27.7 billion in general purpose reserves.

DHCS annual audit – In October 2021, the California Department of Health Care Services (DHCS) formally engaged CalOptima Health for its annual medical audit. The audit covered the provision of Medi-Cal services for the period of February 1, 2020 through December 31, 2021, and assessed CalOptima Health's compliance with its Medi-Cal contract and regulations. As of this writing, CalOptima Health is waiting for the draft findings report from DHCS.

DMHC routine examination – In February 2022, the California Department of Managed Health Care (DMHC) performed its routine, triannual examination to review CalOptima Health's fiscal and administrative areas. CalOptima received the final report from DMHC in July 2022. The report confirmed acceptance of CalOptima Health's corrective actions for one (1) finding that the fidelity bond policy was not in compliance with state regulation, with no further response required. This audit is considered closed.

Economic Factors and the State's Fiscal Year 2022-21 Budget (continued)

CMS audit – The Centers for Medicare & Medicaid Services (CMS) engaged CalOptima Health for a virtual, full-scope program audit of the OneCare and OneCare Connect programs in early June 2021. The audit began in mid-July 2021 and ended in early August 2021. CalOptima received the final report from CMS in November 2021. The report included one (1) Immediate Corrective Action Required (ICAR), eight (8) Corrective Action Required (CAR), and eleven (11) observations. In January 2022, CMS confirmed acceptance of CalOptima Health's corrective actions for non-ICAR conditions and requested CalOptima Health to undergo an independent validation audit (IVA) by July 2022 in order to demonstrate correction of all conditions cited in the final report. CalOptima has completed the IVA and submitted the findings report to CMS. As of this writing, CalOptima is waiting for CMS's response to the IVA report.

Requests for information – This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of CalOptima Health's operations. If the reader has questions or would like additional information, please direct the requests to CalOptima Health, 505 City Parkway West, Orange, CA 92868 or call 714.347.3237.

MOSSADAMS

Report of Independent Auditors

The Board of Directors
Orange County Health Authority, a Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Orange County Health Authority, a Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health (the "Organization"), which comprise the statements of net position as of June 30, 2022 and 2021, and the related statements of revenues, expenses, and changes in net position and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Organization as of June 30, 2022 and 2021, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Organization and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Organization's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Organization's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis, schedule of changes in net pension liability and related ratios, schedule of plan contributions, and schedule of changes in total OPEB liability and related ratios, as listed in the table of contents, be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Moss Adams LLP

Irvine, California
September 20, 2022

Orange County Health Authority, a Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health
Statements of Net Position

	June 30, 2022	June 30, 2021
CURRENT ASSETS		
Cash and cash equivalents	$ 823,489,345	$ 281,834,498
Investments	1,014,460,504	1,065,409,806
Premiums due from the State of California and CMS	405,192,387	427,337,768
Prepaid expenses and other	94,264,454	59,536,860
Total current assets	2,337,406,690	1,834,118,932
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH		
Cash and cash equivalents	44,968,923	60,144,705
Investments	566,159,456	585,534,360
Restricted deposit	300,051	300,000
	611,428,430	645,979,065
CAPITAL ASSETS, NET	66,864,042	45,727,881
Total assets	3,015,699,162	2,525,825,878
DEFERRED OUTFLOWS OF RESOURCES		
Net pension	6,610,593	10,542,297
Other postemployment benefit	3,015,000	4,450,000
Total deferred outflows of resources	9,625,593	14,992,297
Total assets and deferred outflows of resources	$ 3,025,324,755	$ 2,540,818,175

See accompanying notes to the financial statements.

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Orange County Health Authority, a Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health
Statements of Net Position (Continued)

	June 30, 2022	June 30, 2021
CURRENT LIABILITIES		
Medical claims liability and capitation payable		
Medical claims liability	$ 301,852,721	$ 288,919,790
Provider capitation and withholds	193,214,628	144,779,788
Accrued reinsurance costs to providers	3,371,697	3,168,388
Due to the State of California and CMS	1,014,382,064	690,131,523
Unearned revenue	8,049,101	13,173,904
	1,520,870,211	1,140,173,393
Accounts payable and other	10,872,861	9,053,913
Accrued payroll and employee benefits and other	19,567,540	16,216,919
Total current liabilities	1,551,310,612	1,165,444,225
POSTEMPLOYMENT HEALTH CARE PLAN	22,178,000	31,610,000
NET PENSION LIABILITY	577,854	30,620,005
Total liabilities	1,574,066,466	1,227,674,230
DEFERRED INFLOWS OF RESOURCES		
Net pension	23,578,504	3,054,143
Other postemployment benefit	8,211,000	1,309,000
Total deferred inflows of resources	31,789,504	4,363,143
NET POSITION		
Net investment in capital assets	66,771,871	45,600,553
Restricted by legislative authority	107,345,553	101,509,138
Unrestricted	1,245,351,361	1,161,671,111
Total net position	1,419,468,785	1,308,780,802
Total liabilities, deferred inflows of resources, and net position	$ 3,025,324,755	$ 2,540,818,175

See accompanying notes to the financial statements.

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Orange County Health Authority, a Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health
Statements of Revenues, Expenses, and Changes in Net Position

	Years Ended June 30,	
	2022	2021
REVENUES		
Premium revenues	$ 4,227,258,732	$ 4,148,335,657
Total operating revenues	4,227,258,732	4,148,335,657
OPERATING EXPENSES		
Medical expenses		
Claims expense to providers and facilities	1,590,269,416	1,273,147,198
Provider capitation	1,261,380,136	1,184,937,807
Other medical	366,949,658	266,737,045
Prescription drugs	343,010,111	623,943,048
OneCare Connect	314,389,750	323,080,537
PACE	34,575,969	33,312,760
OneCare	35,273,613	24,310,717
Total medical expenses	3,945,848,653	3,729,469,112
Administrative expenses		
Salaries, wages, and employee benefits	95,941,713	97,268,662
Supplies, occupancy, insurance, and other	28,074,582	23,040,905
Purchased services	15,060,187	12,344,872
Depreciation	6,610,745	6,185,440
Professional fees	4,755,869	2,326,477
Total administrative expenses	150,443,096	141,166,356
Total operating expenses	4,096,291,749	3,870,635,468
OPERATING INCOME	130,966,983	277,700,189
NON-OPERATING (LOSS) REVENUES		
Net investment (loss) income and other	(20,360,668)	5,949,308
Rental income, net of related expenses	81,668	-
Total non-operating (loss) revenues	(20,279,000)	5,949,308
Increase in net position	110,687,983	283,649,497
NET POSITION, beginning of year	1,308,780,802	1,025,131,305
NET POSITION, end of year	$ 1,419,468,785	$ 1,308,780,802

See accompanying notes to the financial statements.

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Orange County Health Authority, a Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health
Statements of Cash Flows

	Years Ended June 30, 2022	Years Ended June 30, 2021
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation payments received and other	$ 4,568,529,851	$ 4,127,412,627
Payments to providers and facilities	(3,884,277,573)	(3,742,483,984)
Payments to vendors	(80,707,011)	(46,143,958)
Payments to employees	(99,272,178)	(91,035,844)
Net cash provided by operating activities	504,273,089	247,748,841
CASH FLOWS USED IN CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(27,839,179)	(5,841,274)
Net cash used in capital and related financing activities	(27,839,179)	(5,841,274)
CASH FLOWS FROM (USED IN) INVESTING ACTIVITIES		
Investment income received	9,424,036	9,894,229
Purchases of securities	(25,441,955,393)	(13,933,382,931)
Sales of securities	25,497,752,294	13,584,618,259
Net cash provided by (used in) investing activities	65,220,937	(338,870,443)
Net change in cash and cash equivalents	541,654,847	(96,962,876)
CASH AND CASH EQUIVALENTS, beginning of year	281,834,498	378,797,374
CASH AND CASH EQUIVALENTS, end of year	$ 823,489,345	$ 281,834,498
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	$ 130,966,983	$ 277,700,189
ADJUSTMENT TO RECONCILE OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Depreciation	6,703,018	6,767,969
Changes in assets and liabilities		
Premiums due from the State of California and CMS	22,145,381	(24,037,325)
Prepaid expenses and other	(34,727,594)	(9,768,069)
Medical claims liability	12,932,931	(13,138,718)
Provider capitation and withholds	48,434,840	1,798,760
Accrued reinsurance costs to providers	203,309	(1,674,914)
Due to the State of California and CMS	324,250,541	12,633,890
Unearned revenue	(5,124,803)	(9,519,595)
Accounts payable and other	1,818,948	753,836
Accrued payroll and employee benefits and other	3,350,621	2,595,042
Postemployment health care plan	(1,095,000)	1,476,000
Net pension liability	(5,586,086)	2,161,776
Net cash provided by operating activities	$ 504,273,089	$ 247,748,841
SUPPLEMENTAL SCHEDULE OF NON-CASH OPERATING AND INVESTING ACTIVITIES		
Change in unrealized (depreciation) appreciation on investments	$ (25,359,620)	$ 3,259,508

See accompanying notes to the financial statements.

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Note 1 – Organization

Orange County Health Authority, a Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima, is a County-Organized Health System (COHS) serving primarily Medi-Cal beneficiaries in Orange County, California. Effective August 4, 2022, Orange County Health Authority changed its dba name to CalOptima Health ("CalOptima Health" or the "Organization"). Pursuant to the California Welfare and Institutions Code, CalOptima Health was formed by the Orange County Board of Supervisors as a public/private partnership through the adoption of Ordinance No. 3896 in August 1992. The agency began operations in October 1995.

As a COHS, CalOptima Health maintains an exclusive contract with the State of California (the "State"), Department of Health Care Services (DHCS) to arrange for the provision of health care services to Orange County's Medi-Cal beneficiaries. Orange County had approximately 897,100 and 825,000 Medi-Cal beneficiaries for the years ended June 30, 2022 and 2021, respectively. CalOptima Health also offers OneCare, a Medicare Advantage Special Needs Plan, via a contract with the Centers for Medicare & Medicaid Services (CMS). OneCare served approximately 2,700 and 1,900 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2022 and 2021, respectively. In July 2015, CalOptima Health began offering the OneCare Connect Cal MediConnect Plan, a Medicare-Medicaid Plan, via a contract with CMS and DHCS. OneCare Connect served approximately 14,400 and 15,000 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2022 and 2021, respectively. In January 2016, CalOptima Health began transferring subscribers from OneCare to the OneCare Connect Cal MediConnect Plan. CalOptima Health also contracts with the California Department of Aging to provide case management of social and health care services to approximately 456 Medi-Cal eligible seniors under the State's Multipurpose Senior Services Program (MSSP). Effective January 1, 2022, MSSP transitioned from a managed care plan benefit to a carved-out waiver benefit. The Program of All-Inclusive Care for the Elderly (PACE) provides services to 55 years of age or older members who reside in the PACE service area and meet California nursing facility level of care requirements. The program receives Medicare and Medi-Cal funding and served approximately 430 members.

CalOptima Health, in turn, subcontracts the delivery of health care services through health maintenance organizations and provider-sponsored organizations, known as Physician/Hospital Consortia, and Shared Risk Groups. Additionally, CalOptima Health has direct contracts with hospitals and providers for its fee-for-service network.

CalOptima Health is Knox-Keene licensed for purposes of its Medicare programs and is subject to certain provisions of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act") to the extent incorporated by reference into CalOptima Health's contract with DHCS. As such, CalOptima Health is subject to the regulatory requirements of the Department of Managed Health Care (DMHC) under Section 1300, Title 28 of the California Administrative Code of Regulations, including minimum requirements of Tangible Net Equity (TNE), which CalOptima Health exceeded as of June 30, 2022 and 2021.

Note 2 – Summary of Significant Accounting Policies

Basis of presentation – CalOptima Health is a COHS plan governed by a 10-member Board of Directors appointed by the Orange County Board of Supervisors. Effective for the fiscal year ended June 30, 2014, CalOptima Health began reporting as a discrete component unit of the County of Orange, California. The County made this determination based on the County Board of Supervisors' role in appointing all members of the Board of Directors.

Basis of accounting – CalOptima Health uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. The accompanying financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB).

Use of estimates – The preparation of the financial statements in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and cash equivalents – The Organization considers all highly liquid investments with original maturities of three months or less to be cash and cash equivalents.

Investments – Investments are stated at fair value in accordance with GASB Codification Section 150. The fair value of investments is estimated based on quoted market prices, when available. For debt securities not actively traded, fair values are estimated using values obtained from external pricing services or are estimated by discounting the expected future cash flows using current market rates applicable to the coupon rate, credit, and maturity of the investments.

All investments with an original maturity of one year or less when purchased are recorded as current investments, unless designated or restricted.

Board-designated assets and restricted cash – Board-designated assets include amounts designated by the Board of Directors for the establishment of certain reserve funds for contingencies at a desired level between 1.4 and 2 months of premium revenues and amounts designated by the Board of Directors for CalOptima Health's homeless health initiative (see Note 3). Restricted cash represents a $300,051 restricted deposit required by CalOptima Health as part of the Act (see Note 9).

Capital assets – Capital assets are stated at cost at the date of acquisition. The costs of normal maintenance, repairs, and minor replacements are charged to expense when incurred.

Note 2 – Summary of Significant Accounting Policies (continued)

Depreciation is calculated using the straight-line method over the estimated useful lives of the assets. Long-lived assets are periodically reviewed for impairment. The following estimated useful lives are used:

	Years
Furniture	5 years
Vehicles	5 years
Computers and software	3 years
Leasehold improvements	15 years or life of lease, whichever is less
Building	40 years
Building components	10 to 30 years
Land improvements	8 to 25 years
Tenant improvements	7 years or life of lease, whichever is less

Fair value of financial instruments – The financial statements include financial instruments for which the fair market value may differ from amounts reflected on a historical basis. Financial instruments of the Organization consist of cash deposits, investments, premium receivable, accounts payable, and certain accrued liabilities. The Organization's other financial instruments, except for investments, generally approximate fair market value based on the relatively short period of time between origination of the instruments and their expected realization.

Medical claims liability and expenses – CalOptima Health establishes a claims liability based on estimates of the ultimate cost of claims in process and a provision for incurred but not yet reported (IBNR) claims, which is actuarially determined based on historical claim payment experience and other statistics. Such estimates are continually monitored and analyzed with any adjustments made as necessary in the period the adjustment is determined. CalOptima Health retains an outside actuary to perform an annual review of the actuarial projections. Amounts for claims payment incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled.

Note 2 – Summary of Significant Accounting Policies (continued)

Provider capitation and withholds – CalOptima Health has provider services agreements with several health networks in Orange County, whereby the health networks provide care directly to covered members or through subcontracts with other health care providers. Payment for the services provided by the health networks is on a fully capitated basis. The capitation amount is based on contractually agreed-upon terms with each health network. CalOptima Health withholds amounts from providers at an agreed-upon percentage of capitation payments made to ensure the financial solvency of each contract. CalOptima Health also records a liability related to quality incentive payments and risk-share provisions. The quality incentive liability is estimated based on member months and rates agreed upon by the Board of Directors. For the risk-share provision liability, management allocates surpluses or deficits, multiplied by a contractual rate, with the shared-risk groups. Estimated amounts due to health networks pertaining to risk-share provisions were approximately $12,882,000 and $33,304,000 as of June 30, 2022 and 2021, respectively, and are included in provider capitation and withholds on the statements of net position. During the years ended June 30, 2022 and 2021, CalOptima Health incurred approximately $1,412,247,000 and $1,341,598,000, respectively, of capitation expense relating to health care services provided by health networks. Capitation expense is included in the provider capitation, OneCare Connect, and OneCare line items in the statements of revenues, expenses, and changes in net position. Estimated amounts due to health networks as of June 30, 2022 and 2021, related to the capitation withhold arrangements, quality incentive payments, and risk-share provisions were approximately $193,215,000 and $144,780,000, respectively.

Premium deficiency reserves – CalOptima Health performs periodic analyses of its expected future health care costs and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is accrued. Investment income is not included in the calculation to estimate premium deficiency reserves. CalOptima Health's management determined that no premium deficiency reserves were necessary as of June 30, 2022 and 2021.

Accrued compensated absences – CalOptima Health's policy permits employees who are regularly scheduled to work more than 20 hours per week to accrue 18 days of paid time off (PTO) (23 days for exempt employees) based on their years of continuous service, with an additional week of accrual after three years of service and another after 10 years of service. In the event that available PTO is not used by the end of the benefit year, employees may carry unused time off into subsequent years, up to the maximum accrual amount equal to two (2) times the employee's annual accrual. If an employee reaches his or her maximum PTO accrual amount, the employee will stop accruing PTO. Accumulated PTO will be paid to the employees upon separation from service with CalOptima Health. All compensated absences are accrued and recorded in accordance with GASB Codification Section C60 and are included in accrued payroll and employee benefits.

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Note 2 – Summary of Significant Accounting Policies (continued)

Net position – Net position is reported in three categories, defined as follows:

- *Net investment in capital assets* – This component of net position consists of capital assets, including restricted capital assets, net of accumulated depreciation, and is reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable (if any) to the acquisition, construction, or improvement of those assets.

- *Restricted by legislative authority* – This component of net position consists of external constraints placed on net asset use by creditors (such as through debt covenants), grantors, contributors, or the law or regulations of other governments. It also pertains to constraints imposed by law or constitutional provisions or enabling legislation (see Note 9).

- *Unrestricted* – This component of net position consists of net position that does not meet the definition of "restricted" or "net investment in capital assets."

Operating revenues and expenses – CalOptima Health's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with arranging for the provision of health care services. Operating expenses are all expenses incurred to arrange for the provision of health care services, as well as the costs of administration. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in operating expenses. Non-exchange revenues and expenses are reported as nonoperating revenues and expenses.

Revenue recognition and due to or from the State and CMS – Premium revenue is recognized in the period the members are eligible to receive health care services. Premium revenue is generally received from the State each month following the month of coverage based on estimated enrollment and capitation rates as provided for in the State contract. As such, premium revenue includes an estimate for amounts receivable from or refundable to the State for these retrospective adjustments. These estimates are continually monitored and analyzed, with any adjustments recognized in the period when determined. OneCare premium revenue is generally received from CMS each month for the month of coverage. Premiums received in advance are recorded in unearned revenue on the statements of net position. Included in premium revenue are retroactive adjustments favorable to CalOptima Health in the amount of approximately $313,981,000 and $215,600,000 related to retroactive capitation rate adjustments based receipt of new information from DHCS during the years ended June 30, 2022 and 2021, respectively.

These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the statements of revenues, expenses, and changes in net position. Eligibility of beneficiaries is determined by DHCS and validated by the State. The State provides CalOptima Health the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of premium revenue for the respective month.

Note 2 – Summary of Significant Accounting Policies (continued)

Effective with the enrollment of the Medi-Cal Expansion population per the Affordable Care Act (ACA), CalOptima Health is subject to DHCS requirements to meet the minimum 85 percent medical loss ratio (MLR) for this population. Specifically, CalOptima Health is required to expend at least 85 percent of the Medi-Cal premium revenue received for this population on allowable medical expenses as defined by DHCS. In the event CalOptima Health expends less than the 85 percent requirement, CalOptima Health will be required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses. CalOptima Health was notified in December 2020 that CalOptima Health is not required to remit any payment to DHCS, nor will DHCS make any additional payment for fiscal year 2018.

In April 2019, CalOptima Health was notified by DHCS that CMS will be working with DHCS to perform their own reconciliation of the MLR data. As of the date the financial statements were available to be issued, DHCS has not released the results of the reconciliation. As of June 30, 2022 and 2021, approximately $135,390,000 was accrued. This liability is presented in the Due to State of California and CMS line item in the accompanying statements of net position.

Premium revenue and related net receivables as a percent of the totals were as follows:

	Years Ended June 30,			
	2022		2021	
	Revenue	%	Revenue	%
Revenue				
Medi-Cal	$ 3,802,802,931	90.0%	$ 3,739,173,008	90.2%
OneCare	38,061,315	0.9%	25,967,205	0.6%
OneCare Connect	344,402,500	8.1%	344,174,513	8.3%
PACE	41,991,986	1.0%	39,020,931	0.9%
	$ 4,227,258,732	100.0%	$ 4,148,335,657	100.0%

	As of June 30,			
	2022		2021	
	Receivables	%	Receivables	%
Receivables				
Medi-Cal	$ 379,774,086	93.7%	$ 403,849,267	94.5%
OneCare	3,035,680	0.8%	2,558,056	0.6%
OneCare Connect	19,606,213	4.8%	18,217,285	4.3%
PACE	2,776,408	0.7%	2,713,160	0.6%
	$ 405,192,387	100.0%	$ 427,337,768	100.0%

Note 2 – Summary of Significant Accounting Policies (continued)

Intergovernmental transfer – CalOptima Health entered into an agreement with DHCS and Governmental Funding Entities to receive an IGT through a capitation rate increase of approximately $71,747,000 and $140,446,000 during the years ended June 30, 2022 and 2021, respectively. Under the agreement, approximately $49,076,000 and $95,298,000 of the funds that were received from the IGT were passed through to Governmental Funding Entities and other contracted providers and organizations during the years ended June 30, 2022 and 2021, respectively. Under GASB, the amounts that will be passed through to Governmental Funding Entities are not reported in the statements of revenues, expenses, and changes in net position or the statements of net position. CalOptima Health accounts for the IGT for CalOptima Health purposes as an exchange transaction requiring funds to be expended prior to revenue recognition. CalOptima Health retains a portion of the IGT, which must be used to enhance provider reimbursement rates and strengthen the delivery system. Starting with rate year 2017-2018, funds expended must be tied to covered medical services provided to CalOptima Health's Medi-Cal beneficiaries. A retainer in the amount of approximately $7,744,000 and $12,721,000 as of June 30, 2022 and 2021, respectively, is included in unearned revenues in the statements of net position.

Directed Payments – DHCS implemented a new hospital Directed Payment program with CalOptima Health. The program implements enhanced reimbursement to eligible and participating network hospitals for contracted services. This hospital Directed Payment program is broken into three types: 1) Private Hospital Directed Payment Program (PHDP), 2) Public Hospital Enhanced Payment Program (EPP), and 3) Public Hospital Quality Incentive Program (QIP). Under the Directed Payment program, approximately $271,516,000 and $200,856,000 of the funds that were received from DHCS were passed through to hospitals as requested by DHCS during the years ended June 30, 2022 and 2021, respectively. The receipts from DHCS are included in premium revenues, and the payments made to the hospitals are included in other medical expenses in the statements of net position.

Medicare Part D – CalOptima Health covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments CalOptima Health receives monthly from program premiums, which are determined from its annual bid, represent amounts for providing prescription drug insurance coverage. CalOptima Health recognizes premiums for providing this insurance coverage ratably over the term of its annual contract. CalOptima Health's CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies, as well as receipts for certain discounts on brand name prescription drugs in the coverage gap, represent payments for prescription drug costs for which CalOptima Health is not at risk.

Note 2 – Summary of Significant Accounting Policies (continued)

The risk corridor provisions compare costs targeted in CalOptima Health's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to CalOptima Health or require CalOptima Health to refund to CMS a portion of the premiums CalOptima Health received. CalOptima Health estimates and recognizes an adjustment to premiums revenue related to these risk corridor provisions based upon pharmacy claims experience to date, as if the annual contract were to terminate at the end of the reporting period. Accordingly, this estimate provides no consideration to future pharmacy claims experience. CalOptima Health records a receivable or payable at the contract level and classifies the amount as current or long-term in the accompanying statements of net position based on the timing of expected settlement. As of June 30, 2022 and 2021, the Part D payable balance was approximately $360,000 and $645,000, respectively, and is included in the Due to the State of California and CMS line item on the accompanying statements of net position. As of June 30, 2022 and 2021, the Part D receivable balance was approximately $41,888,000 and $36,868,000, respectively, and is included in the prepaid expenses and other line item on the accompanying statements of net position.

