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

FEBRUARY 2, 2023
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.	Vacant
Nancy Shivers, R.N.	Trieu Tran, M.D.

Supervisor Vicente Sarmiento, Alternate

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

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

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

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

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_KtgUSXCoSaW-R-JKLwwcFQ and Join the Meeting.

Webinar ID: 892 4864 3776
Passcode: 135549-- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
1. Orange County Business Council's 2022 Public Private Partnership Award Presentation

MANAGEMENT REPORTS
2. 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
3. Minutes
   a. Approve Minutes of the December 1, 2022 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the September 14, 2022 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

4. Adopt Board Resolution No. 23-0202, 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)

5. Ratify an Amendment to CalOptima Health's Primary Agreement with the California Department of Health Care Services

6. Approve Modifications to CalOptima Health Budget Approval and Budget Reallocation Policy

7. Approve New CalOptima Health Policy GA.7110p: Street Medicine

8. Authorize Amendment of Federal Advocacy Services Contract with Potomac Partners DC, LLC and Proposed Budget Allocation Change in the CalOptima Health Fiscal Year 2022-23 Operating Budget

9. Approve Actions Related to the Procurement of a Member and Provider Engagement Platform Solution

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

REPORTS/DISCUSSION ITEMS

11. Authorize Actions for Contracts for the Proposed Community Living and PACE Center in the City of Tustin

12. Approve Actions Related to the Homeless Health Initiatives

13. Authorize Expansion of the CalOptima Health Outreach Strategy to Enroll Eligible CalOptima Health Members into CalFresh and other Public Assistance Programs and Support Redetermination Services

14. Authorize Contract with Vendor to Assist with Member Health Needs Assessment 2023 Activities

15. Approve an Amendment to the Kaiser Foundation Health Plan, Inc. Medi-Cal Health Maintenance Organization Contract to Extend Current Capitation Rates

16. Authorize the Chief Executive Officer to Execute a Contract Amendment with The Burgess Group, LLC to Implement a Batch Modeling Solution in Support of CalOptima Health's Digital Transformation Strategy

ADVISORY COMMITTEE UPDATES

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

CLOSED SESSION

~~CS-1 Pursuant to Government Code section 54956.8 CONFERENCE WITH REAL PROPERTY NEGOTIATIORS~~
~~Property: 7900 Garden Grove Avenue, Garden Grove, CA 92841~~
~~Agency Negotiator: David Kluth, and Mai Hu, Newmark Knight Frank~~
~~Negotiating Parties: Lvt Inc.~~
~~Under Negotiation: Price and terms of payments~~

Rev. 2/2/2023 Agenda Item Pulled

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 February 2, 2023 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_KtgUSXCoSaW-R-JKLwwcFQ

To **Join** from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join.
https://us06web.zoom.us/s/89248643776?pwd=Q0dGWSt2UmRiSXdVOU1NWGlWNFJSQT09

Passcode: **135549**

Or One tap mobile:
+16694449171,,89248643776#,,,,*135549# US
+17207072699,,89248643776#,,,,*135549# 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 +1 253 205 0468 or +1 253 215 8782 or +1 346 248 7799 or +1 719 359 4580 or +1 386 347 5053 or +1 507 473 4847 or +1 564 217 2000 or +1 646 558 8656 or +1 646 931 3860 or +1 689 278 1000 or +1 301 715 8592 or +1 305 224 1968 or +1 309 205 3325 or +1 312 626 6799 or +1 360 209 5623

Webinar ID: **892 4864 3776**
Passcode: **135549**
International numbers available**: https://us06web.zoom.us/u/kbVCGL2Jmh**

PRESENTATIONS/INTRODUCTIONS

1. Orange County Business Council's 2022 Public-Private Partnership Award Presentation

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MEMORANDUM

DATE:	January 25, 2023
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — February 2, 2023, 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. <u>New Year Brings Continued Progress in CalAIM Implementation</u>

- ***Five New Community Supports Begin***
  On January 1, CalOptima Health launched five additional Community Supports, which now completes our offering of all 14 services that are part of CalAIM's expansion of Medi-Cal benefits. The five new supports are respite services (for caregivers), home modifications, transition services from nursing facilities, diversion services from nursing facilities to assisted living, and asthma remediation. We now have more than 60 community providers under contract to provide the variety of Community Supports.