Income taxes – CalOptima Health operates under the purview of the Internal Revenue Code (IRC), Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, CalOptima Health is not subject to federal or state taxes on related income. Accordingly, no provision for income tax has been recorded in the accompanying financial statements.

Premium taxes – Effective July 1, 2016, Senate Bill X2-2 (SB X2-2) *Managed Care Organization Tax* authorized DHCS to implement a Managed Care Organization (MCO) provider tax subject to approval by CMS. This approved tax structure is based on enrollment (total member months) between specified tiers that are assessed different tax rates. During fiscal year 2020, the MCO tax was extended with an effective date of January 1, 2020. Using the approved structure, each MCO's total tax liability for years ended June 30, 2022 and 2021, were calculated. CalOptima Health recognized premium tax expense of approximately $166,145,000 and $149,694,000 as a reduction of premium revenues in the statements of revenue, expenses, and changes in net position for the years ended June 30, 2022 and 2021, respectively. As of June 30, 2022 and 2021, CalOptima Health's MCO tax liability amounted to approximately $41,563,000 and $37,511,000, respectively, and is included in due to the State of California and CMS line item on the accompanying statements of net position.

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Note 2 – Summary of Significant Accounting Policies (continued)

Risk corridors – During the year ended June 30, 2021, CalOptima Health's contract with DHCS was subject to a risk corridor for the Managed Long-Term Services and Supports program for the period of July 1, 2015 through June 30, 2017. Additionally, the State's fiscal year 2020-21 enacted budget included a COVID-19 (previously called Gross Medical Expense) risk corridor for the initial period of July 1, 2019 to December 31, 2021, and was extended to June 30, 2022. The State's fiscal year 2021-22 enacted budget included the Enhanced Care Management (ECM) risk corridor for the period of January 1, 2022 through June 30, 2022. CalOptima Health also participates in the Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) risk corridor for the period of July 1, 2019 through June 30, 2022. All risk corridors are subject to certain thresholds of medical expenses compared to premium revenues. Variances exceeding the thresholds may require CalOptima Health to refund premium revenues back to DHCS. CalOptima Health estimates and recognizes an adjustment to premium revenues based on actual membership and capitation rates in effect. As of June 30, 2022 and 2021, CalOptima Health recognized a liability of approximately $413,031,000 and $224,240,000, respectively, related to the risk corridors, which is included in the due to the State of California and CMS line item on the statements of net position. During the years ended June 30, 2022 and 2021, the reduction of premium revenue was approximately $195,655,000 and $67,126,000, respectively, related to the risk corridors, which is included in premium revenues on the statements of revenues, expenses, and changes in net position.

Pensions – For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions and pension expense, information about the fiduciary net position of CalOptima Health's Miscellaneous Plan of the Orange County Health Authority (the "CalPERS Plan") and additions to/deductions from the Plan's fiduciary net position have been determined on the same basis as they are reported by California Public Employees Retirement Systems (CalPERS). For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Recent accounting pronouncements – In May 2020, the GASB issued Statement No. 96, *Subscription-based Information Technology Arrangements (SBITAs)*. This Statement provides guidance on the accounting and financial reporting for subscription-based information technology arrangements (SBITAs) for government end users (governments). This Statement (1) defines a SBITA; (2) establishes that a SBITA results in a right-to-use subscription asset—an intangible asset—and a corresponding subscription liability; (3) provides the capitalization criteria for outlays other than subscription payments, including implementation costs of a SBITA; and (4) requires note disclosures regarding a SBITA. To the extent relevant, the standards for SBITAs are based on the standards established in Statement No. 87, *Leases,* as amended. This Statement is effective for the Organization for the year ended June 30, 2023, and management is evaluating the impact of this Statement on the financial statements.

Note 2 – Summary of Significant Accounting Policies (continued)

In June 2017, the GASB issued Statement No. 87, *Leases*. The objective of this Statement is to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. This Statement requires recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under this Statement, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about governments' leasing activities. The Organization adopted the provisions of this Statement during the fiscal year ended June 30, 2022; however, the adoption of this Statement did not have a material impact on the Organization's financial statements.

Note 3 – Cash, Cash Equivalents, and Investments

Cash and investments are reported in the statements of net position as follows:

	June 30, 2022	June 30, 2021
Current assets		
Cash and cash equivalents	$ 823,489,345	$ 281,834,498
Investments	1,014,460,504	1,065,409,806
Board-designated assets and restricted cash		
Cash and cash equivalents	44,968,923	60,144,705
Investments	566,159,456	585,534,360
Restricted deposit	300,051	300,000
	$ 2,449,378,279	$ 1,993,223,369

Board-designated assets and restricted cash are available for the following purposes:

	June 30, 2022	June 30, 2021
Board-designated assets and restricted cash		
Contingency reserve fund	$ 570,491,640	$ 588,880,152
Homeless Health Initiative fund	40,636,739	56,798,913
Restricted deposit with DMHC	300,051	300,000
	$ 611,428,430	$ 645,979,065

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Note 3 – Cash, Cash Equivalents, and Investments (continued)

Custodial credit risk deposits – Custodial credit risk is the risk that, in the event of a bank failure, the Organization may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. As of June 30, 2022 and 2021, no deposits were exposed to custodial credit risk, as the Organization has pledged collateral to cover the amounts.

Investments – CalOptima Health invests in obligations of the U.S. Treasury, other U.S. government agencies and instrumentalities, state obligations, corporate securities, money market funds, and mortgage or asset-backed securities.

Interest rate risk – In accordance with its annual investment policy (investment policy), CalOptima Health manages its exposure to decline in fair value from increasing interest rates by matching maturity dates to the extent possible with CalOptima Health's expected cash flow draws. Its investment policy limits maturities to five years, while also staggering maturities. CalOptima Health maintains a low-duration strategy, targeting a portfolio duration of three years or less, with the intent of reducing interest rate risk. Portfolios with low duration are less volatile because they are less sensitive to interest rate changes. As of June 30, 2022 and 2021, CalOptima Health's investments, including cash equivalents, had the following modified duration:

	June 30, 2022			
		Investment Maturities (in Years)		
Investment Type	Fair Value	Less Than 1	1–5	More Than 5
U.S. Treasury notes	$ 327,894,991	$ 36,710,632	$ 291,184,359	$ -
U.S. Agency notes	27,968,953	-	27,968,953	-
Corporate bonds	502,565,436	33,238,714	469,326,722	-
Asset-backed securities	280,622,076	-	280,622,076	-
Mortgage-backed securities	92,451,578	36,471,259	55,980,319	-
Municipal bonds	129,008,045	45,231,381	83,776,664	-
Tax exempt municipal bonds	1,208,815	-	1,208,815	-
Supranational	29,858,329	-	29,858,329	-
Commercial paper	35,969,792	5,976,862	29,992,930	-
Certificates of deposit	148,728,528	136,032,127	12,696,401	-
Cash equivalents	767,204,575	767,204,575	-	-
Cash	3,462,526	3,462,526	-	-
	2,346,943,644	$ 1,064,328,076	$ 1,282,615,568	$ -
Accrued interest receivable	4,343,416			
	$ 2,351,287,060			

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Note 3 – Cash, Cash Equivalents, and Investments (continued)

	June 30, 2021			
		Investment Maturities (in Years)		
Investment Type	Fair Value	Less Than 1	1–5	More Than 5
U.S. Treasury notes	$ 384,597,567	$ 212,905,109	$ 171,692,458	$ -
U.S. Agency notes	145,970,235	46,408,728	99,561,507	-
Corporate bonds	433,093,746	62,753,919	370,339,827	-
Asset-backed securities	205,797,496	933,416	204,864,080	-
Mortgage-backed securities	59,941,816	977,812	58,964,004	-
Municipal bonds	197,208,250	50,269,488	146,938,762	-
Tax exempt municipal bonds	7,756,668	3,999,876	3,756,792	-
Supranational	79,450,167	20,445,676	59,004,491	-
Commercial paper	1,798,780	1,798,780	-	-
Certificates of deposit	131,384,520	129,385,206	1,999,314	-
Cash equivalents	281,460,545	281,460,545	-	-
Cash	5,852,311	5,852,311	-	-
	1,934,312,101	$ 817,190,866	$ 1,117,121,235	$ -
Accrued interest receivable	3,944,921			
	$ 1,938,257,022			

Investment with fair values highly sensitive to interest rate fluctuations – When interest rates fall, debt is refinanced and paid off early. The reduced stream of future interest payments diminishes the fair value of the investment. The mortgage-backed and asset-backed securities in the CalOptima Health portfolio are of high credit quality, with relatively short average lives that represent limited prepayment and interest rate exposure risk. CalOptima Health's investments include the following investments that are highly sensitive to interest rate and prepayment fluctuations to a greater degree than already indicated in the information provided above:

	June 30,	
	2022	2021
Asset-backed securities	$ 280,622,076	$ 205,797,496
Mortgage-backed securities	92,451,578	59,941,816
	$ 373,073,654	$ 265,739,312

Note 3 – Cash, Cash Equivalents, and Investments (continued)

Credit risk – CalOptima Health's investment policy conforms to the California Government Code as well as to customary standards of prudent investment management. Credit risk is mitigated by investing in only permitted investments. The investment policy sets minimum acceptable credit ratings for investments from the three nationally recognized rating services: Standard and Poor's Corporation (S&P), Moody's Investor Service (Moody's), and Fitch Ratings (Fitch). For an issuer of short-term debt, the rating must be no less than A-1 (S&P), P-1 (Moody's), or F-1 (Fitch), while an issuer of long-term debt shall be rated no less than an "A."

Note 3 – Cash, Cash Equivalents, and Investments (continued)

As of June 30, 2022, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt from Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	$ 613,661,310	N/A	$ 613,661,310	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	112,992,781	N/A	112,992,781	-	-	-	-	-	-
Corporate bonds	504,698,493	A-	-	13,168,534	18,224,140	82,365,369	97,504,233	179,834,076	113,602,141
Asset-backed securities	280,779,086	AAA	-	268,943,920	11,835,166	-	-	-	-
Mortgage-backed securities	92,633,657	AAA	-	92,633,657	-	-	-	-	-
Municipal bonds	141,722,001	A	-	46,435,063	60,559,471	29,755,026	2,174,741	2,797,700	-
Supranational	29,898,404	AAA	-	29,898,404	-	-	-	-	-
Repurchase agreement	175,007,174	N/A	175,007,174	-	-	-	-	-	-
Certificates of deposit	153,404,888	A1/P1	-	153,404,888	-	-	-	-	-
Commercial paper	243,026,740	A1/P1	-	211,532,422	31,494,318	-	-	-	-
Money market mutual funds	3,462,526	AAA	-	3,462,526	-	-	-	-	-
Total	$ 2,351,287,060		$ 901,661,265	$ 819,479,414	$ 122,113,095	$ 112,120,395	$ 99,678,974	$ 182,631,776	$ 113,602,141

As of June 30, 2021, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt from Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	$ 469,042,863	N/A	$ 469,042,863	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	191,616,279	N/A	191,616,279	-	-	-	-	-	-
Corporate bonds	349,716,328	A-	-	1,006,377	28,927,365	56,252,688	69,946,396	92,778,721	100,804,781
Floating-rate note securities	184,785,689	A-	-	91,501,339	26,293,614	6,288,960	20,563,093	15,289,876	24,848,807
Asset-backed securities	89,786,565	AAA	-	84,157,218	5,629,347	-	-	-	-
Mortgage-backed securities	158,920,715	AAA	-	158,920,715	-	-	-	-	-
Municipal bonds	228,782,972	A	-	62,716,750	95,592,804	56,751,316	10,727,242	2,994,860	-
Supranational	29,795,971	AAA	-	29,795,971	-	-	-	-	-
Repurchase agreement	53,007,361		53,007,361	-	-	-	-	-	-
Certificates of deposit	89,202,923	A1/P1	-	89,202,923	-	-	-	-	-
Commercial paper	87,747,047	A1/P1	-	66,748,544	20,998,503	-	-	-	-
Money market mutual funds	5,852,309	AAA	-	5,852,309	-	-	-	-	-
Total	$ 1,938,257,022		$ 713,666,503	$ 589,902,146	$ 177,441,633	$ 119,292,964	$ 101,236,731	$ 111,063,457	$ 125,653,588

Note 3 – Cash, Cash Equivalents, and Investments (continued)

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of CalOptima Health's investment in a single issuer. CalOptima Health's investment policy limits to no more than 5 percent of the total fair value of investments in the securities of any one issuer, except for obligations of the U.S. government, U.S. government agencies, or government-sponsored enterprises, and no more than 10 percent may be invested in one money market mutual fund unless approved by the governing board. The investment policy also places a limit of 35 percent of the amount of investment holdings with any one government-sponsored issuer and 5 percent of all other issuers. As of June 30, 2022 and 2021, all holdings complied with the foregoing limitations. As of June 30, 2022 and 2021, there was one U.S. Treasury note issued by the United States Treasury that represented 26.14 percent and 24.30 percent of the portfolio, respectively.

The Organization categorizes its fair value investments within the fair value hierarchy established by U.S. GAAP. The hierarchy for fair value measurements is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date.

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for an asset or liability, either directly or indirectly.

Level 3 – Significant unobservable inputs.

The following is a description of the valuation methodologies used for instruments at fair value on a recurring basis and recognized in the accompanying statements of net position, as well as the general classification of such instruments pursuant to the valuation hierarchy.

Marketable securities – Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. If quoted market prices are not available, then fair values are estimated by using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows. These securities are classified within Level 2 of the valuation hierarchy. In certain cases, where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy.

Note 3 – Cash, Cash Equivalents, and Investments (continued)

The following table presents the fair value measurements of assets recognized in the accompanying statements of net position measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall:

	Investment Assets at Fair Value as of June 30, 2022			
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	$ 327,894,991	$ -	$ -	$ 327,894,991
U.S. Agency notes	-	27,968,953	-	27,968,953
Corporate bonds	-	502,565,436	-	502,565,436
Asset-backed securities	-	280,622,076	-	280,622,076
Mortgage-backed securities	-	92,451,578	-	92,451,578
Municipal bonds	-	129,008,045	-	129,008,045
Tax exempt Municipal bonds	-	1,208,815	-	1,208,815
Supranational	-	29,858,329	-	29,858,329
Commercial paper	-	35,969,792	-	35,969,792
Certificates of deposit	-	148,728,528	-	148,728,528
	$ 327,894,991	$ 1,248,381,552	$ -	$ 1,576,276,543

	Investment Assets at Fair Value as of June 30, 2021			
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	$ 384,597,567	$ -	$ -	$ 384,597,567
U.S. Agency notes	-	145,970,235	-	145,970,235
Corporate bonds	-	433,093,746	-	433,093,746
Asset-backed securities	-	205,797,496	-	205,797,496
Mortgage-backed securities	-	59,941,816	-	59,941,816
Municipal bonds	-	197,208,250	-	197,208,250
Tax exempt Municipal bonds	-	7,756,668	-	7,756,668
Supranational	-	79,450,167	-	79,450,167
Commercial paper	-	1,798,780	-	1,798,780
Certificates of deposit	-	131,384,520	-	131,384,520
	$ 384,597,567	$ 1,262,401,678	$ -	$ 1,646,999,245

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Note 4 – Capital Assets

Capital assets activity during the year ended June 30, 2022, consisted of the following:

	June 30, 2021	Additions	Retirements	Transfers	June 30, 2022
Capital assets not being depreciated					
Land	$ 5,876,002	$ 6,036,497	$ -	$ -	$ 11,912,499
Construction in progress	267,512	5,207,679	-	(1,967,308)	3,507,883
	6,143,514	11,244,176	-	(1,967,308)	15,420,382
Capital assets being depreciated					
Furniture and equipment	8,074,334	-	-	240,641	8,314,975
Computers and software	38,173,040	-	-	1,134,242	39,307,282
Leasehold improvements	5,063,118	-	-	(3,709)	5,059,409
Building	45,901,220	16,595,003	-	596,134	63,092,357
	97,211,712	16,595,003	-	1,967,308	115,774,023
Less: accumulated depreciation for					
Furniture and equipment	6,372,964	536,458	-	-	6,909,422
Computers and software	29,618,855	3,970,935	-	-	33,589,790
Leasehold improvements	4,950,031	67,098	-	-	5,017,129
Building	16,685,495	2,128,527	-	-	18,814,022
	57,627,345	6,703,018	-	-	64,330,363
Total depreciable assets, net	39,584,367	9,891,985	-	1,967,308	51,443,660
Capital assets, net	$ 45,727,881	$ 21,136,161	$ -	$ -	$ 66,864,042

Note 4 – Capital Assets (continued)

Capital asset activity during the year ended June 30, 2021, consisted of the following:

	June 30, 2020	Additions	Retirements	Transfers	June 30, 2021
Capital assets not being depreciated					
Land	$ 5,876,002	$ -	$ -	$ -	$ 5,876,002
Construction in progress	3,378,335	5,841,274	-	(8,952,097)	267,512
	9,254,337	5,841,274	-	(8,952,097)	6,143,514
Capital assets being depreciated					
Furniture and equipment	7,398,013	-	(428,186)	1,104,507	8,074,334
Computers and software	32,488,778	-	(2,006,331)	7,690,593	38,173,040
Leasehold improvements	5,063,118	-	-	-	5,063,118
Building	45,744,223	-	-	156,997	45,901,220
	90,694,132	-	(2,434,517)	8,952,097	97,211,712
Less accumulated depreciation for					
Furniture and equipment	6,154,830	646,320	(428,186)	-	6,372,964
Computers and software	28,153,140	3,472,046	(2,006,331)	-	29,618,855
Leasehold improvements	4,363,841	586,190	-	-	4,950,031
Building	14,622,082	2,063,413	-	-	16,685,495
	53,293,893	6,767,969	(2,434,517)	-	57,627,345
Total depreciable assets, net	37,400,239	(6,767,969)	-	8,952,097	39,584,367
Capital assets, net	$ 46,654,576	$ (926,695)	$ -	$ -	$ 45,727,881

The Organization recognized depreciation expense of approximately $6,703,000 and $6,768,000 during the years ended June 30, 2022 and 2021, respectively. During the years ended June 30, 2022 and 2021, depreciation expense of approximately $92,000 and $583,000, respectively, was included within PACE medical expenses on the accompanying statements of revenues, expenses, and changes in net position.

Note 5 – Medical Claims Liability

Medical claims liability consisted of the following:

	June 30, 2022	June 30, 2021
Claims payable or pending approval	$ 48,231,910	$ 19,551,355
Provisions for IBNR claims	253,620,811	269,368,435
	$ 301,852,721	$ 288,919,790

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Note 5 – Medical Claims Liability (continued)

The cost of health care services is recognized in the period in which care is provided and includes an estimate of the cost of services that has been IBNR. CalOptima Health estimates accrued claims payable based on historical claims payments and other relevant information. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in medical claims liability. Estimates are continually monitored and analyzed and, as settlements are made or estimates adjusted, differences are reflected in current operations.

Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided.

The following is a reconciliation of the medical claims liability:

	For the Years Ended June 30,	
	2022	2021
Beginning balance	$ 288,919,790	$ 302,058,508
Incurred		
Current	2,231,310,673	2,334,701,565
Prior	(88,742,120)	(96,907,575)
	2,142,568,553	2,237,793,990
Paid		
Current	1,929,457,952	2,045,781,775
Prior	200,177,670	205,150,933
	2,129,635,622	2,250,932,708
Ending balance	$ 301,852,721	$ 288,919,790

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established prior reporting period liability. Negative amounts reported for incurred, related to prior years, result from claims being adjudicated and paid for amounts less than originally estimated. The results included a decrease of prior year incurred of approximately $88,742,000 and $96,908,000 for the fiscal years ended June 30, 2022 and 2021, respectively. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

Note 5 – Medical Claims Liability (continued)

The amounts accrued in the due to the State of California and CMS line item represent excess payments from DHCS that are primarily due to capitation payments received that do not reflect the current Medi-Cal rates issued by DHCS. DHCS continues to process the recoupments and the remaining overpayments not yet recouped are included within the due to the State of California and CMS line item on the statements of net position.

Note 6 – Defined Benefit Pension Plan

Plan description – CalOptima Health's defined benefit pension plan, the CalPERS Plan, provides retirement and disability benefits, annual cost of living adjustments, and death benefits to plan members and beneficiaries. The CalPERS Plan is part of the public agency portion of CalPERS, an agent multiple-employer plan administered by CalPERS, which acts as a common investment and administrative agent for participating public employers within the State. A menu of benefit provisions as well as other requirements is established by state statutes within the Public Employees' Retirement Law (PERL). CalOptima Health selects optional benefit provisions from the benefit menu by contract with CalPERS and adopts those benefits through the Board of Directors' approval. CalPERS issues a publicly available financial report that includes financial statements and required supplementary information for CalPERS. Copies of the report can be obtained from CalPERS Executive Office, 400 P Street, Sacramento, CA 95814.

Benefits provided – CalPERS provides service retirement and disability benefits, annual cost of living adjustments, and death benefits to plan members, who must be public employees and beneficiaries. Benefits are based on years of credited service, equal to one full year of full-time employment. Members with five years of total service are eligible to retire at age 50 with statutorily reduced benefits. All members are eligible for non-duty disability benefits after 10 years of service. The death benefit is one of the following: The Basic Death Benefit, the 1957 Survivor Benefit, or the Optional Settlement 2W Death Benefit. The cost of living adjustments for the plan are applied as specified by the PERL.

The CalPERS Plan's provisions and benefits in effect as of June 30, 2022, are summarized as follows:

Hire date	Prior to January 1, 2013	On or after January 1, 2013
Benefit formula	2% at 60	2% at 62
Benefit vesting schedule	5 years of service	5 years of service
Benefit payments	monthly for life	monthly for life
Retirement age	50 plus	52 plus
Monthly benefits as a % of eligible compensation	1.092% to 2.418%	1.0% to 2.5%
Required employee contribution rates	7.00%	7.75%
Required employer contribution rates	8.52%	8.52%

Note 6 – Defined Benefit Pension Plan (continued)

The following is a summary of plan participants:

	June 30, 2022	June 30, 2021
Active employees	1,438	1,369
Retirees and beneficiaries		
Receiving benefits	72	71
Deferred retirement benefits		
Terminated employees	77	173
Surviving spouses	3	3
Beneficiaries	3	3

Contributions – Section 20814(c) of the California Public Employees' Retirement Law requires that the employer contribution rates for all public employers are determined on an annual basis by the actuary and shall be effective on the July 1 following notice of a change in the rate. The total plan contributions are determined through CalPERS' annual actuarial valuation process. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. The employer is required to contribute the difference between the actuarially determined rate and the contribution rate of employees. The average active employee contribution rate is 7.75 percent of annual pay for the years ended June 30, 2022 and 2021. The employer's contribution rate is 8.52 percent of annual payroll for the years ended June 30, 2022 and 2021.

Note 6 – Defined Benefit Pension Plan (continued)

CalOptima Health's net pension liability for the CalPERS Plan is measured as the total pension liability, less the pension plan's fiduciary net position. For the measurement period ended June 30, 2021 (the measurement date), the total pension liability was determined by rolling forward the June 30, 2020 total pension liability. Total pension liabilities were based on the following actuarial methods and assumptions as of June 30, 2021 and June 30, 2020:

Valuation date	June 30, 2020
Measurement date	June 30, 2021
Actuarial cost method	Entry age normal
Actuarial assumptions	
Discount rate	7.15%
Inflation	2.50%
Salary increases	Varies by entry age and service
Investment rate of return	7.0% net of pension plan investment and administrative expenses; includes inflation
Mortality rate table	Derived using CalPERS' membership data for all funds
Post-retirement benefit increase	Contract COLA up to 2.0% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.50% thereafter

The mortality table used was developed based on CalPERS-specific data. The table includes 15 years of mortality improvements using Society of Actuarials Scale MP 2016. For more details on this table, please refer to the December 2017 experience study report based on CalPERS demographic data from 1997 to 2015 that can be found on the CalPERS website.

Note 6 – Defined Benefit Pension Plan (continued)

Changes in the net pension liability are as follows:

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2021	$ 212,182,252	$ 181,562,247	$ 30,620,005
Changes during the year			
Service cost	16,033,791	-	16,033,791
Interest on the total pension liability	15,591,711	-	15,591,711
Differences between expected and actual experience	(477,252)	-	(477,252)
Contributions from the employer	-	10,742,812	(10,742,812)
Contributions from employees	-	7,981,938	(7,981,938)
Net investment income	-	42,647,021	(42,647,021)
Benefit payments, including refunds of employee contributions	(3,311,997)	(3,311,997)	-
Administrative expenses	-	(181,370)	181,370
Net changes during the year	27,836,253	57,878,404	(30,042,151)
Balance at June 30, 2022	$ 240,018,505	$ 239,440,651	$ 577,854

Note 6 – Defined Benefit Pension Plan (continued)

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2020	$ 187,171,344	$ 160,048,471	$ 27,122,873
Changes during the year			
Service cost	15,223,385	-	15,223,385
Interest on the total pension liability	13,770,107	-	13,770,107
Differences between expected and actual experience	(405,662)	-	(405,662)
Contributions from the employer	-	9,608,656	(9,608,656)
Contributions from employees	-	7,518,241	(7,518,241)
Net investment income	-	8,189,430	(8,189,430)
Benefit payments, including refunds of employee contributions	(3,576,922)	(3,576,922)	-
Administrative expenses	-	(225,629)	225,629
Net changes during the year	25,010,908	21,513,776	3,497,132
Balance at June 30, 2021	$ 212,182,252	$ 181,562,247	$ 30,620,005

Discount rate and long-term rate of return – The discount rate used to measure the total pension liability was 7.15 percent. The projection of cash flows used to determine the discount rate assumed that contributions from plan members will be made at the current member contribution rates and that contributions from employers will be made at statutorily required rates, actuarially determined. Based on those assumptions, the plan's fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

Note 6 – Defined Benefit Pension Plan (continued)

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Using historical returns of all of the funds' asset classes, expected compound (geometric) returns were calculated over the short-term (first 10 years) and the long-term (11+ years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the rounded single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equal to the single equivalent rate calculated above and adjusted to account for assumed administrative expenses.

The table below reflects long-term expected real rate of return by asset class.

New Strategic Asset Class	Real Return Allocation	Real Return Years 1–10 (a)	Years 11+ (b)
Global equity	50.0%	4.80%	5.98%
Global fixed income	28.0%	1.00%	2.62%
Inflation sensitive	0.0%	0.77%	1.81%
Private equity	8.0%	6.30%	7.23%
Real estate	13.0%	3.75%	4.93%
Liquidity	1.0%	0.00%	-0.92%

(a) An expected inflation of 2.00% was used for this period
(b) An expected inflation of 2.92% was used for this period

Note 6 – Defined Benefit Pension Plan (continued)

The following presents the net pension liability of the CalPERS Plan calculated using the discount rate, as well as what the net pension liability would be if it were calculated using a discount rate that is 1 percentage point lower or 1 percentage point higher than the current rate:

	June 30, 2022		
	Discount Rate -1% 6.15%	Current Discount Rate 7.15%	Discount Rate +1% 8.15%
Net pension liability	$ 40,373,662	$ 577,854	$ (31,585,618)

	June 30, 2021		
	Discount Rate -1% 6.15%	Current Discount Rate 7.15%	Discount Rate +1% 8.15%
Net pension liability	$ 66,024,233	$ 30,620,005	$ 2,041,896

Note 6 – Defined Benefit Pension Plan (continued)

Pension expense and deferred outflows/inflows of resources related to pensions – CalOptima Health recognized pension expense of approximately $6,790,000, and $13,022,000 for the years ended June 30, 2022 and 2021, respectively. These amounts are presented within salaries, wages, and employee benefits in the statements of revenues, expenses, and changes in net position. As of June 30, 2022 and 2021, CalOptima Health recognized deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	June 30, 2022	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	$ 1,931,845	$ -
Net differences between projected and actual earnings on plan investments	-	(20,982,636)
Changes in assumptions	2,325,077	(1,909,305)
Differences between expected and actual experiences	2,353,671	(686,563)
	$ 6,610,593	$ (23,578,504)

	June 30, 2021	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	$ 1,508,025	$ -
Net differences between projected and actual earnings on plan investments	2,104,780	-
Changes in assumptions	3,692,771	2,709,945
Differences between expected and actual experiences	3,236,721	344,198
	$ 10,542,297	$ 3,054,143

Note 6 – Defined Benefit Pension Plan (continued)

The deferred inflows of resources related to employer contributions subsequent to the measurement date will be recognized as an increase to the net pension liability during the year ended June 30, 2022. The net differences reported as deferred outflows of resources related to pensions will be recognized as pension expense as follows:

	Deferred Outflows (Inflows) of Resources
Years Ending June 30,	
2022	$ (3,853,726)
2023	(4,006,677)
2024	(5,131,665)
2025	(5,760,673)
2026	(110,301)
Thereafter	(36,714)
	$ (18,899,756)

Note 7 – Employee Benefit Plans

Deferred compensation plan – CalOptima Health sponsors a deferred compensation plan created in accordance with Internal Revenue Code Section 457 (the "457 Plan") under which employees are permitted to defer a portion of their annual salary until future years. CalOptima Health may make discretionary contributions to the 457 Plan as determined by the Board of Directors. For the years ended June 30, 2022 and 2021, no discretionary employer contributions were made.

Defined contribution plan – Effective January 1, 1999, CalOptima Health established a supplemental retirement plan for its employees called the CalOptima Public Agency Retirement System Defined Contribution Supplemental Retirement Plan ("PARS Plan"). All regular and limited-term employees are eligible to participate in the PARS Plan. The current PARS Plan design does not require employee contributions. CalOptima Health makes discretionary employer contributions to the PARS Plan as authorized by the Board of Directors. Vesting occurs over 16 quarters of service. For the years ended June 30, 2022 and 2021, CalOptima Health contributed approximately $4,743,000 and $4,420,000, respectively.

Note 8 – Postemployment Health Care Plan

Plan description – CalOptima Health sponsors and administers a single-employer, defined benefit postemployment health care plan to provide medical and dental insurance benefits to eligible retired employees and their beneficiaries. Benefit provisions are established and may be amended by the Board of Directors.

Effective January 1, 2004, CalOptima Health terminated postemployment health care benefits for employees hired on or after January 1, 2004. For employees hired prior to January 1, 2004, the employee's eligibility for retiree health benefits remains similar to the eligibility requirements for the defined benefit pension plan.

During the year ended June 30, 2006, CalOptima Health modified the benefit offered to eligible participants, requiring participants to enroll in Medicare and specifying that CalOptima Health would be responsible only for the cost of Medicare supplemental coverage, subject to a cost sharing between the participant and CalOptima Health.

For purposes of measuring the total postemployment retirement liability, deferred outflows of resources and deferred inflows of resources related to other postemployment benefit (OPEB), and OPEB expense, information about the fiduciary net position of the CalOptima Health's plan, and additions to/deductions from the OPEB plan's fiduciary net position have been determined on the same basis. For this purpose, benefit payments are recognized when currently due and payable in accordance with the benefit terms.

U.S. GAAP requires that the reported results must pertain to liability and asset information within certain defined timeframes. For this report, the following timeframes are used:

Measurement date	June 30, 2021
Measurement period	July 1, 2020 – June 30, 2021
Valuation date	January 1, 2022

Covered employees – The following numbers of participants were covered by the benefit terms:

	June 30, 2022	June 30, 2021
Inactives currently receiving benefits	72	73
Active employees	73	71
Total	145	144

Note 8 – Postemployment Health Care Plan (continued)

Contributions – The contribution requirements of plan members and CalOptima Health are established and may be amended by the Board of Directors. CalOptima Health's contribution is based on projected pay-as-you-go financing requirements, with no additional amount to prefund benefits. CalOptima Health contributed $529,000, including $464,000 in premium payments for retirees and $65,000 for implied subsidies, for the year ended June 30, 2022. CalOptima Health contributed $544,000, including $485,000 in premium payments for retirees and $59,000 for implied subsidies, for the year ended June 30, 2021. The most recent actuarial report for the postemployment health care plan was June 30, 2021. As of that point, the actuarial accrued liability and unfunded actuarial accrued liability for benefits were approximately $22,178,000.

Actuarial assumptions – CalOptima Health's total postemployment retirement liability was measured as of June 30, 2021, and the total postemployment retirement liability used to calculate the total postemployment retirement liability was determined by an actuarial valuation dated January 1, 2021, that was rolled forward to determine the June 30, 2021 total postemployment retirement liability, based on the following actuarial methods and assumptions:

Salary increases	2.75% per annum, in aggregate
Medical trend	Non-Medicare – 6.5% for 2023, decreasing to an ultimate rate of 3.75% in 2076 Medicare(Non-Kaiser) – 5.65% for 2023, decreasing to an ultimate rate of 3.75% 3.75% in 2076 Medicare(Kaiser) – 4.6% for 2023, decreasing to an ultimate rate of 3.75% in 2076
Discount rate	2.16% at June 30 2021, Bond Buyer 20 Index 2.21% at June 30 2020, Bond Buyer 20 Index
Mortality, retirement, disability, termination	CalPERS 2000-2019 Experience Study Post-retirement mortality projection Scale MP-2021
General inflation	2.50% per annum

Discount rate and long-term rate of return – The discount rate used to measure the total OPEB liability was 2.16 percent for June 30, 2021. There were no plan investments; as such, the expected long-term rate of return on investment is not applicable.

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Note 8 – Postemployment Health Care Plan (continued)

Changes in the net OPEB liability – Changes in the net OPEB liability were as follows:

Balance at June 30, 2021	$ 31,610,000
Changes for the year	
Service cost	1,149,000
Interest	718,000
Actual vs. expected experience	(6,241,000)
Assumption changes	(4,514,000)
Benefit payments	(544,000)
Net changes	(9,432,000)
Balance at June 30, 2022	$ 22,178,000
Balance at June 30, 2020	$ 25,824,000
Changes for the year	
Service cost	811,000
Interest	922,000
Assumption changes	4,623,000
Benefit payments	(570,000)
Net changes	5,786,000
Balance at June 30, 2021	$ 31,610,000

Sensitivity of the net OPEB liability to changes in the discount rate – The following presents the net OPEB liability, as well as what the net OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower (1.16 percent) or 1 percentage point higher (3.16 percent) than the current discount rate:

	1% Decrease (1.16%)	Current Rate (2.16%)	1% Increase (3.16%)
Total OPEB liability	$ 25,656,000	$ 22,178,000	$ 19,327,000

Note 8 – Postemployment Health Care Plan (continued)

Sensitivity of the net OPEB liability to changes in health care cost trend rates – The following presents the net OPEB liability, as well as what the net OPEB liability would be if it were calculated using health care cost trend rates that are 1 percentage point lower or 1 percentage point higher than the current health care cost trend rates:

	1% Decrease	Current Rate	1% Increase
Total OPEB liability	$ 18,900,000	$ 22,178,000	$ 26,384,000

For the year ended June 30, 2022, CalOptima Health recognized a reduction to OPEB expense of approximately $566,000. For the year ended June 30, 2021, CalOptima Health recognized OPEB expense of approximately $2,020,000. As of June 30, 2022 and 2021, the reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	June 30, 2022	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ 4,822,000
Changes in assumptions	2,486,000	3,389,000
Employer contributions made subsequent to measurement date	529,000	-
Total	$ 3,015,000	$ 8,211,000

	June 30, 2021	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ 536,000
Changes in assumptions	3,906,000	773,000
Employer contributions made subsequent to measurement date	544,000	-
Total	$ 4,450,000	$ 1,309,000

Note 8 – Postemployment Health Care Plan (continued)

The $529,000 reported as deferred outflows of resources related to contributions subsequent to the June 30, 2021 measurement date will be recognized as a reduction of the total postemployment retirement liability during the fiscal year ended June 30, 2022. Other amounts reported as deferred inflows of resources related to OPEB will be recognized as expense as follows:

	Deferred Inflows of Resources
Years Ending June 30,	
2023	$ (1,852,000)
2024	(1,839,000)
2025	(2,034,000)
	$ (5,725,000)

The required schedule of changes in total OPEB liability immediately following the notes to the financial statements presents multiyear trend information about the actuarial accrued liability for benefits.

Note 9 – Restricted Net Position

On June 28, 2000, CalOptima Health became a fully licensed health care service plan under the Act, as required by statutes governing the Healthy Families program. Under the Act, CalOptima Health is required to maintain and meet a minimum level of TNE as of June 30, 2022 and 2021, of $ 107,345,553 and $101,509,138, respectively. As of June 30, 2022 and 2021, the Organization is in compliance with its TNE requirement.

The Act further required that CalOptima Health maintain a restricted deposit in the amount of $300,000. CalOptima Health met this requirement as of June 30, 2022 and 2021.

Note 10 – Lease Commitments

CalOptima Health leases office space and equipment under noncancelable, long-term operating leases, with minimum annual payments as follows:

	Minimum Lease Payments
Years Ending June 30,	
2023	$ 712,818
2024	712,818
2025	712,818
2026	712,818
2027	712,818
Thereafter	3,207,682
	$ 6,771,772

Rental expense under operating leases was approximately $592,000 and $471,000 for the years ended June 30, 2022 and 2021, respectively.

Note 11 – Contingencies

Litigation – CalOptima Health is party to various legal actions and is subject to various claims arising in the ordinary course of business. Management believes that the disposition of these matters will not have a material adverse effect on CalOptima Health's financial position or results of operations.

Regulatory matters – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties. Management believes that CalOptima Health is in compliance with fraud and abuse, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

COVID-19 pandemic – In March 2020, the World Health Organization declared the novel coronavirus (COVID-19) a global pandemic. This contagious disease outbreak, which has continued to spread, and any related adverse public health developments have adversely affected workforces, customers, economies, and financial markets globally, potentially leading to an economic downturn. It has also disrupted the normal operations of many businesses, including that of the Organization's operations. The Organization's management has been closely monitoring the impact of COVID-19 on the Organization's operations. At this time, the Organization cannot reasonably estimate the duration and severity of this pandemic, which could have a material adverse impact on the Organization's operations.

Supplementary Information

Orange County Health Authority, a Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Schedule of Changes in Net Pension Liability and Related Ratios

	June 30,							
	2022	2021	2020	2019	2018	2017	2016	2015
Total pension liability								
Service cost	$ 16,033,791	$ 15,223,385	$ 14,303,164	$ 13,491,596	$ 13,118,795	$ 10,272,406	$ 8,363,183	$ 6,464,105
Interest	15,591,711	13,770,107	12,107,314	10,431,464	9,136,725	7,702,198	6,620,025	5,661,111
Differences between expected and actual experience	(477,252)	(405,662)	1,904,567	2,812,748	632,642	102,384	1,444,808	-
Changes in assumptions	-	-	-	(4,737,905)	9,163,547	-	(1,963,270)	-
Benefit payments, including refunds of employee contributions	(3,311,997)	(3,576,922)	(2,841,212)	(2,748,699)	(2,068,356)	(2,111,578)	(1,676,666)	(1,326,364)
Net change in total pension liability	27,836,253	25,010,908	25,473,833	19,249,204	29,983,353	15,965,410	12,788,080	10,798,852
Total pension liability – beginning	212,182,252	187,171,344	161,697,511	142,448,307	112,464,954	96,499,544	83,711,464	72,912,613
Total pension liability – ending	240,018,505	212,182,252	187,171,344	161,697,511	142,448,307	112,464,954	96,499,544	83,711,465
Plan fiduciary net position								
Contributions – employer	10,742,812	9,608,656	8,661,466	7,588,200	5,234,580	3,787,544	3,033,171	3,119,804
Contributions – employee	7,981,938	7,518,241	6,853,391	6,213,420	5,793,911	4,951,820	4,142,126	3,385,296
Net investment income	42,647,021	8,189,430	9,377,613	10,225,467	11,496,425	498,498	1,913,380	12,062,654
Benefit payments, including refunds of employee contributions	(3,311,997)	(3,576,922)	(2,841,212)	(2,748,699)	(2,068,356)	(2,111,578)	(1,676,666)	(1,326,364)
Other changes in fiduciary net position	(181,370)	(225,629)	(98,234)	(530,428)	(143,264)	(54,828)	(101,246)	-
Net change in fiduciary net position	57,878,404	21,513,776	21,953,024	20,747,960	20,313,296	7,071,456	7,310,765	17,241,390
Plan fiduciary net position – beginning	181,562,247	160,048,471	138,095,447	117,347,487	97,034,191	89,962,735	82,651,970	65,410,580
Plan fiduciary net position – ending	239,440,651	181,562,247	160,048,471	138,095,447	117,347,487	97,034,191	89,962,735	82,651,970
Plan net pension liability – ending	$ 577,854	$ 30,620,005	$ 27,122,873	$ 23,602,064	$ 25,100,820	$ 15,430,763	$ 6,536,809	$ 1,059,495
Plan fiduciary net position as percentage of the total liability	99.76%	85.57%	85.51%	85.40%	82.38%	86.28%	93.23%	98.73%
Covered-employee payroll	$ 103,913,095	$ 98,088,822	$ 91,587,145	$ 85,764,390	$ 80,217,654	$ 68,583,296	$ 55,676,606	$ 40,940,556
Plan net pension liability as a percentage of covered-employee payroll	0.56%	31.22%	29.61%	27.52%	31.29%	22.50%	11.74%	2.59%

See accompanying report of independent auditors.

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Orange County Health Authority, a Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Schedule of Plan Contributions

	Years Ended June 30,							
	2022	2021	2020	2019	2018	2017	2016	2015
Actuarially determined contributions	$ 10,742,812	$ 9,608,656	$ 8,661,466	$ 7,588,200	$ 5,234,580	$ 3,787,544	$ 3,033,171	$ 3,119,804
Contributions in relation to the actuarially determined contribution	(10,742,812)	(9,608,656)	(8,661,466)	(7,588,200)	(5,234,580)	(3,787,544)	(3,033,171)	(3,119,804)
Contribution deficiency (excess)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Covered-employee payroll	$ 103,913,095	$ 98,088,822	$ 91,587,145	$ 85,764,390	$ 80,217,654	$ 68,583,296	$ 55,676,606	$ 40,940,556
Contributions as a percentage of covered-employee payroll	10.34%	9.80%	9.46%	8.85%	6.53%	5.52%	5.45%	7.62%

See accompanying report of independent auditors.

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Orange County Health Authority, a Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Schedule of Changes in Total OPEB Liability and Related Ratios

	2021-2022 (Measurement Period 2020–2021)	2020-2021 (Measurement Period 2019–2020)	2019–2020 (Measurement Period 2018–2019)	2018–2019 (Measurement Period 2017–2018)	2017–2018 (Measurement Period 2016–2017)
Changes in total OPEB liability					
Service cost	$ 1,149,000	$ 811,000	$ 832,000	$ 867,000	$ 1,012,000
Interest	718,000	922,000	977,000	900,000	770,000
Actual vs. expected experience	(6,241,000)	-	(1,072,000)	-	-
Assumption changes	(4,514,000)	4,623,000	938,000	(1,067,000)	(2,923,000)
Benefit payments	(544,000)	(570,000)	(556,000)	(560,000)	(572,000)
Net changes	(9,432,000)	5,786,000	1,119,000	140,000	(1,713,000)
Total OPEB liability (beginning of year)	31,610,000	25,824,000	24,705,000	24,565,000	26,278,000
Total OPEB liability (end of year)	$ 22,178,000	$ 31,610,000	$ 25,824,000	$ 24,705,000	$ 24,565,000
Total OPEB liability	$ 22,178,000	$ 31,610,000	$ 25,824,000	$ 24,705,000	$ 24,565,000
Covered employee payroll	9,126,000	8,513,000	8,353,000	8,150,000	9,135,000
Total OPEB liability as a percentage of covered employee payroll	243.0%	371.3%	309.2%	303.1%	268.9%

See accompanying report of independent auditors.

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MOSSADAMS

CalOptima Health

2022 AUDIT RESULTS

Discussion with the Board of Directors (the “Board”)
October 6, 2022

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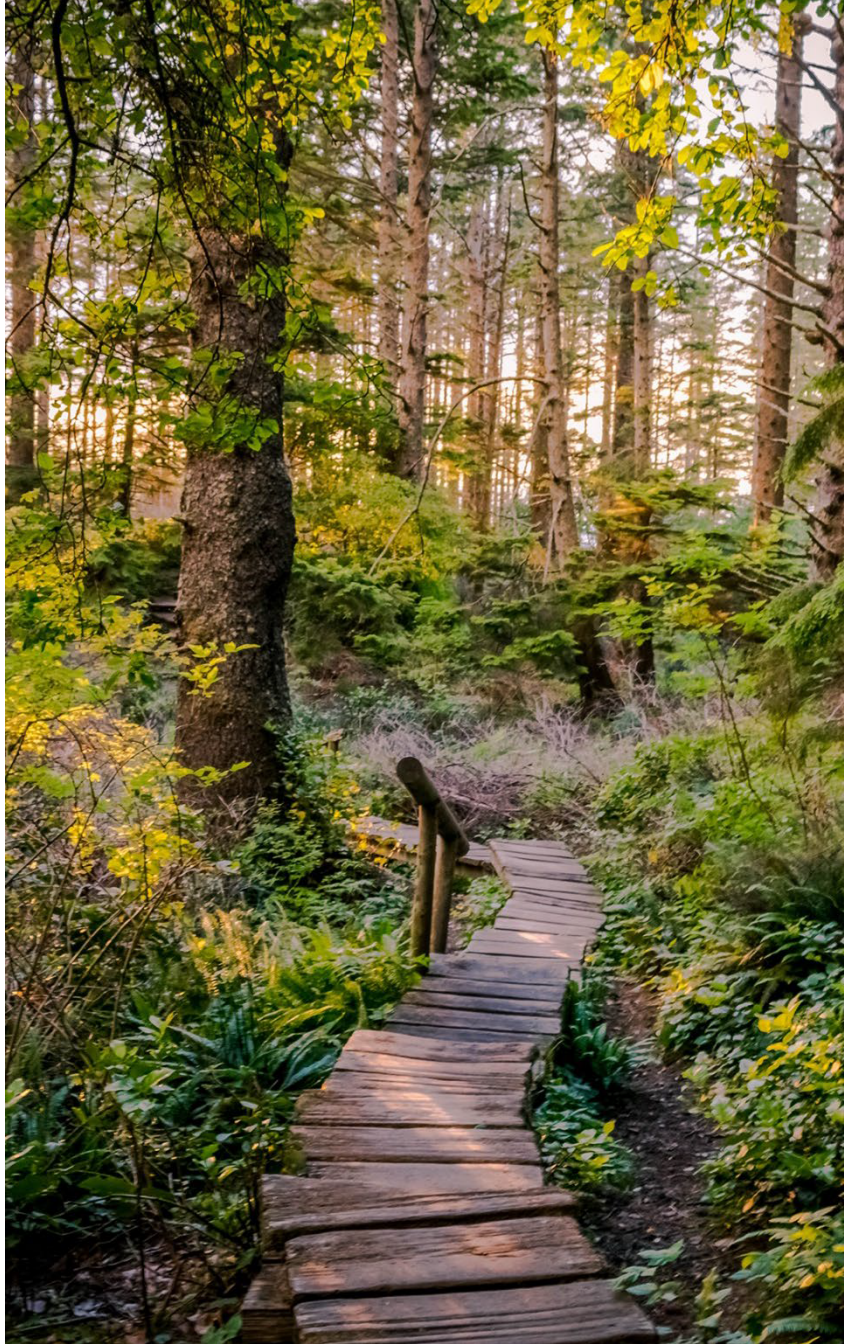
Agenda

1. Scope of Services
2. Summary of Audit Process
3. Areas of Audit Emphasis
4. Matters Required to Be Communicated to the Board
5. Your Service Team

EXHIBIT

Exhibit 1 – Management Representation Letter



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Scope of Services

We have performed the following services for CalOptima Health:

Annual Audit

Annual financial statement audit as of and for the year ended June 30, 2022.

Non-Attest Services

- Assisted management with drafting the financial statements, excluding Management's Discussion and Analysis, as of and for the year ended June 30, 2022.
- Assisted in the completion of the Auditee portion of the Data Collection Form for the single audit as of and for the year ended June 30, 2022.

Summary of Audit Process

- Our audit was generally performed in accordance with our initial plan. When the results of a planned audit procedure did not provide sufficient evidence or our original plan was based on an incorrect understanding of a transaction, process, or accounting policy of the entity, we made the necessary adjustments to our audit plan to incorporate the procedures necessary to support our opinion on the financial statements.

- We have completed our testing of all significant account balances and classes of transactions.

- We issued our independent auditor's report and have communicated required internal control related matters dated September 20, 2022.

Areas of Audit Emphasis

During the audit, we identified the following:

Significant Risks	Procedures
Medical claims liability and claims expense	• Tested the internal controls for claims payments and provider capitation systems • Tested the data used by the actuary to estimate the claims liability and reviewed the experience and qualifications of the actuary • Performed a retrospective review of the prior year's claims liability
Capitation revenue and receivables	• Developed independent expectations of revenue using membership data and rates • Obtained an understanding of management's reserve methodology and validated key inputs through our audit procedures • Verified subsequent receipt of cash and other substantive procedures
Amounts due to the State of California or DHCS	• Tested the provider capitation and other accrual calculations and agreed amounts accrued to subsequent payments • Obtained an understanding of the nature of the amounts payable to the State of California • Tested inputs into the estimates used to calculate the amounts due

Matters Required to Be Communicated to the Board

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

The objectives of our audit are also to evaluate the presentation of the supplementary information in relation to the financial statements as a whole and report on whether the supplementary information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Matters Required to Be Communicated to the Board

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS) as well as *Government Auditing Standards*, issued by the Comptroller General of the United States. As part of an audit conducted in accordance with these auditing standards, we exercised professional judgment and maintained professional skepticism throughout the audit.

Matters Required to Be Communicated to the Board

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

Our audit of the financial statements included obtaining an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control or to identify deficiencies in the design or operation of internal control. Accordingly, we considered the entity's internal control solely for the purpose of determining our audit procedures and not to provide assurance concerning such internal control.

Matters Required to Be Communicated to the Board

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are also responsible for communicating significant matters related to the financial statement audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

The supplementary information was subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves.

Matters Required to Be Communicated to the Board

MATTERS TO BE COMMUNICATED

Significant Accounting Practices

Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures.

MOSS ADAMS COMMENTS

The quality of the entity's accounting policies and underlying estimates are discussed throughout this presentation. There were no changes in the entity's approach to applying the critical accounting policies.

- Significant management estimates impacted the financial statements including the following: **fair value of investments, capital asset lives, actuarially determined accruals for incurred but not reported (IBNR) medical claims liabilities, other non-IBNR medical liabilities, pension, and other postemployment liabilities.**

Matters Required to Be Communicated to the Board

MATTERS TO BE COMMUNICATED

Significant Accounting Practices

Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures.

MOSS ADAMS COMMENTS

The disclosures in the financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statements users. We call your attention to the following notes:

- Note 3 – Cash, Cash Equivalents, and Investments
- Note 5 – Medical Claims Liability
- Note 6 – Defined Benefit Pension Plan
- Note 8 – Postemployment Health Care Plan

Matters Required to Be Communicated to the Board

MATTERS TO BE COMMUNICATED	MOSS ADAMS COMMENTS
Significant Unusual Transactions	No significant unusual transactions were identified during our audit of the entity's financial statements.

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Matters Required to Be Communicated to the Board

MATTERS TO BE COMMUNICATED

Significant Difficulties Encountered During the Audit

We are to inform those charged with governance of any significant difficulties encountered in performing the audit. Examples of difficulties may include significant delays by management, an unreasonably brief time to complete the audit, unreasonable management restrictions encountered by the auditor, or an unexpected extensive effort required to obtain sufficient appropriate audit evidence.

MOSS ADAMS COMMENTS

No significant difficulties were encountered during our audit of the entity's financial statements.

Matters Required to Be Communicated to the Board

MATTERS TO BE COMMUNICATED

Disagreements With Management

Disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the entity's financial statements, or the auditor's report.

MOSS ADAMS COMMENTS

There were no disagreements with management.

Matters Required to Be Communicated to the Board

MATTERS TO BE COMMUNICATED

Circumstances that Affect the Form and Content of the Auditor's Report

MOSS ADAMS COMMENTS

There were no circumstances that affected the form and content of the auditor's report.

Matters Required to Be Communicated to the Board

MATTERS TO BE COMMUNICATED

Other Findings or Issues Arising from the Audit that are, in the Auditor's Professional Judgment, Significant and Relevant to Those Charged with Governance Regarding their Oversight of the Financial Reporting Process

MOSS ADAMS COMMENTS

There were no other findings or issues arising from the audit to report.

Matters Required to Be Communicated to the Board

MATTERS TO BE COMMUNICATED

Uncorrected Misstatements

MOSS ADAMS COMMENTS

Uncorrected misstatements, or matters underlying those uncorrected misstatements, as of and for the year ended June 30, 2022, could potentially cause future-period financial statements to be materially misstated. No uncorrected misstatements were noted during the audit.

Matters Required to Be Communicated to the Board

MATTERS TO BE COMMUNICATED

Material, Corrected Misstatements

Material, corrected misstatements that were brought to the attention of management as a result of audit procedures.

MOSS ADAMS COMMENTS

No material misstatements were identified as a result of our audit, nor any uncorrected misstatements identified as previously discussed.

Matters Required to Be Communicated to the Board

MATTERS TO BE COMMUNICATED

Representations Requested of Management

We requested certain representations from management that are included in the management representation letter dated September 20, 2022.

MOSS ADAMS COMMENTS

See Exhibit 1.

Matters Required to Be Communicated to the Board

MATTERS TO BE COMMUNICATED

Management's Consultation with Other Accountants

When we are aware that management has consulted with other accountants about significant auditing or accounting matters, we discuss with those charged with governance our views about the matters that were the subject of such consultation.

MOSS ADAMS COMMENTS

We are not aware of instances where management consulted with other accountants about significant auditing or accounting matters.

Matters Required to Be Communicated to the Board

MATTERS TO BE COMMUNICATED

Significant Issues Arising from the Audit that Were Discussed, or the Subject of Correspondence with Management

MOSS ADAMS COMMENTS

No significant issues arose during the audit that have not been addressed elsewhere in this presentation.

Matters Required to Be Communicated to the Board

MATTERS TO BE COMMUNICATED

AU-C 240, *Consideration of Fraud in a Financial Statement Audit*

AU-C 250, *Consideration of Laws and Regulations in an Audit of Financial Statements*

AU-C 265, *Communicating Internal Control Related Matters Identified in an Audit*

AU-C 550, *Related Parties*

AU-C 560, *Subsequent Events and Subsequently Discovered Facts*

AU-C 570, *The Auditor's Consideration of An Entity's Ability to Continue as a Going Concern*

AU-C 600, *Audits of Group Financial Statements (Including the Work of Component Auditors)*

MOSS ADAMS COMMENTS

Nothing to note other than there were no material weaknesses noted and no significant deficiencies to communicate.

Matters Required to Be Communicated to the Board

MATTERS TO BE COMMUNICATED

AU-C 701, *Communicating Key Audit Matters in the Independent Auditor's Report*

AU-C 705, *Modifications to the Opinion in the Independent Auditor's Report*

AU-C 706, *Emphasis-of-Matter Paragraphs and Other-Matter Paragraphs in the Independent Auditor's Report*

AU-C 720, *The Auditor's Responsibilities Relating to Other Information Included in Annual Reports*

AU-C 730, *Required Supplementary Information*

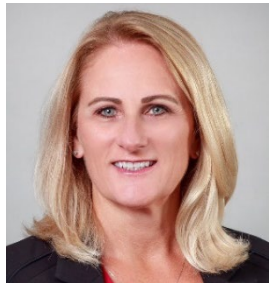
AU-C 930, *Interim Financial Information*

AU-C 935, *Compliance Audits*

MOSS ADAMS COMMENTS

Nothing to note.

Your Service Team

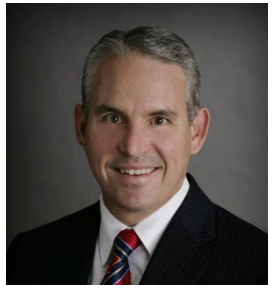


Stacy J. Stelzriede
Audit Engagement Partner

Stacy.stelzriede@mossadams.com
949-517-2684

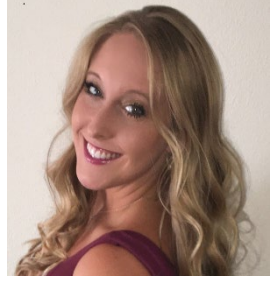
Aparna Venkateswaran
Engagement Reviewer

Aparna.venkateswaran@mossadams.com
949-517-9473



Chris Pritchard
Concurring Reviewer

Chris.pritchard@mossadams.com
415-677-8262



Ashley Merda
Audit Manager

Ashley.merda@mossadams.com
949-517-9431

Exhibit 1
Management Representation Letter

DocuSign Envelope ID: 1A33B8EF-7416-4475-82CA-8555A2605076

CalOptima Health

CalOptima Health
A Public Agency
505 City Parkway West
Orange, CA 92868
☎ 714-246-8400
TTY: 711
caloptima.org

September 20, 2022

Moss Adams LLP
2040 Main Street, Suite 900
Irvine, CA 92614

We are providing this letter in connection with your audit of the financial statements of Orange County Health Authority, A Public Agency, dba Orange Prevention & Treatment Integrated Medical Assistant, dba CalOptima Health which comprise the statements of net position and the related statements of revenues, expenses, and changes in net position, and cash flows as of June 30, 2022, and June 30, 2021, and for the years then ended and the related notes to the financial statements for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP). Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Except where otherwise stated below, immaterial matters less than $5,000,000 collectively are not considered to be exceptions that require disclosure for the purpose of the following representations. This amount is not necessarily indicative of amounts that would require adjustment to or disclosure in the financial statements.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of the date of this letter.

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated on March 3, 2021, for the preparation and fair presentation of the financial statements in accordance with U.S. GAAP.
2. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.
3. We acknowledge our responsibility for the design, implementation, and maintenance of internal controls to prevent and detect fraud.
4. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.
5. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.

Full letter available upon request

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THANK YOU

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Approve Amendments to Mental Health Provider Contracts to Increase Rates for Medi-Cal Outpatient Counseling Services.

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health Integration, (714) 796-6168
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Action

Authorize amendments to the Medi-Cal fee-for-service mental health provider contracts to reflect increases to reimbursement rates effective January 1, 2023.

Background

CalOptima Health is required by the Department of Health Care Services (DHCS) to provide non-specialty mental health services that include outpatient counseling under All Plan Letter 22-006, Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services. CalOptima Health is also required to provide mental health services in accordance with timely access standards, pursuant to Welfare and Institutions Code section 14197 and the contract with DHCS.

On January 1, 2018, CalOptima Health assumed responsibility for mental health services from its external vendor and established a network of contracted mental health providers. In 2021, over 20,000 CalOptima Health members received outpatient mental health counseling services. So far in calendar year 2022 through August, approximately 30,000 members have accessed counseling services. The need for mental health services continues to increase, particularly the need for outpatient counseling and therapy services.

CalOptima Health's contracted network of mental health psychologists and therapists plays a vital role in providing these services to members. In order to maintain a comprehensive network to provide required mental health services, staff recommends increasing the Medi-Cal mental health provider reimbursement rates.

Discussion

The COVID-19 pandemic has had widespread effects on mental health and the continued need for mental health services. CalOptima Health anticipates a future increase in the need for mental health services as well, and therefore seeks to be proactive and address this issue thoughtfully and comprehensively.

CalOptima Health assessed market equivalency with commercial and Medi-Cal organizations and payers and determined that an increase in reimbursement rates is needed to compete in the market and to ensure CalOptima Health's members have continued quality care.

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The proposed amendments will increase rates for Medi-Cal FFS mental health outpatient assessment and counseling services by an average of 22.9% effective January 1, 2023. Rate increases will vary by provider type, impacted by their corresponding service mix, ranging from a 0% to an approximate 100% increase above current funding. This action will support continued quality care for CalOptima Health's members.

Fiscal Impact

The recommended action to amend Medi-Cal fee-for-service mental health provider contracts has an annual fiscal impact of approximately $4.3 million. The proposed rate adjustment for the period of January 1, 2023, through June 30, 2023, is a budgeted item under the Fiscal Year 2022-23 Operating Budget approved by the Board on June 2, 2022. Management will include updated medical expenses in future operating budgets.

Rationale for Recommendation

The rate increases to the Medi-Cal FFS mental health provider contracts will help support quality, network adequacy and continued access to required mental health services.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Proposed Mental Health provider contract amendment
2. APL22-006 MEDI-CAL MANAGED CARE HEALTH PLAN RESPONSIBILITIES FOR NON-SPECIALTY MENTAL HEALTH SERVICES

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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ATTACHMENT B
CONFIDENTIAL COMPENSATION TERMS

CalOptima shall reimburse Professional and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. MEDI-CAL PROGRAM

For Covered Services provided to referred Medi-Cal Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

CalOptima
Medi-Cal Mental Health Fee Schedule

CPT	Procedure Description	Physician (AF Modifier)	Psychologist (AH Modifier)	Master's level (AJ or HO Modifier)	Clinical Nurse Specialist / Physician Asst. (AS Modifier)	Registered Psych Assist / Assoc. Social Worker / MFTI (HL Modifier)
90791	Psychiatric Diagnostic Evaluation – No Medical Svcs	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90792	Psychiatric Diagnostic Evaluation With Medical Svcs	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90832	Psychotherapy W/patient, 30 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90834	Psychotherapy W/patient, 45 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90837	Psychotherapy W/ Patient, 60 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90846	Family Psychotherapy W/o Patient, 50 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90847	Family Psychotherapy W/ Patient, 50 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90849	Multiple-family Group Psychotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90853	Group Psychotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96116	Neurobehavioral Stats Exam	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99203	Office Outpatient Visit, New Patient, 30 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99204	Office Outpatient Visit, New Patient, 45 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99205	Office Outpatient Visit, New Patient, 60 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99211	Office Outpatient Visit, Established Patient, 5 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99212	Office Outpatient Visit, Established Patient, 10 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99213	Office Outpatient Visit, Established Patient, 15 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99214	Office Outpatient Visit, Established Patient, 25 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99215	Office Outpatient Visit, Established Patient, 40 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99241	Outpatient Consultation, Straightforward, 15 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

CPT	Procedure Description	Physician (AF Modifier)	Psychologist (AH Modifier)	Master's level (AJ or HO Modifier)	Clinical Nurse Specialist / Physician Asst. (AS Modifier)	Registered Psych Assist / Assoc. Social Worker / MFTI (HL Modifier)
99242	Outpatient Consultation, Straightforward, 30 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99243	Outpatient Consultation, Straightforward, 40 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99244	Outpatient Consultation, Moderate Complexity, 60 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99304	Nursing Facility Consultation, Low Complexity, 25 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99305	Nursing Facility Consultation, Moderate Complexity, 35 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99306	Nursing Facility Consultation, High Complexity, 45 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99307	Subsequent Nursing Facility Consultation, Straightforward, 10 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99308	Subsequent Nursing Facility Consultation, Low Complexity, 15 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99309	Subsequent Nursing Facility Consultation, Moderate Complexity, 25 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99310	Subsequent Nursing Facility Consultation, High Complexity, 35 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99326	Domiciliary/rest Home/custodial Care Services, New Patient, 45 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99327	Domiciliary/rest Home/custodial Care Services, New Patient, 60 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99334	Domiciliary/rest Home/custodial Care Services, Established Patient, 15 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99335	Domiciliary/rest Home/custodial Care Services, Established Patient, 25 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99336	Domiciliary/rest Home/custodial Care Services, Established Patient, 40 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99337	Domiciliary/rest Home/custodial Care Services, Established Patient, 60 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99343	Home Psychotherapy, New Patient, 45 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99344	Home Psychotherapy, New Patient, 60 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99347	Home Psychotherapy, Established Patient, 15 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99348	Home Psychotherapy, Established Patient, 25 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99349	Home Psychotherapy, Established Patient, 40 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99350	Home Psychotherapy, Established Patient, 60 Min	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

CPT	Procedure Description	Physician (AF Modifier)	Psychologist (AH Modifier)	Master's level (AJ or HO Modifier)	Clinical Nurse Specialist / Physician Asst. (AS Modifier)	Registered Psych Assist / Assoc. Social Worker / MFTI (HL Modifier)
99367	Medical Team Conference With Interdisciplinary Team Of Health Care Professionals, Patient And/or Family Not Present, 30 Min Or More; Participation By Physician	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99368	Medical Team Conference With Interdisciplinary Team Of Health Care Professionals, Patient And/or Family Not Present, 30 Min Or More; Participation By Nonphysician Qualified Health Care Professional	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

NOTES:

1. Discipline levels will vary from state to state. N/B indicates a non-billable service for this discipline level.
2. Reimbursement is based on the treating provider's licensure, certification, and CalOptima credentialing requirements for that discipline, and is not based on provider's academic credentials alone.
3. Rates include reimbursement for travel time and expense.
4. Rates for all services are subject to the provisions and limitations of the member's benefit plan including authorization requirements. Nothing in this schedule should be construed as altering member's benefits.
5. The coding definitions (e.g., DRGs, ICD Codes, Procedures, CPT Codes) assigned in this Agreement shall be considered automatically updated based on revised codes and newly introduced codes consistent with guidance provided from the organization(s) responsible for code set updates (e.g. DHS, AMA, WHO, etc.), as applicable, and consistent with industry standards. If codes are changed by addition or deletion as stated in the current year's Coding Publications, it is understood that services will automatically convert to the new code(s) that best apply to the service.
6. Any CPT or HCPCS code not contained in the above fee schedule at the time of service shall default at one hundred percent (100%) of the Current CalOptima Medi-Cal Fee Schedule, as defined in CalOptima Policy for those services. Medi-Cal billing rules and payment and authorization policies and guidelines for billing and payment will apply.
7. Claims not submitted with the appropriate modifier are not reimbursable and will be denied.

II. PACE PROGRAM

Not Applicable to this Contract

III. ONECARE AND ONECARE CONNECT PROGRAMS

For Covered Services provided to OneCare and OneCare Connect Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima the lesser of billed charges or:

Psychiatrist (MD)	Psychologist or PhD	Nurse Practitioner (NP), Physician Assistant (PA)	Licensed Clinical Social Worker (LCSW)	Marriage, Family, Therapist (MFT)
[redacted] of the current year CalOptima Medicare Allowable Participating Fee Schedule for locality 26.	[redacted] of the current year CalOptima Medicare Allowable Participating Fee Schedule for locality 26.	[redacted] of the current year CalOptima Medicare Allowable Participating Fee Schedule for locality 26.	[redacted] of the current year CalOptima Medicare Allowable Participating Fee Schedule for locality 26.	[redacted]

1. Prior authorization rules apply for payment of services.
2. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.
3. Services with Un-established Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   3.1 "By Report & Unlisted" codes will be paid at forty percent (40%) of billed charges and follow Medicare billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

   3.2 Professional shall utilize current payment codes and modifiers for Medicare.

   3.3 CPT or HCPCS codes not contained in the Medicare fee schedule at the time of services are not reimbursable.

   3.4 Should Medicare consider a service as non-covered, then Medi-Cal guidelines and reimbursement shall be applied in accordance to the guidelines identified in this contract. Professional may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

   3.5 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

IV. PAYMENT PROCEDURES

1. CalOptima agrees to grant Professional access to Member management information systems. Professional agrees to verify each Member's eligibility to receive Covered Services on the date of service.
2. Billing and Claims Submission. Professional shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.
3. Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and Procedures.
4. Claim Completion and Accuracy. Professional shall be responsible for the completion and accuracy of all Claims submitted, whether on paper forms or electronically, including claims submitted for

the Professional by other parties. Use of a billing agent does not abrogate Professional's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Professional acknowledges that Professional remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

5. Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Professional notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

6. Coordination of Benefits (COB). Professional shall coordinate benefits with other programs or entitlements recognizing where Other Health Coverage (OHC) is primary coverage in accordance with CalOptima Program requirements. Professional acknowledges that Medi-Cal is the payor of last resort.

7. Crossover Claims – Dual Eligible Members. "Crossover Claims" are claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or other health care coverage (OHC) is the Primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services (Refer to Welfare and Institutions Code, Section 14109.5.)

   "Dual Eligible Members" are members who are eligible for both Medicare or other health care coverage (OHC) and Medi-Cal benefits.

   The Medi-Cal reimbursement rates in this contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims payment CalOptima will reimburse in accordance with CalOptima Policies, and state and federal regulations.

8. Member Financial Protections. Professional shall comply with Member financial protections as follows:

   8.1 Professional agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Professional for any amounts which are owed by, or are the obligation of, CalOptima.

   8.2 Professional agrees to hold Member harmless and not liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Professional may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Professional will:

      1) accept the plan payment as payment in full, or

      2) bill the appropriate State source.

   8.3 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or the Professional's insolvency, or breach of this contract by CalOptima, shall the Professional, or any of its Practitioners, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Professional may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

8.4 This provision does not prohibit Professional from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

8.5 Upon receiving notice of Professional invoicing or balance billing a Member for the difference between the Professional's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Professional or take other action as provided in this Contract.

This Section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between Professional and its Practitioners. Language to ensure the foregoing shall be included in all of Professional's Subcontracts.

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

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: April 8, 2022

ALL PLAN LETTER 22-006
SUPERSEDES ALL PLAN LETTER 17-018

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN RESPONSIBILITIES FOR NON-SPECIALTY MENTAL HEALTH SERVICES

PURPOSE:
The purpose of this All Plan Letter (APL) is to explain the responsibilities of Medi-Cal managed care health plans (MCPs) for the provision or arrangement of clinically appropriate and covered non-specialty mental health services (NSMHS) and the regulatory requirements for the Medicaid Mental Health Parity Final Rule (CMS-2333-F). This APL also delineates MCP responsibilities for referring to, and coordinating with, County Mental Health Plans (MHPs) for the delivery of specialty mental health services (SMHS). This APL supersedes APL 17-018.[1]

BACKGROUND:
With the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department of Health Care Services (DHCS) aims to address Medi-Cal beneficiaries' needs across the continuum of care, ensure that all beneficiaries receive coordinated services, and improve beneficiary health outcomes. DHCS' goal is to ensure that beneficiaries have access to the right care, in the right place, at the right time. CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including requirements regarding SMHS and NSMHS.[2]

Medical Necessity for SMHS
The federal Section 1915(b) Medi-Cal Waiver requires Medi-Cal members needing SMHS to access these services through MHPs.[3] For individuals under 21 years of age and in accordance with California Welfare & Institutions Code (W&I Code) sections

[1] APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[2] For more information regarding CalAIM, please visit the CalAIM webpage at: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx.
[3] SHMS Waiver Information can be found at: http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx.

14059.5 and 14184.402, a service is "medically necessary" or a "medical necessity" if the service meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard set forth in Section 1396d(r)(5) of Title 42 of the United States Code (USC).[4]

The federal EPSDT mandate requires states to furnish all services it defines as appropriate and medically necessary services that could be covered under Medicaid 42 USC Section 1396d(a) necessary to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the state's Medicaid State Plan.

Consistent with federal guidance from the Centers for Medicare & Medicaid Services (CMS), behavioral health services need not be curative or completely restorative to ameliorate a behavioral health condition.[5] Services that sustain, maintain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and are covered under the EPSDT mandate.

By contrast, for members who are 21 years of age and older, a service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.[6]

County MHPs are contractually required to provide or arrange for the provision of SMHS for members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder, in accordance with SMHS access criteria described in Behavioral Health Information Notice (BHIN) No: 21-073.[7]

---

[4] State law is searchable at: https://leginfo.legislature.ca.gov/faces/codes.xhtml.
See Section 1396d(r)(5) of Title 42 of the USC (requiring provision of all services that are coverable under Section 1905(a) of the Social Security Act (42 U.S.C. § 1396d(a)) and that are necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan) The USC is searchable at: https://uscode.house.gov/.
[5] CMS' federal EPSDT guidance can be found at: https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf.
[6] W&I Code section 14059.5.
[7] 2021 BHINs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/2021-MHSUDS-BH-Information-Notices.aspx.

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POLICY:

Medical Necessity for NSMHS

In accordance with W&I Code sections 14059.5 and 14184.402, for individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the EPSDT standard set forth in Section 1396d(r)(5) of Title 42 of the USC.

The federal EPSDT mandate requires states to furnish all appropriate and medically necessary services that could be covered under a Medicaid State Plan (as described in 42 USC Section 1396d(a)) as needed to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the state's Medicaid State Plan.

Consistent with federal guidance from CMS, behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and are covered as EPSDT services.

In accordance with W&I Code sections 14059.5 and 14184.402, for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

MCP Responsibility for NSMHS[8, 9,10]

MCPs must provide or arrange for the provision of the following NSMHS:

1. Mental health evaluation and treatment, including individual, group and family psychotherapy.
2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
3. Outpatient services for the purposes of monitoring drug therapy;
4. Psychiatric consultation.
5. Outpatient laboratory, drugs,[11] supplies, and supplements.

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[8] The Medi-Cal Provider Manual, Non-Specialty Mental Health Services: Psychiatric and Psychological Services is available at https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/nonspecmental.pdf.

[9] W&I Code Section 14184.402

[10] More information regarding MCPs' responsibility for alcohol and substance use disorder screening, referral, and services can be accessed in APL 21-014.

[11] This does not include medications covered under the Medi-Cal Rx Contract Drug List, which can be accessed at: https://medi-calrx.dhcs.ca.gov/home/cdl/

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MCPs must provide or arrange for the provision of NSMHS for the following populations:

- Members who are 21 years of age and older 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;[12]
- Members who are under the age of 21, to the extent they are eligible for services through the EPSDT benefit, regardless of the level of distress or impairment, or the presence of a diagnosis;[13] and,
- Members of any age with potential mental health disorders not yet diagnosed.

In addition to the above requirements, MCPs must provide psychotherapy to members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder. MCPs are also required to cover up to 20 individual and/or group counseling sessions for pregnant and postpartum individuals with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth. Details regarding NSMHS psychiatric and psychological services, including psychotherapy coverage, Current Procedural Terminology (CPT) codes that are covered, and information regarding eligible provider types can be found in the Medi-Cal Provider Manual, Non-Specialty Mental Health Services: Psychiatric and Psychological Services.[14]

Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications. Supplies may include laboratory supplies.

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[12] Presence of a neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a recipient meets criteria to receive NSMHS. However, MCPs must provide or arrange for NSMHS for recipients with any of these or other co-occurring physical health or substance use disorders if they also have a mental health disorder (or potential mental health disorders not yet diagnosed) and meet criteria for NSMHS.

[13] See Section 1396d(r)(5) of Title 42 of the USC (requiring provision of all services that are coverable under Section 1905(a) of the Social Security Act (42 USC Section 1396d(a)) and that are necessary to correct or ameliorate a condition, including a behavioral health condition discovered by a screening service, whether or not such services are covered under the State Plan. The USC is searchable at: https://uscode.house.gov/.

[14] Medi-Cal Provider Manuals are searchable at: https://files.medi-cal.ca.gov/pubsdoco/manuals_menu.aspx. The Medi-Cal Provider Manual, Non-Specialty Mental Health Services: Psychiatric and Psychological Services is available at https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/nonspecmental.pdf

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Consistent with state law, clinically appropriate and covered NSMHS are covered by MCPs even when:[15]

1) Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;
2) Services are not included in an individual treatment plan;
3) The member has a co-occurring mental health condition and substance use disorder (SUD); or
4) NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

More information regarding 1 to 4 and the No Wrong Door for Mental Health Services Policy can be found in APL 22-005.

At any time, members can choose to seek and obtain a mental health assessment from a licensed mental health provider within the MCP's provider network. Each MCP is obligated to ensure that a mental health screening of members is conducted by network Primary Care Providers (PCP). Members with positive screening results may be further assessed either by the PCP or by referral to a network mental health provider. The member may then be treated by the PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP must refer the member to a mental health provider, first attempting to refer within the MCP network.

DHCS is developing a set of statewide tools (effective in 2023 pursuant to future guidance) to facilitate screenings and transitions care for the specialty mental health, Medi-Cal managed care, and fee for service systems. Future guidance regarding these tools will be provided through future updates to APL 22-005, No Wrong Door For Mental Health Services Policy.

MCPs must cover outpatient laboratory tests, drugs,[16] supplies, and supplements prescribed by mental health providers in the MCP's network and PCPs, including physician administered drugs administered by a health care professional in a clinic, physician's office, or outpatient setting through the medical benefit, to assess and treat mental health conditions. The MCP may require that NSMHS for adults are provided through the MCP's provider network, subject to a medical necessity determination.

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[15] See W&I Code section 14184.402(f).
[16] This does not include medications covered under the Medi-Cal Rx Contract Drug List, which can be accessed at: https://medi-calrx.dhcs.ca.gov/home/cdl/

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Consistent with APL 21-006[17] or subsequent guidance, the MCP must ensure that its network is adequate to provide the full range of covered NSMHS to its members.

MCPs must also cover and pay for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations (CCR).[18] This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member. Emergency services include facility and professional services and facility charges claimed by emergency departments.

MCP Responsibility for Alcohol and Substance Use Disorder Screening, Referral, and Services

MCPs must provide covered SUD services, including alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) for members ages 11 and older, including pregnant members, in primary care settings and tobacco, alcohol, and illicit drug screening in accordance with American Academy of Pediatrics Bright Futures for Children recommendations and United States Preventive Services Taskforce grade A and B recommendations for adults as outlined in APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. Further, MCPs must provide or arrange for the provision of:

- Medications for Addiction Treatment (also known as Medication-Assisted Treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings.
- Emergency services necessary to stabilize the member.[19]

Care Management and Care Coordination

MCPs continue to be required to provide medical case management and cover and pay for all medically necessary Medi-Cal-covered physical health care services for an member receiving SMHS. The MCP must coordinate care with the MHP. The MCP is responsible for the appropriate management of a member's mental and physical health

[17] Network Certification Requirement, APL 21-006: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-006.pdf

[18] The CCR is searchable at: https://govt.westlaw.com/calregs/index?__lrTS=20210423013246097&transitionType=Default&contextData=%28sc.Default%29.

[19] Including voluntary inpatient detoxification as a benefit available to MCP members through the Medi-Cal fee-for-service program, as described in APL 18-001.

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care, which includes, but is not limited to, medication reconciliation and the coordination of all medically necessary, contractually required Medi-Cal-covered services, including mental health services, both within and outside the MCP's provider network.

Mental Health Parity

Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR) provides that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits.[20] This precludes any restrictions to a member's access to an initial mental health assessment. Therefore, MCPs must not require prior authorization for an initial mental health assessment.

DHCS recognizes that while many PCPs provide initial behavioral health assessments but not all do. If a member's PCP cannot perform the mental health assessment, they must refer the member to the appropriate provider and ensure that the referral to the appropriate delivery system for mental health services, either in the MCP's provider network or the county mental health plan's network, is made in accordance with the No Wrong Door policies set forth in W&I Code section 14184.402(h) and APL 22-005.

MCPs must ensure direct access to an initial mental health assessment by a licensed mental health provider within the MCP's provider network. MCPs must not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a mental health network provider. MCPs must notify members of this policy, and the MCP's member informing materials must clearly state that referral and prior authorization are not required for a member to seek an initial mental health assessment from a network mental health provider. MCPs are required to cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely and geographical access requirements set forth in APL 19-002 or subsequent guidance.

If further services are needed that require authorization, MCPs are required to follow guidance developed for mental health parity, as set out below.

MCPs must disclose the utilization management or utilization review policies and procedures that they utilize to DHCS, their Network Providers, and any Subcontractors they use to authorize, modify, or deny health care services via prior authorization, concurrent authorization or retrospective authorization, under the benefits included in the MCP contract.

[11] See 42 CFR Subpart K – Parity in Mental Health and Substance Use Disorder Benefits: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-K.

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MCPs' policies and procedures (P&P) must ensure that authorization determinations are based on the requested medically necessary health care service in a manner that is consistent with current evidence-based clinical practice guidelines. Such utilization management P&Ps may also take into consideration the following:

- Service type.
- Appropriate service usage.
- Cost and effectiveness of service and service alternatives.
- Contraindications to service and service alternatives.
- Potential fraud, waste, and abuse.
- Patient and medical safety.
- Providers' adherence to quality and access standards.
- Other clinically relevant factors.

The P&Ps must be consistently applied to medical/surgical, mental health, and SUD benefits. The MCP must notify network providers of all services that require prior authorization, concurrent authorization or retrospective authorization and ensure that all network providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

The disclosure requirements for MCPs include making utilization management criteria for medical necessity determinations for mental health and SUD benefits available to members, eligible beneficiaries, and network providers upon request in accordance with Title 42, CFR, Section 438.915(a). MCPs must also provide to members the reason for any denial or partial denial for reimbursement or payment of services or any other adverse benefit determination for mental health or SUD in accordance with Title 42, CFR, Section 438.915(b). In addition, all services must be provided in a culturally and linguistically appropriate manner.[21]

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's P&Ps, the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

[21] Cultural and Linguistic Requirements can be found in Title 22 CCR Section 53876.

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MCPs are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.[22] These requirements must be communicated by each MCP to all subcontractors and network providers. If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[22] For more information on subcontractors and network providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

17. Approve Actions Related to the Procurement of a Cybersecurity Asset Management Software Solution

Contacts

Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
David O'Brien, Sr. Director, Information Technology Services, (657) 900-1269

Recommended Actions

1. Authorize reallocation of budgeted but unused funds in an amount up to $400,000 from the "Network Bandwidth Upgrade for All Sites (Wide Area Network)" capital project to a new project "Cybersecurity Asset Management Software Solution" under the "Infrastructure" category in the CalOptima Health Fiscal Year (FY) 2022-2023 Digital Transformation Year One Capital Budget;
2. Approve the scope of work (SOW) for the Cybersecurity Asset Management Software Solution; and
3. Authorize the Chief Executive Officer to release the Cybersecurity Asset Management Software Solution request for proposal (RFP) with the approved SOW, and to negotiate and contract with the selected vendor.

Background

As part of CalOptima Health's Workplace Modernization and Digital Transformation Strategy, Information Technology Services will be evaluating and deploying multiple solutions. These solutions coincide with CalOptima Health's Cloud First strategy and take regulatory compliance and security measures into consideration. These initiatives will assist CalOptima Health in achieving its Vision Statement of removing barriers to achieve real-time claims payments and 24-hour treatment authorizations and doing annual assessments around social determinants of health by 2027. The projects and products that CalOptima Health implements will result in value-based care and improvements for member, provider, and employee experiences. These enhancements will provide CalOptima Health with the ability to be robust and agile and to scale as a future-focused healthcare organization.

Discussion

Approving the SOW and issuing an RFP will allow CalOptima Health to procure a vendor solution with functionality that provides the capability for CalOptima Health's Cybersecurity and Information Technology teams to discover and manage unauthorized and non-traditional IT devices on the CalOptima Health's technical network. Unauthorized and non-traditional IT devices include Internet of Things (IoT) devices, Medical Internet of Things (MIoT), and Wireless and Bluetooth devices, as well as CalOptima Health vendor and partner devices, which may or may not serve a legitimate business purpose. These devices are not as secure as CalOptima Health's approved and managed devices, pose a potential threat of software/hardware vulnerabilities, and can be a pathway for a potential breach by bad actors. The proposed solution may also have the capability to discover and categorize traditional IT

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devices and integrate with the CalOptima Health configuration management database and asset repository.

A cybersecurity asset management software solution is a cloud-based system that will scan, discover, capture, identify, categorize, and assist the Cybersecurity team's efforts to block and neutralize threats. These software solutions integrate with CalOptima Health's existing IT software suite and allow for seamless management of assets throughout the technical landscape.

Staff is requesting reallocation of budgeted funds within the "Network Bandwidth Upgrade for All Sites (Wide Area Network)" to procure a cybersecurity asset management software solution. Staff included the best available information at the time of budgeting. Upon further review of existing partners and selected infrastructure solutions under the budgeted capital project, staff projects a positive variance in year one that will be sufficient to support the new capital project.

The attached SOW will support the release of the RFP, which will support CalOptima Health's business requirement to enhance healthcare and to continuously deliver essential services for CalOptima Health members and providers as it works toward real-time claims payments and 24-hour treatment authorizations. If approved, the RFP will be issued consistent with CalOptima Health's procurement process. Review of bids by a committee with a representation of stakeholders from multiple departments will take place to ensure collaboration and selection integrity by CalOptima Health staff. Based on the scoring from the bid review, CalOptima Health will request that vendors provide a demonstration for evaluation and functionality scoring to select a vendor.

Fiscal Impact

The fiscal impact for the recommended action is budget neutral. As proposed, unspent funds in an amount up to $400,000 that were approved as part of the CalOptima Health FY 2022-23 Digital Transformation Year One Capital Budget on June 2, 2022, will fund the expenses for the new capital project "Cybersecurity Asset Management Software Solution."

Rationale for Recommendation

This additional capability will provide CalOptima Health with the ability to discover, capture, identify, categorize, and act upon unauthorized devices discovered within the CalOptima Health's technical network. This software solution will help prevent security threats and subsequent business impact.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. SOW_Cybersecurity_Asset_Management

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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Cybersecurity Asset Management SCOPE OF WORK

1. OBJECTIVE

CalOptima Health is seeking to implement a Cybersecurity Asset Management Solution. The proposed solution will provide cloud-native functionality to discovery, capture, identify categorize, as well as prioritize non-IT devices that are discoverable by CalOptima Health's network, and potentially traditional IT devices. This solution will integrate (not replace) the existing CalOptima Health ITSM toolset and its associated CMDB (containing master device data). The proposed solution may provide supplemental data on assets that are not discoverable by conventional Asset discovery products. This solution will support the Vulnerability management activities of the CalOptima Health Cybersecurity team and all discoverable assets should be reportable and actionable. The proposed solutions must be capable of scaling with CalOptima Health and provide the necessary functions/solutions to meet our current Hybrid cloud technology landscape.

2. SCOPE OF SERVICES

2.1. System Architectural and Performance Requirements

1.1.1 Operate in a cloud-based architecture as a SAAS.
1.1.2 Provide high availability and accessibility, with redundancy, to the system during peak usage.
1.1.3 Uses agent-less low friction technology to collect detail hardware inventory and software information
1.1.4 The system will communicate using secure network protocols
1.1.5 Provide API or other integration capabilities into existing security tooling (i.e., SEIM)
1.1.6 Works with Chrome or Edge browsers

2.2. System Functional Requirements

1.2.1 The system will connect natively to inventory data within ServiceNow.
1.2.2 Integrate with other business systems and IT tools to import, export and store information related to SAM assets, such as ITSM tools.
1.2.3 Ability to add custom data entry fields that can be reported on.
1.2.4 Retrieve detailed hardware configuration, including capacities, cores, and processors.
1.2.5 Ability to track location of devices.
1.2.6 System will detect and track configuration changes to hardware and software (versions).
1.2.7 System will assign role to hardware assets (test, dev, production) with operating status (in stock, installed, assigned) and generate inventory reports.
1.2.8 Creates an accurate inventory for all devices in the organization. This accounting of devices should include all devices that connect to the organization's network.

1.2.9 Ability to discover assets on platforms such as, IOT, IOMT, networking, storage, printing, and unified communications (UC), such as voice over IP (VoIP).

1.2.10 Metadata associated with the inventory entries should identify medical device characteristics that enable analysis for operational and cybersecurity purposes. The resulting database used to store the inventory should be accessible to all other systems in the organization with functional associations with medical devices, such as ITSM or CMMS systems.

1.2.11 Ability to examine all inventory items reviewing each for cybersecurity vulnerabilities.

1.2.12 System will have the capability to create a remediation plan for the organization to follow to eliminate or reduce the risk introduced by medical devices. The plan will include performing firmware updates on devices, updating operating system versions, changing communication protocols, applying vendor-provided patches for known vulnerabilities.

1.2.13 System will support MFA (Multi-factor Authentication) access to the platform.

1.2.14 System will integrate with Active Directory (AD) or Lightweight Directory Access Protocol (LDAP) user, group, and organizational information.

1.2.15 Ability to integrate with CalOptima's public/government Azure cloud infrastructure.

1.2.16 System will automatically send notifications based on defined criteria or use cases

1.2.17 System needs to be able to integrate with market leading ticketing systems (i.e., ServiceNow, Snow, BMC Remedy, etc.)

1.2.18 Asset data is manageable via desktop and mobile devices (iOS app)

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

18. Approve Actions Related to the Procurement of a Data Protection and Recovery Operations Software Solution

Contacts

Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
David O'Brien, Sr. Director, Information Technology Services, (657) 900-1269

Recommended Actions

1. Authorize reallocation of budgeted but unused funds in an amount up to $450,000 from the "Network Bandwidth Upgrade for All Sites (Wide Area Network)" capital project to a new project "Data Protection and Recovery Operations Software Solution" under the "Infrastructure" category in the CalOptima Health Fiscal Year (FY) 2022-2023 Digital Transformation Year One Capital Budget.
2. Approve the scope of work (SOW) for the Data Protection and Recovery Operations software solution.
3. Authorize the Chief Executive Officer to release the Data Protection and Recovery request for proposal (RFP) with the approved SOW and to negotiate and contract with the selected vendor.

Background

As part of CalOptima Health's Workplace Modernization and Digital Transformation Strategy, Information Technology Services will be evaluating and deploying multiple solutions. These solutions coincide with CalOptima Health's Cloud First strategy and take regulatory compliance and security measures into consideration. These initiatives will assist CalOptima Health in achieving its Vision Statement of removing barriers to achieve real-time claims payments and 24-hour treatment authorizations and doing annual assessments around social determinants of health by 2027. The projects and products that CalOptima Health implements will result in value-based care and improvements for member, provider, and employee experiences. These enhancements will provide CalOptima Health with the ability to be robust and agile and to scale as a future-focused healthcare organization.

Discussion

Approving the SOW and issuing an RFP will allow CalOptima Health to procure a vendor solution with functionality that provides a comprehensive data protection solution (including cloud backups, recovery, immutability, replication, archival, and data management capabilities). Protecting and managing business and member data enhances CalOptima Health's ability to execute against its digital transformation. This proposed solution, combined with CalOptima Health's ongoing digital transformation, will ensure the ability for CalOptima Health to manage through a security incident (ransomware), technical failure or disaster, recovering critical systems and member data in a timely and efficient manner. The advantages of a modern and cloud data management and recovery solution will reduce downtime thresholds, immutability of data, logical data backups, leading to enhanced protection of data and improved performance for IT operational activities.

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Staff is requesting reallocation of budgeted funds within the "Network Bandwidth Upgrade for all Sites (Wide Area Network)" to procure a comprehensive data protection solution. Staff included the best available information at the time of budgeting. Upon further review of existing partners and selected infrastructure solutions under the budgeted capital project, staff projects a positive variance in year one that will be sufficient to support the new capital project.

The attached SOW will support the release of the RFP, which will support CalOptima Health's business requirement to enhance healthcare and to continuously deliver essential services for CalOptima Health members and providers as it works toward real-time claims payments and 24-hour treatment authorizations. If approved, the RFP will be issued consistent with CalOptima Health's procurement process. Review of bids by a committee with a representation of stakeholders from multiple departments will take place to ensure collaboration and selection integrity by CalOptima Health staff. Based on the scoring from the bid review, CalOptima Health will request that vendors provide a demonstration for evaluation and functionality scoring to select a vendor.

Fiscal Impact

The fiscal impact for the recommended action is budget neutral. As proposed, unspent funds in an amount up to $450,000 that were approved as part of the CalOptima Health FY 2022-23 Digital Transformation Year One Capital Budget on June 2, 2022, will fund the expenses for the new capital project, "Data Protection and Recovery Operations Software Solution."

Rationale for Recommendation

This additional capability will provide CalOptima Health with the ability to manage and recover data quickly in the event of a security or technical disruption; thereby reducing business impact to its sensitive data.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Proposed Backup Recovery Solution SOW

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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1. OBJECTIVE

CalOptima Health is seeking to implement Data Protection and Recovery Operations Software Solution. The proposed solution will provide functionality providing cloud native backups, efficient data recovery, data immutability, replication, archival and data management capabilities. Protecting and managing our business and member data enhances CalOptima Health's ability to ensure the ability for CalOptima Health to manage through a security incident (ransomware), technical failure or disaster, recovering critical systems and members data in a timely and efficient manner. The advantages of a modern and cloud data management and recovery solution will be reduced downtime thresholds, immutability of data, logical data backups, leading to enhanced protection of data and improved performance for IT operational activities. The proposed solutions must be capable of scaling with CalOptima Health and provide the necessary functions/solutions to meet our current Hybrid data needs.

2. SCOPE OF SERVICES

1.1 Performing Backup and Recovery Operations

Required

- Physical Server backup and recovery: The Successful Offeror must provide backup and recovery function for standalone physical servers on premises.
- VM instant recovery: The Successful Offeror must enable VMware VM restoration and VM restart within seconds of a VM restore request, even before the VM has been fully restored to primary storage, by enabling access to a read-only backup copy of the VM image in a network file share presented by the backup storage and software to the hypervisor.
- Searchable index for object-level restore: The backup interface must provide an indexed searchable database that allows for access to backed up resources to quickly find individual files, objects and/or systems for recovery.
- VMware VM snapshot image backup with single-step file-/table-/item-level recovery: Backup software must be able to capture a full VMware VM image (leveraging all its VMDKs) and support granular file/data restores using the preserved VM image snapshot. File restoration from backups must not require a full VM to be restored first in order to recover files contained in the VM image backup.
- Forever incremental VMware VM image backups (leveraging VMware VADP/CBT): VMware's Changed Block Tracking (CBT) technology efficiently tracks block location changes so that backup and replication software may leverage this knowledge across consecutive VM image snapshots. The VMware vSphere Storage APIs — Data Protection interface allows backup and replication vendors to create full VM image snapshots and subsequent incremental VM backups using CBT. Backup vendors must support CBT via VMware vSphere Storage APIs — Data Protection to very efficiently create and update previous point-in-time VM backups.

- Support for VM image hardware snapshots of VMware VADP VM snapshots: The backup product must reduce the impact on VM-based application performance of having VMware VM image snapshots that utilize copy-on-write I/O through the following method:
    - Enable a hardware (storage device) snapshot to be created as soon as VM image software snapshots have been created.
    - Given such a hardware snapshot, the software VM image snapshot may be deleted, and application processing can continue without the VM Software snapshot I/O and processing overhead.

  The Successful Offeror must support superimposing at least three different major storage array vendors' hardware snapshots over VMware VADP-created copy-on- write snapshots.

- Synthetic full VMware VM image backup creation: Synthetic backups are identical to regular full backups in terms of data but are created from previous full and incremental backups. They are useful for improving recovery time, avoiding the need to perform repeated full VM backups and accelerating the copy of VM backup images to other backup media. Backup products must support the periodic creation of synthetic full backups (or a logical equivalent that allows full recovery) from previous CBT-based incremental VM image backups and an earlier full backup.
- Support for P2V and V2P restore: The Successful Offeror must support physical to virtual (P2V) and virtual to physical (V2P) restores for x86-based servers.
- Hyper-V VM snapshot image backup with file-/table-/item-level recovery: Backup software must be able to capture a full Hyper-V VM image (leveraging all its VHDs) and support granular file/data restores using the preserved VM image snapshot. File restoration from backups must not require a full VM to be restored first in order to recover files contained in the VM image backup.
- Hyper-V change log-based incremental backups (CBT) and resilient change tracking (RCT): Backup vendors must have enabled Windows file change logging with RCT or CBT to avoid file system scans for Hyper-V VM backups.
- Support for self-service restore: For easy access to restores, The Successful Offeror must offer the ability for an application administrator, system owner and/or end user to restore their data themselves without the need to contact the backup administrator.

Preferred

- Support for instant snapshot restore: Similar to the earlier criterion for VM recovery, this feature allows for immediate access to data directly from the snapshot image without first transferring files back to the primary storage. This is distinct from recovering data by retrieving it from the storage snapshot. Backup software must present data in native format directly to the application server for granular object-level recovery.
- Support for recovery verification/sandbox: This feature allows for access to backup images for testing or restoration to alternate sandbox locations for verification or nonproduction use. Backup software must provide a method to boot VMs within an isolated network without impacting production applications.
- Native file format access: Traditionally, backup software writes data to its storage pools in compressed or deduplicated proprietary formats, and it is necessary to restore data to

its primary (or alternate) location prior to access. To improve recovery time, backup software must be able to provide access to data in native format for applications that are protected by the Successful Offeror directly from the backup storage repository.

- Support for continuous data protection on-premises: Continuous data protection (CDP) is an approach to continuously, or nearly continuously, capture and transmit changes to applications, files and/or blocks of data. Depending on your solution architecture, real-time changes are journaled or replicated to a local or remote storage target. This capability provides options for more granular recovery point objectives and is used for backup/recovery, disaster recovery and data migration use cases. The Successful Offeror must be able to provide CDP capabilities that can be configured to capture changes continuously (true CDP) or at scheduled times (near-continuous data protection).
- Integrated replication management: VM or host-based replication (synchronous or asynchronous) must be offered and managed within the integrated backup solution.

Optional

- Support for cross-hypervisor restore: This capability allows VMs to be recovered to an alternate hypervisor. Backup software must be able to restore VMs created within VMware to Hyper-V and vice versa.
- Support for bare metal restore: The Successful Offeror must be able to recover a full server inclusive of the boot disk/operating system to dissimilar server (or storage) within the same CPU family hardware but with differing configuration.

1.2 Protected Client Operating System and Applications

Required

- Backup support for recent Windows Server releases: The latest major release and N-1 version (previous major release) of the Microsoft Windows Server operating system that Microsoft supports require data protection and must be supported by the backup solution. The vendor must have a policy that full support will be offered within 90 days for new releases. This policy must be documented, or the vendor must be able to provide evidence that this 90-day window has been met for previous released versions. Support is needed for both physical and virtual instances, but it can be achieved via a backup agent or agentless solution for VMware/Hyper-V VMs.
- Backup support for recent enterprise Linux releases: The latest major release and N-1 versions (previous major release) of the Red Hat Enterprise Linux (RHEL) and SUSE Linux Enterprise Server (SLES) operating systems that the providing vendor supports require data protection and must be supported by the backup solution. The vendor must have a policy that full support will be offered within 90 days for new releases. This policy must be documented, or the vendor must be able to provide evidence that this 90-day window has been met for previous released versions. Support is needed for both physical and virtual instances, but it can be achieved via a backup agent or agentless solution for VMware/Hyper-V VMs.
- Oracle Recovery Manager (RMAN) integration support: Oracle RMAN integration is needed to create and restore backups from Oracle Database. The Successful Offeror must support the most recent and previous major Oracle release of Oracle Database. The vendor must have a policy that full support will be offered within 90 days for new

releases. This policy must be documented, or the vendor must be able to provide evidence that this 90-day window has been met for previous released versions.

- VSS support: To create application-consistent backup images within a Microsoft Windows Server environment, support for volume shadow copy service (VSS) must be available from the backup software.
- Microsoft SQL Server support: A VSS-enabled method must be available to back up Microsoft SQL Server. The Successful Offeror must support the most recent and previous major Microsoft-supported release of Microsoft SQL Server. Table-level visibility and recovery granularity are also required, as is support for running in physical and virtual machines. The vendor must have a policy that full support will be offered within 90 days for new releases. This policy must be documented, or the vendor must be able to provide evidence that this 90-day window has been met for previous released versions.
- Microsoft Exchange support: A VSS-enabled method must be available to back up Exchange. The Successful Offeror must support the most recent and previous major Microsoft-supported release of Microsoft Exchange. Mailbox- and folder-level visibility and recovery granularity are also required, as is support for running in physical and virtual machines. The vendor must have a policy that full support will be offered within 90 days for new releases. This policy must be documented, or the vendor must be able to provide evidence that this 90-day window has been met for previous released versions.

Preferred

- Backup support for previous Windows Server releases: All Microsoft Windows Server versions that Microsoft currently supports must be supported as backup clients. The vendor must have a policy that full support will be offered within 90 days for new releases. This policy must be documented, or the vendor must be able to provide evidence that this 90-day window has been met for previous released versions. Support is needed for both physical and virtual instances, but it can be achieved via a backup agent or agentless solution for VMware/Hyper-V VMs (see the Hypervisor Integration section).
- Backup support for previous Enterprise Linux Client releases: All currently supported RHEL and SLES versions that are supported by Red Hat and Micro Focus, respectively, must be supported as backup clients. The vendor must have a policy that full support will be offered within 90 days for new releases. This policy must be documented, or the vendor must be able to provide evidence that this 90-day window has been met for previous released versions. Support is needed for both physical and virtual instances, but it can be achieved via a backup agent or agentless solutions for VMware/Hyper-V VMs (see the Hypervisor Integration section).
- Backup support for recent UNIX operating systems: The latest major release and N-1 versions (previous major release) of the provider-supported versions of IBM AIX, HPE HP-UX and Oracle Solaris must be supported by the backup solution. The vendor must have a policy that full support will be offered within 90 days for new releases. This policy must be documented, or the vendor must be able to provide evidence that this 90-day window has been met for previous released versions.
- MongoDB support: Backup software must support granular recovery based on either time or query as well as recovery of MongoDB collections directly into the same MongoDB database. The software also needs support for recovery of sharded to unshared, unshared to sharded or sharded to sharded for the highest levels of database recovery capabilities.

- PostgreSQL support: The solution must support a PostgreSQL-specific agent or backup within the enterprise backup solution using filesystem snapshot technology to take a cohesive backup or orchestrated PostgreSQL database dumps to an external file and backing that up.
- Kubernetes support: Backup software must support backup/restore of Kubernetes clusters, including cluster configuration and containerized applications running on the cluster.

Optional

- Backup support for previous UNIX releases: All currently supported versions for at least one of the following operating systems — IBM AIX, HPE HP-UX, or Oracle Solaris — must be supported as backup clients. The vendor must have a policy that full support will be offered within 90 days for new releases. This policy must be documented, or the vendor must be able to provide evidence that this 90-day window has been met for previous released versions. Support is needed for both physical and virtual instances, but it can be achieved via a backup agent or agentless solution for VMware/Hyper-V VMs (see the Hypervisor Integration section).
- Microsoft SharePoint support: The backup solution must offer full and incremental backup and document-level recovery granularity support for the latest and previous major release of Microsoft-supported versions of SharePoint.

1.3 Backup Platform Capability

Required

- Backup server runs on Microsoft Windows Server: It is permissible for backup vendors to require their software to run on Windows to enable integration with hypervisors or serve as a backup proxy. The backup server should be capable of running on the latest Microsoft-supported major release and N-1 version (previous major release) of the Microsoft Windows Server operating system.
- Backup server runs on Linux: The latest major release and N-1 versions (previous major release) of the RHEL or SLES operating systems that the providing vendor supports are needed.
- Disk target support: The Successful Offeror supports a disk-based backup target. This disk target must include locally attached direct attached storage (DAS), storage area network (SAN), Internet Small Computer System Interface (iSCSI), Amazon Simple Storage Service (Amazon S3) Compatible or network-attached storage (NAS).
- Backup server runs on VMware virtual machine (VM): The Successful Offeror must offer certified support to run the backup server in VMware VMs with full, documented, and tested vendor support from the Successful Offeror provider. The operating system of choice needs to conform with the defined OS criteria in this section.
- Auto discovery of VMware vSphere virtual machines: The backup solution must have a way to discover VMs that have been created, started, and stopped using interfaces with VMware vCenter Server or other VMware vSphere VM management tools.
- Proxy-based VM image backups: To avoid backups consuming precious CPU, memory, and input/output (I/O) resources of VM hosts that are burdened with having to run many VMs, VMware and other hypervisor vendors enable backup vendors to offload backup

processing and data transfers to alternate proxy hosts. This enables higher VM density on the existing VM hosts than is otherwise possible. Backup vendors must support proxy based VM backups for at least VMware ESXi VM hosts.

- Agentless backup of Microsoft Windows file, SQL Server, and Exchange VM servers: Using VMware- or Microsoft-provided automatically installed in-guest VM tools, backup vendors must be able to leverage Windows VSS to perform application-consistent snapshot backups of Windows file servers, SQL Server databases and Exchange email. Other server applications may require an agent to enable better than crash-consistent backups.
- Server-/target-side deduplication: The Successful Offeror must have the ability to deduplicate within the backup server infrastructure. This offloads deduplication processing from the application host and minimizes the impact on running applications. The Successful Offeror must be able to enable backup-server-based deduplication or integrate with backup-target-appliance-based deduplication at the job and client level.
- Client-side deduplication: Client-side data deduplication minimizes the resource load that backup places on servers and network infrastructure, allowing deduplication of data to occur on the backup client before sending over the network. The Successful Offeror must be able to enable client-based deduplication at the job and client level.
- Auto-discovery of Hyper-V VMs: The backup solution must provide a way to automatically discover Hyper-V VMs that have been created, started, and/or stopped using interfaces with Microsoft System Center Virtual Machine Manager or other Hyper-V VM management tools.
- Support for global deduplication: The backup infrastructure includes many backup clients and a variety of client types and data. The Successful Offeror must include a common deduplication pool per backup storage target that eliminates the need to store redundant data blocks across different backup clients.
- Support for compression: The Successful Offeror must be able to enable or disable compression of the backup image data within the backup software prior to storing in the target device.
- Policy-based optimization of VM backup execution on VM hosts or VM proxies: Backup software must provide a user interface to define VM backup scheduling policies that include a limit (from one to at least 10) on the number of VM backup jobs running against VM storage devices, VM hosts and proxy hardware at any given time. It must enable chaining backup jobs together via real-time monitoring of resource consumption to accelerate the completion of a set of VM backups.

Preferred

- Backup server runs on Hyper-V VM: The Successful Offeror must have certified support to run the backup server in Hyper-V VMs with full, documented, and tested vendor support from The Successful Offeror provider. The operating system of choice also needs to conform with the defined OS criteria in this section.
- Coordinate integrated data reduction: All backup appliances have their own unique data deduplication mechanism, so The Successful Offeror must integrate with a backup target appliance to reduce data transfers to the backup storage. To distribute deduplication processing across clients, servers, and storage appliances, integration must be available with the backup target via an API. The Successful Offeror must support the ability to

perform deduplication on both the backup server and backup storage target for at least one backup target appliance in this manner. Dell EMC PowerProtect Data Domain Boost (DD Boost) is an example mechanism for this.

- Tape target support: The backup solution must support the latest major leading tape libraries and Linear Tape-Open (LTO) drives to ensure backward compatibility as new generations of tape drive become available.
- Backup server runs on backup-vendor-integrated appliances: Many vendors offer all-in-one, integrated appliances that include backup software as well as compute and storage hardware. A vendor-provided appliance must be available as a unique part number that is managed, maintained, and supported as a unit. The operating system also needs to conform with the defined OS criteria in this section.
- Third-party backup target appliances: Backup appliances must be stand-alone disk systems that serve as a target for backup data and replicated backup data. Backup software must support a minimum of three disk appliances such as Dell EMC PowerProtect, HPE StoreOnce or ExaGrid.
- vSphere Web Client UI integration: VMware VM administrators must be able to initiate or manage backups and restores from the vSphere Web Client UI, the most widely used VM administrative interface.
- Customizable configuration settings for managing VM host resources: Backup products must enable administrators to set CPU and I/O per second resource consumption limits that throttle the number of VM backup jobs.
- Integration with HCIS management: Some hyperconverged integrated system (HCIS) vendors provide their own tools that HCIS administrators use to manage their HCIS environments. Backup vendors must integrate with one or more HCIS products (for example, Nutanix, VxRail or vSAN), tools or snapshot mechanisms to enable more convenient VM backup in HCIS environments.
- VMware backup proxy load balancing: Backup software must be able to optimize backup job performance and availability by dynamically assigning VM backup jobs to the set of available proxy hosts.

Optional

- Backup server runs on Kernel-based Virtual Machine (KVM): With the latest hypervisors, many performance and scalability limitations are removed, enabling backup servers to be hosted within the virtual infrastructure. The Successful Offeror must have certified support to run the backup server in KVM VMs with full, documented, and tested vendor support from the backup software provider. The operating system of choice also needs to conform with the defined OS criteria in this section.
- Backup server runs on third-party appliances: It is often the case that backup software vendors rely on hardware partners or other service providers to bundle an integrated solution together. A third party must be available to provide this appliance as a unique part number that is managed, maintained, and supported as a unit.
- Appliance replication management and backup tracking: Backup software must support management and tracking of the backup target replication images for a minimum of one backup target appliance such as Dell EMC PowerProtect or HPE StoreOnce.

- Media management and tracking: The Successful Offeror must support media management for removable media such as tape volumes, whereby cartridge location, shelf life and so on can be centrally managed and reported on.
- VM guest auto discovery and support for Xen Project and KVM hypervisors: For KVM managed VMs, backup software must automatically discover the VMs through a mechanism based in the software itself or provided by the hypervisor.
- Support for non-Windows systems data change logs: Traditional file systems or application agents required a full-system scan to determine which changed files were necessary to include in the incremental backup. Techniques such as CBT or interrogating the file system journal are available; such techniques can eliminate those scans. For Linux or UNIX file system data backup, The Successful Offeror must use a file system change journal for determining data inclusion for incremental backups.
- Intelligent data-type-specific deduplication: The feature refers to support for newer deduplication techniques for detecting the file or data type to improve deduplication efficiency. This is often referred to as adaptive deduplication. The Successful Offeror must include application- or data-specific algorithms to enhance deduplication rates.

1.4 Management, Scalability and Architecture

Required

- Centralized backup policy management: Backup solution must include management of the ongoing set of tasks for operating backups while supporting a potentially dynamic server and storage infrastructure. A single management console must be able to set and manage policies and settings for all components of the backup infrastructure.
- Integrated authentication with Active Directory (AD)/Lightweight Directory Access Protocol (LDAP): Managing users and controlling access is critical for any enterprise-class application. To ease this burden and enable secure access, backup software must manage users through standard toolsets, including AD and/or LDAP.
- Backup copy job management: The Successful Offeror must support policies that dictate the scheduling, location and movement of backup copy data and images to additional data storage destinations. This includes backup data replication to off-site media. This is often implemented as disk-to-disk-to-tape (D2D2T), disk-to-disk-to-cloud (D2D2C) or, more generically, as disk-to-disk-to-whatever (D2D2X) capability.
- Support for three leading storage arrays: The Successful Offeror should be able to leverage hardware snapshots for improved RPOs and RTOs including sufficient integration to ensure application recoverability through quiescing and flushing data to disk for consistent snapshots. The Successful Offeror must support this capability for at least three array families (e.g., Pure X Series or HPE 3PAR) from among the major storage array providers.
- Single point of administration with RBAC: Backup software is typically installed and running on multiple servers either within the same backup domain or separate backup domains. Backup software must allow role-based management of all components including across backup domains from a single management console with role-based access.
- Monitoring, reporting, and logging support: Separate from the day-to-day management of backups, a centralized (aggregated across backup domains) backup infrastructure and

backup job management and reporting capability must be available. This must also include skipped file or skipped client indications, trending/capacity reports, logging of configuration changes and user activities (audit trails), and the ability to view/forward information and events for analysis and correlation.

- Network Data Management Protocol (NDMP): NDMP is a protocol for transporting data between NAS and backup devices. Backup software must support the creation of full copies of backup data directly from the NAS device. For reducing backup data and reducing resource consumption, backup software must support incremental backups via NDMP.
- Indexed snapshots: Effective use of snapshots in data protection requires the enablement of browsable indexed snapshots through the integration of storage snapshots in on-premises and cloud-based data protection solutions. The Successful Offeror must facilitate management of snapshots that can be mounted and indexed by the backup solution allowing for granular file-level and VM-level restores by mounting the snapshot.
- Instance-based licensing: The backup solution must sell the instance licenses in pools of varying amounts. The instance licensing can be used for any workload in the backup solution allowing licenses to be used universally and removing the need for licensing for different modules or workloads.
- Storage-based capacity licensing: The backup solution measures the total amount of storage capacity that backup data consumes and then sets its monthly or annual software license fee based on that total.
- Subscription-based licensing: Backup solution provides subscription-based licensing, which can be an all-inclusive model that provides better entry-level pricing and the ability to add features as customers mature and gain value from the initial experience. The Successful Offeror must offer subscription-based licensing as an option to adapt to the changing purchasing models.
- Protection for 1,000 clients per management domain: The Successful Offeror must support daily backups for up to 1,000 clients (servers or VMs) within a single management domain. Vendors must be able to provide customer references to verify that backup software is able to set backup policies, define schedules, and monitor status for 1,000 or more clients from a single management domain interface.
- Backup configuration data replication support: To help eliminate single points of failure within the backup infrastructure itself and to move data off-site to meet regulatory requirements or disaster recovery support, backup software must be able to replicate backup data asynchronously or periodically to an alternate location. Whether this is executed by the backup software or a hardware-based backup target, the backup catalog must be able to recover from any data location.

Preferred

- Automated physical server discovery: Backup software must support automated discovery of new physical machines with a configurable choice for inclusion or notification for administrators to take action for adding into the appropriate policy.
- Automated fault recovery: The Successful Offeror must enable recovery — without manual intervention — from backup server fault conditions that affect backup job completion (by automatically restarting failed jobs).

- ROBO deployment time of one hour or less: Management tasks for protecting remote locations should be modest. Backup server software and one client must take one hour or less to install/configure/start ROBO backups by the customer.
- Snapshot management: When the Successful Offeror integrate and orchestrate snapshots in storage, virtualization platforms and cloud the software must be able to control the retention of the snapshots. The creation and removal of snapshots is required to manage and maintain critical backup data.
- Support for at least seven arrays: Some backup vendors only support integration with their own company's storage hardware (if offered), but wider snapshot support is preferred because most enterprises have a multivendor storage strategy. The Successful Offeror must support seven or more storage arrays (e.g., Pure X Series or HPE 3PAR) from among the major storage array providers.
- WAN acceleration/optimization for ROBO: WAN acceleration is a feature that optimizes network data transfers. Backup software that includes this feature may eliminate the need for other special-purpose appliances. The Successful Offeror must include the ability to reduce data (caching/deduplication/compression), multistream data or shape traffic when sending data across wide-area networks (WANs) between corporate locations.
- Protection for up to 10,000 clients per management domain: Vendors must be able to provide customer references that backup software is able to set backup policies, define schedules and monitor status for up to 10,000 clients from a single management domain interface.
- Support for backup of VVOLs: For this feature, the backup software must be able to support hardware snapshots at the vSphere Virtual Volumes (vVols) level (as opposed to the logical unit number [LUN] level).

Optional

- Snapshot to tape: The Successful Offeror must be able to manage the data movement to tape directly from the hardware storage snapshot (e.g., NetApp SnapMirror).
- Support for at least 10 arrays: The Successful Offeror must support at least 10 storage arrays (e.g., Dell EMC Unity or IBM FlashSystem 5200) from among the major storage array vendors.
- Automated client installation: When using backup agents, The Successful Offeror must be able to install backup client and server software updates via push distribution with group configuration policies, or else be able to integrate with software distribution tools to perform this function. For the latter approach, the backup software must also integrate with Microsoft System Center and/or other tools such as Ivanti.
- Agentless backup for physical servers: For physical servers, backup software must be able to support backup/restore without the need for agent installation. Agentless backup for virtual servers is separately covered in the Hypervisor Integration section.
- Local self-contained backup infrastructure for ROBOs: A single server at the remote office with local backup must be self-contained with its own backup repository and catalog so that backup catalog or file/image metadata does not traverse the network between remote office and central data center.

1.5 Cloud Capability

Note: CalOptima use Azure Government Cloud and O365 Government Cloud

Required

- Software support for deduplicated backup data storage in Azure cloud storage: Backup software must support deduplicated data storage in Microsoft Azure Premium Storage and Microsoft Azure Blob Storage. It is permissible for the vendor to place a cloud-based backup server in the cloud vendor's environment to facilitate this process.
- At least two major public clouds supported: Backup software must support or offer backup integration with two major public cloud providers (e.g., AWS or Azure) including backing up VMs and managing snapshot orchestration of the public cloud storage platform.
- Software support for backup data storage in Azure cloud: Backup software must support connection to Azure Blob Storage as a backup repository or auto tiering location.
- Support for data backup and individual file/item restore: Enterprise cloud backup vendors must support individual file and item recovery without first requiring a full snapshot restore.
- Application-aware backup of cloud VMs: Backup software should support application-aware backup mechanisms more advantageous to public or government cloud IaaS users.
- Native snapshot management in cloud: The backup solution must integrate with public and government cloud platforms and manage the backup of VMs via native cloud snapshots. The snapshots must be indexed and browsable by the backup solution to allow for granular file-level and VM-level restores by mounting the snapshot.
- Support for migration from on-premises to cloud platforms: Backup software must be able to convert VMware VM image backups to Azure VHDX format.
- Auto tiering to the government and public cloud: As enterprises become increasingly comfortable with data residing in the cloud, use of the cloud as another storage tier or off-site data repository continues to expand. In order to potentially reduce the need for off-site tape and also provide a path for recovery in the cloud for disaster recovery (DR) events, the backup solution must support automatic tiering to public and government cloud services.
- Recovery in the public and government cloud: An instance of the Successful Offeror must be installable in the public and government cloud so that backup data can be restored to a compute instance in the public cloud.

Preferred

- WAN acceleration for data transfer to/from cloud storage: To enable higher data throughput to (and from) cloud vendors, backup vendors must integrate WAN optimization methods like TCP multistreaming, in-line data compression or data deduplication into their data transfer functions.
- Cloud DR support by vendor or through DRaaS provider partnerships: Cloud DR is gaining increasingly wide use, especially from small and midsize organizations with fewer than 50 VMs. Backup vendors must have developed cloud DR documentation for their customers or support solutions with two disaster recovery as a service (DRaaS) partners to provide cloud-based DR implementation documentation and support for customers.

- Cloud DR orchestration automation for recovery: Backup vendors must enable and document x86 system recovery scripting for sets of VMs, such as Zerto or VMware Site Recovery Manager (SRM). This is very helpful in reducing DR times.
- Azure VMs-resident system backup client and Azure VM system restore: Organizations are increasingly interested in hosting services in the Azure cloud. Backup clients and servers must be supported in the Azure cloud with a documented architecture.
- Support for PaaS SQL backups and restores: Backup solution offers integration and support for database level backup and restores of PaaS database services such as Microsoft Azure SQL.

Optional

- Support for automated recovery: Disaster recovery is the process of bringing your application back online and functional in any way possible when an outage has occurred. Automation can ensure that the current state of the infrastructure is written in code. The backup solution must offer some capability to automate the capture of your infrastructure in code and redeploy the codified infrastructure in another data center, availability zone (AZ) or region.
- Support for VMware VM conversion capability for supported cloud: The Successful Offeror must support the automated conversion on restore of VMware VM to non-VMware-based DR service provider. Although some replication solutions (e.g., VMware SRM and Zerto) enable hypervisor migrations for VMs and backup solutions and allow guest (agent-based) backups that are portable across environments, the backup solution must be able to convert VMware VM image backups to public cloud VM image formats such as vhdx, ami or VM in Google Cloud Platform (GCP).

1.6 Microsoft 365

Required

- Choice of backup location: Microsoft 365 backup solutions separate backups from the data they protect, which is often a regulatory requirement. The vendor must offer the ability to locate the data in some other public or government cloud storage besides Azure.
- Backup retention: The solution must offer unlimited and configurable retention periods.
- Backup frequency: The backup vendor must provide periodic, configurable backups that allow for granular backup recovery point configuration. The frequency must be able to be configured to back up data more than one time per 24-hour time period.
- Restore granularity: Granular recovery avoids having to restore unnecessary data and sort through duplicate items to keep the appropriate copies. Vendors must have the flexibility to perform granular file recovery from a point in time, as well as to allow restore to other users or to the file system.
- ISO/IEC 27001 and 27018: The backup solution's information security management system (ISMS) must be implemented, maintained, and certified to ISO/IEC 27001 and ISO/IEC 27018, consisting of policies, procedures and controls that govern data security practices within the organization protecting the data.
- Data encryption: To ensure that no unauthorized person has access to the backed-up contents, the backup for Microsoft 365 must encrypt Microsoft 365 and SharePoint Online data during the backup process to provide additional protection to the storage.

- Password-protected storage: The backup solution allows Microsoft 365 to restrict access to storage by setting up a password. This ensures only authorized access, editing or restoration of items in Microsoft 365 repositories.
- Support for Microsoft 365 MFA: Multifactor authentication (MFA) prevents unauthorized access to organizations. The Successful Offeror must support Microsoft 365 MFA levels of protection for your tenant's security.
- Optimizing backup and restore performance: All vendors must use Microsoft APIs to back up and restore data from the Microsoft 365 tenant. To manage Microsoft 365 health, Microsoft may throttle throughput for these APIs. Vendors must include mechanisms to maximize the backup and restore throughput that Microsoft allows, such as by automatically adding service accounts and running separate backup processes concurrently.
- Subscription-based licensing model: Vendors must provide subscription-based licensing to be all-inclusive of the backup service. BaaS solutions such as Keepit, AvePoint or Commvault (Metallic) offer a per-user, subscription-based licensing model similar in structure to Microsoft 365's licensing scheme.
- Capacity-based licensing model: Backup vendors must be able to allow organizations to choose capacity-based licensing models.

Preferred

- Vendor management: BaaS vendors can provide flexibility to allow self-management of the backup and restore configuration. The vendor must offer management assistance services to offload some administrative tasks from the organization.
- Enhanced search: The ability to search across multiple Microsoft 365 services via a common interface is a valuable feature. This enhanced search capability becomes even more valuable when the solution can extend to sources of data outside the Microsoft 365 ecosystem. The third-party solution must have advanced litigation hold capabilities, including a searchable index across Microsoft 365 services.
- Malware detection: Some third-party vendors can differ widely on whether, when and how they detect malware. The backup vendor must offer any of the capabilities such as deep scanning, detection of zero-day attacks, the ability to identify questionable behavior and help in recovering damaged files.
- Backup reporting: The backup solution must report backup statistics and job failures, and also report storage usage if applicable.
- SharePoint recovery: Vendors must have the ability to perform granular recovery of a site, subsite, list, library, folder, or document.

Optional

- No criteria for this category.

1.7 Security

Required

- Encryption at rest: Backup solution provides software-level AES 256-bit encryption with internal or external key management. This option must be offered by the enterprise backup or cloud software provider to enable encryption at rest for the backup data.

- Encryption in flight: In some applications, such as remote replication, data may be encrypted while it is at rest on drive arrays, but unencrypted while it is being transmitted. The backup solution must provide encryption of data while moving data inside the backup infrastructure, such as replication or backup copies to off-site.
- Key management: The solution must include key management software offering the ability to generate random encryption keys for the stored data and also manage the secure storage of these keys.
- Immutable/write once, read many (WORM): Immutable backup or storage features make the backed-up data fixed and unchangeable. The immutable backup cannot be altered or changed until the policy has expired.
- Ransomware resilience, detection, and remediation: Vendors must have capabilities to detect ransomware attacks by tracking large changes to file systems.
    - The Successful Offeror shall identify a ransomware attack is occurring or has occurred. Please specify the workloads this functionality support.
    - Successful Offeror should identify if sensitive data, like personally identifiable information (PII), has been impacted in the event of a ransomware attack. Please specify what workloads this capability support.
    - The Successful Offeror should provide solution to protect against external threats from 3rd-party solutions.
    - Successful Offeror should identify dormant malware within backups using the solution.
- Ransomware recovery: Vendors simplify the ransomware recovery process through the ability to open ransomware recovery support tickets, create an isolated test environment and provide clean copies of backup to recover specific files.
    - recovery after a ransomware attack has occurred.
    - Successful Offeror should have the flexibility in being able to recover an entire VM or recover data within the VM (individual files) in the event of a ransomware attack.
    - Successful Offeror should provide recourse for recovery in the event that a major compromise has occurred, and backup data has been explicitly deleted.

Preferred

- Physical air gap: The backup solution must support the use of an air-gapped computer or network that has no network interfaces, either wired or wireless, connected to outside networks. This is typically done for critical systems or databases that hold sensitive information.
- Virtual air gap: The backup solution must facilitate the creation of a virtual air gap to provide similar protection of a physical air gap while giving you the ability to access these air-gapped assets from anywhere in the world.

Optional

- No criteria for this category.

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item
19. Authorize the Chief Executive Officer to Implement Changes to Executive Level Job Titles

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Brigette Hoey, Chief Human Resources Officer, (714) 246-8405

Recommended Action
Authorize the Chief Executive Officer to implement changes to executive director positions with one (1) net increase to the total number of executive level positions.

Background
CalOptima Health Policy GA.8057, Compensation Program, sets forth the compensation administration guidelines. Pursuant to this policy, additional positions at the level of chief or executive director require approval by the CalOptima Health Board of Directors (Board). Currently, the Board has authorized a total of eighteen (18) positions at the level of chief (8 positions) and executive director (10 positions).

Discussion
Staff proposes to separate the responsibilities and duties of Executive Director Quality & Population Health between two distinct Executive Director positions. Quality and population health are two (2) disciplines that have both increased significantly in regulatory and operational scope and impact CalOptima Health's operational and financial health, members, and providers. CalOptima Health needs leadership focus for each area, which requires a separate and dedicated executive leader over quality and population health. This change will result in one (1) net increase to the total number of executive level positions. If approved, the recruitment for the new position would commence immediately.

Staff recommends the following changes to the executive director positions: Add one (1) Executive Director position for a total of eleven (11) executive directors.

Fiscal Impact
Staff projects current year budget savings within salaries and benefits under the CalOptima Health Fiscal Year (FY) 2022-23 Operating Budget are sufficient to cover projected expenses associated with the new position through June 30, 2023. Staff will include updated expenses in future operating budgets.

Rationale for Recommendation
The addition of one (1) Executive Director position will allow CalOptima Health to dedicate appropriate leadership to two critical areas – quality and population health.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. GA.8057: Compensation Program and Attachment A Compensation Administration Guidelines

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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Policy:	GA.8057
Title:	**Compensation Program**
Department:	CalOptima Administrative
Section:	Human Resources
Interim CEO Approval:	*/s/ Richard Sanchez 06/10/2020*
Effective Date:	05/01/2014
Revised Date:	06/04/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes a compensation program for CalOptima job classifications within clearly defined guidelines that promote consistent, competitive and equitable pay practices.

II. POLICY

A. CalOptima's compensation program is intended to:

1. Provide fair compensation based on organization and individual performance;
2. Attract, retain, and motivate employees;
3. Balance internal equity and market competitiveness to recruit and retain qualified employees; and
4. Be mindful of CalOptima's status as a public agency.

B. The Chief Executive Officer (CEO), in conjunction with the Executive Director of Human Resources, is directed to administer the compensation program consistent with the attached Compensation Administration Guidelines, which defines the principles upon which CalOptima's compensation practices will be managed, procedural aspects of how the compensation procedures will be administered, and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay rates based on the market 50th percentile.
2. Determining appropriate pay rates within the pay range for a position by assessing an employee's or applicant's knowledge, skills, experience, and the pay rates currently being paid to similarly situated incumbents. Employees may be paid anywhere within the pay range based on proficiency levels. The following criteria shall be considered:

Minimum (Min)	The rate paid to an individual possessing the minimum job qualifications & meeting minimum job performance expectations

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Midpoint (Mid) aka: 50th percentile	The rate paid to individuals that are fully proficient in all aspects of the job's requirements & performance expectations
Maximum (Max)	The maximum rate paid to individuals who possess qualifications significantly above market norms & consistently deliver superior performance

3. All new hires and employees should have a pay rate equal to or greater than the pay range minimum, unless the minimum job requirements are not met, then a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months.

4. Base pay for all employees shall be capped at the pay range maximum, and once an employee reaches the base pay maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus provided that the employee's performance warrants this additional compensation.

C. The CEO is authorized and directed to take all steps necessary and proper to implement the CalOptima compensation program and the Compensation Administration Guidelines not inconsistent therewith.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. Compensation Administration Guidelines

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8057	Compensation Program	Administrative
Revised	06/07/2018	GA.8057	Compensation Program	Administrative
Revised	06/04/2020	GA.8057	Compensation Program	Administrative

IX. GLOSSARY

Not Applicable

Compensation Administration Guidelines

Revised June 04, 2020

Implemented March 29, 2020

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Contents

Pay Administration Guidelines

Common pay administration guidelines for CalOptima are detailed in this section. These Guidelines help maintain the integrity of the base pay program by introducing a common set of standards and assist managers in ongoing compensation program administration.

In addition, note the following administration of the Guidelines:

- Chief Executive Officer (CEO) compensation will be established by the Board of Directors.
- Chief and Executive Director compensation will be established by the CEO within the Guidelines.
- The Board will be informed of all Chief and Executive Director hires and compensation changes.

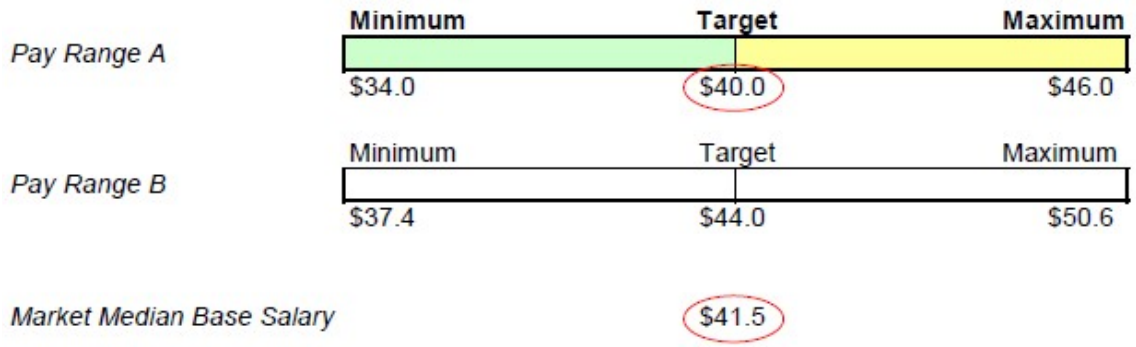
Proposed Pay Administration Guidelines

Pay ranges and pay levels	Pay range target Range minimums and maximums Pay above range maximums Pay range thirds Pay range halves Compa-ratio
Periodic pay adjustments/increases	New hire/Rehire Promotion Lateral Transfer Demotion Temporary Assignment Secondary job Job Re-evaluation Appeal Process Register/Certified Status Base pay program maintenance Salary structure adjustment Annual competitive assessment Market sensitive jobs
Annual pay adjustments/increases	Market Adjustment Merit pay Step increase
Special one-time pay considerations	Recruitment incentive

Pay Ranges and Pay Levels

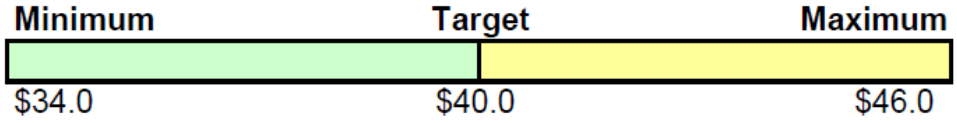
Range Target: internal "going market rate" for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects of the job's requirements and performance expectations.

- For benchmark jobs, the pay range (i.e. pay grade) is determined based on the comparability of values between market median base pay rates and the pay range targets.



Range Target $40.0 is Closest to Market Median of $41.5; job is assigned to Pay Range A

- For non-benchmark jobs, the pay range is determined based on comparability of the job to benchmark jobs within the same job family or other internal positions in terms of knowledge, skills, complexity and organizational impact.



Range Minimum: represents the rate paid to individuals possessing the minimum job qualifications and meeting minimum job performance expectations.

- All employees should have a pay rate equal to or greater than the pay range minimum.
- If the minimum job requirements are not met, a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months while a new incumbent is learning the skills to become proficient in the new role.

Range Maximum: represents the maximum rate paid to individuals who possess qualifications significantly above market norms and consistently deliver superior performance.

- Base pay growth is capped at the pay range maximum.

Pay Above Range Maximum: Employees are not paid above the range maximum.

- Employees whose current pay becomes above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases until such time as their base pay falls below the pay range maximum.

- In lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation.

- As the pay structures and pay ranges move every twelve (12) – thirty-six (36) months or as necessary, the employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases, as appropriate.

Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable, and appropriate pay levels

- Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations.

- Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate one hundred percent (100%) proficiency in all aspects of the job's duties, responsibilities and performance expectations.

- Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills, or abilities that far surpass the market's typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities, and performance expectations.

Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness.

- Compa-Ratio: A compa-ratio is calculated by taking the employee's base pay divided by his/her pay range target.

- Compa-Ratio of 100%: This ratio indicates the employee's base pay equals the pay range target, or the market rate.

  - Compa-Ratio <100%: This ratio indicates the employee's base pay is less than the pay range target.

  - Compa-Ratio >100%: This ratio indicates the employee's base pay is greater than the pay range target.

Illustrative Range Shown Below:

	Minimum	Target	Maximum
Compa-Ratio RNs	87.5%	100.0%	117.0%
Compa-Ratio Non-Exempt	88.0%	100.0%	117.0%
Compa-Ratio Exempt	83.0%	100.0%	118.0%

Note: *Range minimums and maximums will be based on the developed salary range spreads.*

Annual Pay Adjustments/Increases

Market Adjustment: A market adjustment is an increase or decrease to pay range grades based on market pay practices.

- A market adjustment may result in base pay increases for full-time, part-time, and some as-needed and limited term staff paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target).
    - For some market-sensitive jobs, a market adjustment may also be granted to full-time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression.
- A market adjustment may result in a base pay increase to some staff to ensure employees are paid a base pay rate at least equal to the new pay range minimum.
    - If a market adjustment is made, employees paid below the new range minimum receive an increase to their base pay to ensure it is at least equal to the pay range minimum before any merit pay is awarded (cap at 10%).
- The appropriateness of a market adjustment is determined based on:
    1. A competitive assessment of the pay range target versus market base pay practices;
    2. Market trends and practices relative to average base pay and pay range increases; and
    3. Current recruiting and retention issues.
- Market adjustments are made prior to determining merit pay.
- Newly hired employees will be eligible for any market adjustments granted at the annual pay increase date if the employee is paid at or below the pay range target.

Base Pay Adjustment: All employees who achieve a satisfactory level of performance will be eligible for a merit pay adjustment.

- Merit Pay: Merit pay is variable pay that typically affects employees' base pay; it recognizes employees' job proficiency and performance of job duties.
    - Merit pay is applicable to full-time and part-time employees paid below, at, or above the pay range target; Per diem employees are not eligible for merit pay.
    - To be eligible for merit pay, the employee must have started work on or before March 31 to be eligible for a merit increase in July of the same year and have successfully completed the introductory period [three (3) months for transfers and new hires] prior to the annual pay adjustment date.
    - Merit pay will typically be an increase to base pay; however, it may also be delivered

as a one-time lump sum bonus for individuals paid above the pay range maximum.

- The budgeted amount for merit pay, if any, is based on 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and, 4) recruiting and retention issues.

Merit Pay – Staff Paid At and Above Pay Range Target

- The combination of an individual's performance rating, the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity.
  - Merit pay is typically calculated as a percent of base pay in effect on March 31, prorated to reflect the number of months an employee worked during the twelve (12)-month period starting from the first pay period in the fiscal year and ending with the last pay period of that same fiscal year.
  - Managers have the discretion to determine the actual increase amount within the published Guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives.
  - Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and also receive a lump sum amount for the remaining portion of the merit pay. Employees paid over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in two (2) incremental amounts- the first half when merit pay is normally distributed; and the second half six (6) months later.
  - Merit pay may be held altogether or delayed for ninety (90) days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning is active in their record.
  - Merit pay is typically awarded once a year at a specific time.
  - Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment at the same time.
  - Executive Directors and Chief's must approve merit pay increases for all areas for which they are responsible before submitting to HR.
  - HR has final approval of all merit increases.

A Merit Pay Grid similar to the one shown below [assumes a three percent (3%) merit increase budget] is often used to provide managers with a guideline as to what merit pay increase may be appropriate based upon performance and to reflect:**

1. The organization's financial status;
2. Market trends relative to average base pay increases;
3. Competitiveness of current base practices; and

4. Recruiting and retention issues.

	Pay Range Position				
Performance Rating	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	Above Max
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%
Needs Improvement	0%	0%	0%	0%	0%

Above Max = Lump Sum Bonus

***The Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.*

- Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay.

- The increase may be withheld altogether or delayed ninety (90) days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be retroactive; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase.

- Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above.

Special One-time Pay Considerations

Recruitment Incentive

- Recruitment incentives up to fifteen percent (15%) of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima.
    - Recruitment incentives require the approval of the CEO.
    - Board approval is required for recruitment incentives offered to Executive Director and above positions.

Incentives are provided with a "pay-back" provision if the employee terminates within twenty four (24) months of hire.

New Hires/Rehires

- A new hire's pay level corresponds to the appropriate pay range quartile and typically should not exceed the pay range target. Offers above the pay range target require the approval of the Executive Director of Human Resources and the CEO, when necessary.

- Factors to be considered in determining an appropriate pay level for a new hire include:

    - Job-related experience: What is the estimated learning curve given the individual's prior work experience? How many years of experience does the individual have in the same or equivalent classification?

    - Market conditions: What is the going rate of pay in the external market for the individual's skills and knowledge?

    - Internal equity: Is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?

- At hire, external service is typically valued comparable to internal service.

    - For example, an RN having three (3) years of prior job experience is viewed comparably to an RN having three (3) years of job experience at CalOptima.

- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions.

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications.

- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate).

- Determine appropriate pay rate by assessing candidate's knowledge, skills, and experience, as well as pay rates currently being paid to similarly situated incumbents.

- Candidates with superior knowledge, skills, and experience can be paid above the pay range midpoint. Starting pay rates above the pay range midpoint must have approval of the Executive Director of Human Resources and CEO, when necessary.

- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical).

- Pay rates for all positions are reviewed with the Compensation Unit before an offer is made. The Compensation Unit will review internal equity across the system to ensure that the appropriate offer is made.

- Rehires to the same classification should be paid at least the same amount they earned prior to termination, with adjustments and/or credit for recent additional career experience or education earned while away from CalOptima.

- The above policy applies to the current organization structure.
- Additional positions at the level of Chief or Executive Director require Board approval.

Promotion

An employee receives a promotion when the employee applies for and is selected for a job with a higher pay range target.

- An employee will receive a promotional increase to at least the pay range minimum of the new pay range.
- The amount of a promotional increase will be determined based on the incumbent's qualifications, performance, and internal pay practices. The typical promotional increase for a promotion without external competition is up to five percent (5%) of the employee's base pay per one (1) pay grade increase.
- Typically, the promotional increase should not exceed the pay range target.
- When an employee moves from non-exempt to exempt, the loss of overtime pay will be considered. However, the realization that overtime is not guaranteed must also be considered.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- Employees who are promoted after March 31, but prior to receiving their merit increase, will have their merit increase, if any, included in the base pay used to calculate their promotional pay. If the employee's performance evaluation rating and therefore merit increase amount is not known at the time the promotional pay is being calculated, a merit increase equivalent to "Fully Meets Expectations" will be included in the base pay used to calculate their promotional pay.
- The next merit pay adjustment after a promotion may be pro-rated based on the amount of time the employee has spent in the job.

Lateral Transfer

It is considered a lateral transfer if an employee moves to a job having the same pay range target.

- Lateral job changes will not typically result in a base pay increase or adjustment unless otherwise approved by the Executive Director of Human Resources.
- Employees who are laterally transferred after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Demotion

An employee is classified as having been demoted if the employee moves to a job with a lower pay range target.

- The pay of an employee demoted due to an organizational restructure, will not be decreased unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.

- For an involuntary demotion, due to performance, or for a voluntary demotion, the pay grade of the demoted employee will be assigned to the pay grade of the employee's new classification. The employee's base pay will typically be reduced up to five percent (5%) for each pay grade demoted.

- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.

- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.

- Employees who are demoted after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Temporary Assignment

An employee who is asked to assume a full-time temporary assignment in a job having a higher pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase.

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate.

- This increased secondary pay rate is eliminated when the temporary assignment ends.

- The amount of the temporary assignment increase should be consistent with the promotion policy.

Training/Transition Overlap

In order to provide for a transition and/or training period, CalOptima may fill a regular position with a replacement in advance of the separation of a terminating employee. For the transition and/or training period, two employees may fill the same budgeted position for up to thirty (30) calendar days during the period of overlap. The immediate supervisor will determine which employee will be designated for decision-making and regulatory reporting purposes, if applicable.

Job Re-Evaluations

Job re-evaluations will be reviewed in the following priority order:

1. New Positions.

2. Change of thirty-five percent (35%) or more of duties [any change in responsibilities less than thirty-five percent (35%) will not be considered].

    - Enhancements must require a higher level of skills, abilities, scope of authority, autonomy, and/or education to qualify for a re-classification.

    - Additional duties that do not require the above will not be considered for reclassification.

    - All requests for job re-classification must be documented, signed by the department manager and submitted to the Compensation Unit.

    - In the case of management positions being re-classified, the appropriate Chief must sign the documentation.

    - The request must include the incumbent's current job description and revised job description with enhancements highlighted.

    - The request must also include justification that the re-classification supports a business need.

If the job is determined to be a priority, the Compensation Unit will analyze the job according to:

1. The job's scope against other jobs in the same discipline.

2. Available market data.

3. Appropriate title identification. The Compensation Unit will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended.

4. Job family.

5. Fair Labor Standards Act (FLSA) status.

6. Appropriate pay grade – the job will be fit into one (1) of the pay grades that currently exists. No new pay grades created.

7. A pay rate will be determined.

8. A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager.

If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date. The manager will be informed of the decision to move the job to a higher pay grade by the Compensation Unit. The amount of the pay increase should follow the guidelines in the Promotion section. If the upgrade and a pay change occur less than six (6) months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated.

If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive Director of Human Resources.

If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed.

If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed.

Job evaluations and re-evaluations will occur throughout the year; all priority jobs will be evaluated within one (1) month of the request.

If a job is not a priority or does not meet the guidelines, the manager will be notified.

Base Pay Program Maintenance

Salary Structure Adjustment

- The salary structure should be reviewed on a regular basis either annually or every other year to continue to reflect market competitiveness.
- The salary structure updates are designed to relieve any upward pressure on range minimums, midpoints and maximums that may impede the ability to attract, motivate, and retain the workforce.
- The salary structure is dynamic; it needs to be revised at regular intervals based upon market conditions to maintain market competitiveness. The goal is to keep the structure's market rates on track with market data.
- Market adjustments will be applied to the salary schedule as needed at least every two (2) years, using surveyed salary structure adjustment percentages.
- The salary structure adjustment approval process includes:
    - The Executive Director of Human Resources makes a recommendation to the CEO for approval.
    - CEO takes the recommendation to the Board for final approval.

Annual Competitive Assessment

- On a regular basis either annually or every other year, HR will identify the current competitiveness of CalOptima's pay practices by comparing: 1) current pay levels to market practices; 2) current pay levels to pay range targets; and, 3) current pay range targets to market practices.
    - CalOptima will on a regular basis either annually or every other year spot check benchmark jobs to determine market fluctuations in benchmark jobs' pay rates.
    - Based on market findings, the pay grade and ranges will be updated.
    - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations.
- The results of these analyses, along with CalOptima's current financial performance and economic situation, will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets.
- The following criteria is typically used to determine which jobs to market price each year:
    - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues.
    - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and

expenses to identify jobs with potential recruiting issues.

- Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues.
- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review all market-sensitive jobs and those on the "watch list."
- Review top ten (10) highest populated jobs on an annual basis.
- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced.
- It is recommended that at least two (2) jobs be selected from every pay range.

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends.

- On a regular basis either annually or every other year, the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments.
- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process.
    - Adjustments to pay range minimums occur prior to merit pay calculations.

Process for Making Market Adjustments

- HR performs, on a regular basis either annually or every other year, a review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs.
- HR reviews CalOptima's financial operating conditions and quantifies any recruiting/ retention issues.
- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount.
- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target; pay range maximums = 120% of the new pay range target, etc.).

- HR identifies the cost implications for the market adjustment by identifying the difference between 1) current pay rates and new pay range minimums, and, 2) current pay rates.

- The market adjustment approval process will work as follows:

    - The Executive Director of Human Resources recommends an adjustment to the CEO for approval.

    - If the CEO agrees, the CEO will seek Board approval, unless the market adjustment is within the approved pay range for the classification as designated in the Board-approved salary schedule. In such case(s), the CEO may approve the market adjustment and inform the Board of such change(s).

Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruiting and retention challenging.

- Premium pay is built into the pay range targets for these jobs.

    - Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need.

    - The desired market target rate is established on a job-by-job basis to reflect specific market conditions.

- Criteria used to determine if a job is classified as market-sensitive typically includes two (2) or more of the following:

    - Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions.

    - Job offer rejections – statistics will illustrate an increase in the number of employment offers rejected due to low starting rates.

    - Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last three (3) to six (6) months; turnover for the job will be compared to historical results for the same job and to other similarly-situated jobs.

    - Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:

        - a year-to-year increase significantly greater than the average year-to-year increase for other jobs analyzed,

        - a competitive market rate significantly higher [approximately ten percent (10%)] than its current pay range target, or

        - a competitive market rate with significantly higher pay practices [approximately ten percent (10%)] in the labor market than the average of current internal pay practices.

- When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.

- Jobs classified as market-sensitive are reviewed annually to determine if this status still applies.

    - Once a job is classified as market-sensitive, it typically remains as such until the recruiting and retention challenges subside and/or the market pay rates adjust themselves – typically not less than one (1) year.

    - When a job is no longer considered market-sensitive, the job's pay range and grade is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time.

- Throughout the year, jobs that are not yet considered market sensitive, but are showing signs of becoming so are placed on a "watch list" and monitored.

If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 6, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item
20. Consider Approval of Amendments to the Employment Agreement and Agreement Terms for the Chief Executive Officer

Contact
Brigette Hoey, Chief Human Resources Officer, (714) 246-8405

Recommended Action
Approve amendments to the Employment Agreement for the Chief Executive Officer, effective July 3, 2022.

Background
On November 4, 2021, the CalOptima Health Board of Directors (Board) appointed Michael Hunn as the Temporary (Interim) Chief Executive Officer (CEO) and authorized the Chair to execute the Employment Agreement with Mr. Hunn. On March 3, 2022, the Board appointed Mr. Hunn as the permanent CEO, and on March 17, 2022, approved his CEO Employment Agreement with no changes in the terms and conditions stipulated in his (Interim) Employment Agreement.

Discussion
Staff recommends the following amendments to the CEO Employment Agreement:

1. Amend the term of the contract from three (3) years to five (5) years, beginning March 3, 2022;
2. Amend the base salary, effective July 3, 2022;
3. Add an annual performance-based incentive, effective July 1, 2023;
4. Clarify that the amount of life and accidental death and dismemberment insurance provided will be the greater of 1X salary or $1 million; and
5. Increase paid time off days from twenty-eight (28) days to thirty-three (33) days, effective July 3, 2022.

Fiscal Impact
Upon Board approval, staff projects current year budget savings within salaries and benefits under the CalOptima Health Fiscal Year (FY) 2022-23 Operating Budget are sufficient to cover the projected expenses associated with the amendments to the Employment Agreement for the CEO through June 30, 2023. Staff will include updated expenses related to the amendments in future operating budgets.

Rationale for Recommendation
Approval of the amendments to the CEO Employment Agreement is recommended to ensure the smooth operations of CalOptima Health and the drive toward its mission and vision.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
1. CEO Employment Agreement

/s/ Michael Hunn *09/30/2022*
Authorized Signature **Date**

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AMENDED EMPLOYMENT AGREEMENT

FOR

CHIEF EXECUTIVE OFFICER

BETWEEN

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

AND

MICHAEL HUNN

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EMPLOYMENT AGREEMENT

This Employment Agreement ("Agreement") is entered into by and between the Orange County Health Authority, dba Orange Prevention and Treatment Integrated Medical Assistance, dba CalOptima ("Employer" or "CalOptima"), and Michael Hunn ("Employee") (collectively, "the Parties"). This agreement is effective at 12:00 a.m., **March 3, 2022.**

WHEREAS, CalOptima is authorized to employ and requires the services of a Chief Executive Officer ("CEO"); and,

WHEREAS, the Employee will supply the necessary skills and expertise in the area of managed health care plan management;

NOW, THEREFORE, in consideration of the above referenced recitals which are incorporated herein by reference, and the terms, conditions, covenants and promises set forth below, the Parties agree as follows:

SECTION 1. NATURE AND SCOPE OF EMPLOYMENT

Employee expressly acknowledges and agrees that he is an exempt management employee who serves at the will and pleasure of the Board of Directors of CalOptima ("Board"), that he has no property interest in his CalOptima employment, and that he may be terminated with or without cause at any time.

Employee shall function as CalOptima's CEO. His duties shall include those duties and responsibilities: (A) in the job description maintained by CalOptima's Human Resources Department; (B) as provided in the CalOptima bylaws; and (C) necessary to implement CalOptima policies, Board directives, and other duties as the Board may, from time to time, assign to Employee. The Board may use any or all such duties and responsibilities in evaluating Employee's performance. Further, at all times during his employment, Employee shall devote his full-time time, energies and loyalty to CalOptima, and comply with all policies, procedures and directives of CalOptima and the Board.

SECTION 2. TERM OF AGREEMENT; DATE OF EMPLOYMENT BEGINS

The term of this Agreement shall become effective at 12:00 a.m. on March 3, 2022 and remain in effect for an initial term of five (5) years, unless earlier terminated as set forth in Section 7 below. Thereafter, this Agreement shall renew automatically on the same terms and subject to the same conditions herein.

SECTION 3. COMPENSATION

(A) Salary. Effective July 3, 2022, CalOptima shall pay to Employee an annual base salary of _____ Thousand Dollars ($____,000.00), which shall be subject to all applicable payroll taxes and withholdings.

(B) Payment of Salary. Salary shall be paid to Employee on a pro rata basis according to the same pay periods utilized for other CalOptima employees.

(C) Incentive Compensation. The Board may, in its sole discretion, authorize annual incentive compensation to Employee not to exceed ____% of Employee's base salary, effective July 1, 2023.

(D) Modification of Contract Terms. At any time during the term of this Agreement, either party may request, and the parties shall then discuss (with no obligation on the parties, however, to reach mutual agreement) proposed modification of the terms and conditions herein, including but not limited to compensation adjustment as provided for in the 2018 Grant Thornton compensation study.

(E) Reimbursement of Job-Related Expenses. CalOptima shall reimburse Employee for ordinary and necessary job-related expenses incurred on behalf of CalOptima in accordance with CalOptima policy and applicable law. Employee shall not receive mileage for travel to and from CalOptima's office and Employee's residence. Consistent with CalOptima's travel policy, CalOptima shall pay or otherwise reimburse Employee for the cost of necessary meetings and functions Employee attends on CalOptima's behalf, including transportation, registration, meals and hotel accommodations. Employee shall provide appropriate receipts to CalOptima for any expense reimbursements.

(F) Car Allowance. CalOptima will provide Employee with $550 per month to be used as an automobile allowance. Employee will be responsible for all operating expenses of his automobile as well as for procuring and maintaining automobile liability insurance.

(G) Benefits. Employee is entitled to participate in all employee benefit programs and plans established by CalOptima from time to time for the benefit of its employees generally, and for which Employee is eligible. Employee shall also receive the following:

i. To the extent permitted under applicable law, (a) Employer will pay for Employee's portion of contributions to his CalPERS ("PERS") retirement plan under the applicable PERS formula and legal limitations, if applicable; and (b) Employer will make supplemental Public Agency Retirement System ("PARS") retirement contributions based on the same percentage applicable to all employees, subject to wage and other limits under applicable laws.

ii. At Employee's option, Employer will (a) provide term life, and accidental death and dismemberment insurance in the amount of the Employee's annual base salary, not to exceed one million dollars, rounded to the next highest thousand if

Employee's annual base salary is not an even multiple of one thousand, or (b) pay Employee an amount equal to the premium for such insurance.

iii. In addition to the Paid Time Off (PTO) accrued as of the Effective Date of this Agreement, Employee shall accrue PTO at a rate of thirty-three (33) days per year (prorated on a bi-weekly basis), effective as of July 3, 2022.

SECTION 4. HOURS OF WORK; CONFLICTS OF INTEREST

During the term of the Agreement, Employee shall devote appropriate and sufficient ability and attention to the services he is to perform for CalOptima. It is generally intended that Employee shall perform services on behalf of CalOptima during regular business hours (Monday through Friday, 8:00 a.m. to 5:00 p.m.), evening meetings, and at other times as necessary in the performance of his duties. The parties acknowledge and agree that some services to be performed for CalOptima may necessitate Employee being away from CalOptima's facilities, e.g., representing CalOptima in meetings with other health plans, with local, state and federal agencies, and with professional organizations and associations. To avoid any actual or potential conflicts of interest, Employee shall not directly or indirectly render any services of a business, commercial or professional nature to any other person or organization, whether for compensation or otherwise, that competes with the business of CalOptima or interferes with the performance of his duties hereunder while employed by CalOptima. Employee shall comply with all Federal and State laws and CalOptima policies governing conflicts of interest, including those concerning the acceptance and reporting of gifts and business transactions. Employee shall adhere to the highest ethical standards and avoid even the appearance of impropriety in the conduct of CalOptima business, including his dealings with contractors, vendors and customers of CalOptima, as well as in his private life to the extent his activities may reflect on CalOptima.

Employee will be required to uphold CalOptima's Conflict of Interest Code and file a Form 700 – Statement of Economic Interest for Designated Employees.

SECTION 5. EMPLOYEE BENEFITS

Employee shall be entitled to participate in and receive benefits in accordance with the Chief Executive Officer level benefits. Such benefits shall be administered in accordance with CalOptima policy and procedure and as approved by the Board.

SECTION 6. PERFORMANCE EVALUATION; MERIT INCREASE

The Board shall evaluate and review Employee's job performance on an annual basis. Evaluations of Employee's performance may be conducted at any time and more often than on an annual basis, at the discretion of the Board. The evaluations shall be based upon Employee's job description and the mutually agreed-upon performance goals, objectives and standards set by the Board and Employee. At evaluation sessions, the Board may discuss any performance goals,

objectives and standards which Employee is not meeting, and the Board may establish other new reasonable performance goals, objectives and standards that Employee may be required to meet by Employee's next evaluation date. Failure to meet such performance goals, objectives or standards shall be a basis for the Board to consider termination for cause. The judgment of Employee's job performance shall be at the sole discretion of the Board and shall be final. It shall be the Employee's responsibility to place performance evaluation sessions, on an annual basis, on the Board's agenda.

Employee shall be eligible for a merit increase in salary or other compensation at the conclusion of each twelve (12) month period, not to exceed five percent (5%) of the current base salary, such increase to be based on recognition of Employee's job performance, and/or increased job duties. Employee's salary may be adjusted at any time to bring the salary into compliance with Cal Optima's salary schedule and guidelines. Any merit increase in salary shall be effective upon action by the Board with subsequent written amendment to this Agreement duly executed by the Parties.

In addition to Employee's annual review, Employee will meet with the Board on a periodic basis (as determined by the Board) to provide an update and review of Employee's goals.

SECTION 7. TERMINATION OF EMPLOYMENT

(A) This Agreement shall terminate automatically and immediately upon Employee's death. Further, CalOptima may in its discretion, and as authorized by law, terminate this Agreement if Employee is permanently disabled. Employee shall be considered to be permanently disabled under this paragraph if he is unable to perform his duties as set forth in this Agreement or as established by CalOptima from time to time by reason of illness or disability for a continuous period of ninety (90) days.

(B) This Agreement may be terminated at any time by CalOptima in its sole discretion for cause by giving written notice of termination to Employee. The phrase "for cause" shall include, but is not limited to, conduct whereby the Employee: (1) willfully breaches or habitually neglects the duties that he is required to perform under the terms of this Agreement; or (2) inadequately performs his assigned duties, i.e., fails to meet performance goals, objectives or standards, or otherwise is evaluated as unsatisfactory pursuant to Section 6; or (3) is convicted of a felony; or (4) commits acts of dishonesty, fraud, misrepresentation or other acts of moral turpitude.

SECTION 8. PAYMENT UPON TERMINATION

(A) If this Agreement terminates for any reason, Employee shall receive no further compensation or benefits after the date of termination, other than such compensation as may be accrued but unpaid as of such date, or as otherwise required by law.

(B) For purposes of this Section 8, the "date of termination" shall mean the date CalOptima communicates notice of employment termination to Employee, unless otherwise specified in such notice.

(C) Notwithstanding the foregoing, Government Code section 53260 provides that all contracts of employment with a local agency include a provision limiting the maximum cash settlement for termination of the contract to the monthly salary (excluding benefits) multiplied by the number of months left on the unexpired term, but not more than eighteen (18) months if the unexpired term exceeds eighteen (18) months. Should severance pay be provided, it shall not exceed the amount authorized to be paid under Government Code section 53260.

SECTION 9. OWNERSHIP OF MATERIALS, CONFIDENTIALITY

Upon termination of this Agreement, Employee agrees to deliver to CalOptima all equipment, materials, documents and other property belonging to CalOptima. Employee also agrees to maintain the confidentiality of information related to CalOptima obtained during the term of his employment and thereafter, to the extent permitted by law.

SECTION 10. INDEMNIFICATION

CalOptima shall indemnify Employee in accordance with the provisions of the California Labor Code and the California Government Claims Act (Gov. Code §§ 810, *et seq*.)

SECTION 11. NOTICES

(A) Any notices to be given under this Agreement by either party to the other shall be in writing and may be transmitted by personal delivery or mailed by overnight delivery service (e.g., FedEx, UPS, etc.) that is subject to tracking and delivery confirmation. Mailed notices shall be addressed as follows:

If to CalOptima: CalOptima
505 City Parkway West Orange, California 92868
Attention: Chair, Board of Directors

With a Copy to: Kennaday Leavitt PC
Attention: Kelli Kennaday
621 Capitol Mall, Suite 2500
Sacramento, CA 95814

If to Employee: Michael Hunn

_____

_____

(B) Each party may change that party's address by written notice delivered in accordance with this paragraph.

(C) Notices delivered personally shall be deemed communicated as of the date of actual receipt; mailed notices shall be deemed communicated as of the date of mailing.

SECTION 12. MODIFICATION

This Agreement may not be modified or amended in any way unless such modification or amendment is in writing and signed by Employee and CalOptima.

SECTION 13. ENTIRE AGREEMENT

This Agreement supersedes any and all other agreements, either orally or in writing, and including any prior employment contracts or offer letters, between the parties hereto with respect to the employment of Employee by CalOptima, and contains all of the covenants and agreements between the parties with respect to that employment in any manner whatsoever. Each party to this Agreement acknowledges that no representations, inducements, promises or agreements, orally or otherwise, have been made by any party, or anyone acting on behalf of any party, that are not embodied herein, and that no other agreement, statement or promise not contained in this Agreement shall be valid or binding on either party.

SECTION 14. PARTIAL INVALIDITY

If any provision of the Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any way.

SECTION 15. GOVERNING LAW AND VENUE

This Agreement shall be governed by and construed in accordance with the laws of the State of California. Any dispute arising out of this Agreement shall be venued in the Superior Court of California in Orange County, California.

As required under Ordinance No. 3896 of the County of Orange, as amended, the parties hereto acknowledge and agree that the obligations of CalOptima under this Agreement are solely the obligations of CalOptima, and the County of Orange shall have no obligation or liability hereunder.

SECTION 16. DEATH OF EMPLOYEE

If Employee dies prior to the expiration of the term of his employment, any sums that may be due him by CalOptima under this Agreement as of the date of death shall be paid to Employee's executors, administrators, heirs, or legal representatives.

SECTION 17. BINDING EFFECT

This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their heirs, legatees, representatives and successors.

SECTION 18. RECITALS

The recitals are incorporated herein as if set forth in full.

SECTION 19. ACKNOWLEDGMENT

Employee acknowledges that he has carefully read this Agreement and understands its contents; that he has been given the opportunity to consult with an attorney of his choice regarding this Agreement; that he has had sufficient time to review this Agreement; that he is executing this Agreement knowingly and voluntarily, without any coercion or duress; and that he has not relied on any representations or promises of any kind made to him in connection with his decision to execute this Agreement, except for those set forth herein.

SECTION 20. COMPLIANCE WITH GOVERNMENT CODE SECTIONS 53243, *ET SEQ*.

If Employee is convicted of a crime involving an abuse of his office or position, all of the following shall apply:

(A) If Employee is provided with administrative leave pay pending an investigation, Employee shall be required to fully reimburse CalOptima for such amounts paid;

(B) If CalOptima pays for the criminal legal defense of Employee (which would be in its sole discretion, as it is not generally required to pay for a criminal defense), Employee shall be required to fully reimburse CalOptima such amounts paid; and

(C) If this Agreement is terminated, any cash settlement related to the termination that Employee may receive from CalOptima shall be fully reimbursed to CalOptima or void if not yet paid to Employee.

For this subsection, "abuse of office or position" means either (1) an abuse of public authority including, but not limited to, waste, fraud, and violation of the law under color of authority; or

(2) a crime against public justice including, but not limited to, a crime, described in Title 5 (commencing with Section 67), Title 6 (commencing with Section 85), or Title 7 (commencing with Section 92) of Part 1 of the Penal Code, as these statutes may, from time to time, be amended.

SECTION 21. ATTORNEY'S FEES

Except as provided elsewhere in this Agreement, if any legal action or proceeding is brought to enforce or interpret this Agreement, the prevailing party, as determined by the court, shall be entitled to recover from the other party all reasonable costs and attorney's fees, including such fees and costs as may be incurred in enforcing any judgment or order entered in any such action.

SECTION 22. NON-ASSIGNMENT

This is an agreement for personal services and may not be assigned by Employee to any third party.

SECTION 23. COUNTERPARTS

The Agreement may be executed in two (2) or more counterparts, including via facsimile or electronically-transmitted signature, each of which shall be deemed an original, but all of which together shall constitute one-in-the-same document.

(SIGNATURE PAGE TO FOLLOW)

IN WITNESS WHEREOF, the parties hereto certify that the individuals signing below have authority to execute this Agreement on behalf of their respective organizations, and may legally bind them to the terms and conditions of this Agreement, and any attachments hereto. The parties have signed this Professional Services Agreement as set forth below.

MICHEAL HUNN:

By: _____
Michael Hunn

Date: _____

CALOPTIMA:

By: _____
Chair, CalOptima Governing Board

Date: _____

Attest: _____
Secretary, CalOptima Governing Board

Date: _____