- ***Enhanced Care Management (ECM) Academy Launches***
  CalOptima Health developed the ECM Academy to expand the network of organizations providing ECM services. The goal is to train Federally Qualified Health Centers (FQHCs) and community-based organizations (CBOs) to provide ECM benefits, resulting in more members receiving culturally relevant care tailored to their unique needs. The first cohort will participate from January to June. More than 20 FQHCs and CBOs are enrolled. Based on high demand, additional cohorts are planned for the future.

b. <u>Three New Medical Directors Join CalOptima Health</u>

- ***Donna Frisch, M.D.*** is the new PACE Medical Director. Most recently, Dr. Frisch was medical director for Optum while also caring for her patients as an internal medicine physician. As PACE medical director, she will provide clinical leadership for the program, supervise clinical staff, and work with leadership to develop, implement and update policies focused on providing quality care. Dr. Frisch has a bachelor's degree in international relations from UC Davis, a master's degree in exercise physiology from Chapman University, and a medical degree from UC Irvine.

- ***Said Elshihabi, M.D.*** is leading the development of CalOptima Health's value-based neurosurgery and spine program. He is a board-certified neurosurgeon with expertise in managing spinal disorders, brain tumors and cranial trauma and performing interventional spine procedures. Dr. Elshihabi has more than 15 years of active private practice experience and five years of utilization and quality management experience in neurosurgery and spine surgery. He received his medical degree from the University of Texas Health Science Center at San Antonio and completed his neurosurgery residency at the University of Arkansas for Medical Sciences.

- ***Tanu Pandey, M.D., MPH, FACP*** is responsible for health areas including transgender health, appeals and grievances, and quality. She is double board certified in internal and preventive medicine and has a master's degree in public health. She was in clinical practice for more than 20 years before becoming a full-time physician executive. Dr. Pandey also worked in academic medicine as core faculty at Cook County Hospital and Rush University in Chicago, and at the Geffen School of Medicine at UCLA.

c. CalOptima Health Manages Significant Government Affairs Activity

- ***State Advocacy Efforts Expanding***
  In January, I traveled to Sacramento with COO Yunkyung Kim and Donovan Higbee, Senior Manager, Government Affairs, for the swearing-in of the California State Legislature's new 2023–24 session as well as a state strategy session with our contracted state lobbying firm Edelstein Gilbert Robson & Smith, outside general counsel Jim Novello and CalOptima Health's new Senior Director of State Affairs, Kevin Bassett. Together, we laid out a bold agenda for high-touch engagement in Sacramento to advance our key policy priorities in the new year. Later, we attended meet-and-greets with several new and returning legislators and staff in their Capitol offices and shared packets with CalOptima Health educational materials.

- ***CalOptima Health Invited to Participate in Democratic Caucus Policy Retreat***
  Reflecting CalOptima Health's growing influence, Assembly Speaker Anthony Rendon invited Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, and me to speak at the Assembly Democratic Caucus policy retreat in mid-January to share how we are leveraging CalAIM to develop innovative solutions to reduce homelessness. Separately, while in Sacramento, I also held productive in-person meetings with Sen. Bob Archuleta (D) and Sen. Kelly Seyarto (R) and their staffs to discuss CalOptima Health's role in serving constituents in their new districts.

- ***Fiscal Year (FY) 2023 Federal Appropriations Affect Medi-Cal***
  Both houses of Congress passed the FY 2023 omnibus spending bill to fund the federal government through September 30, 2023. Below are key provisions impacting our agency:
  - $2 million earmark for CalOptima Health's Care Traffic Control initiative, sponsored by U.S. Reps. Lou Correa and Young Kim
  - Medicaid redeterminations starting April 1, 2023, regardless of the expiration date of the COVID-19 public health emergency
  - Phase-out of enhanced Medicaid Federal Medical Assistance Percentage (FMAP) between April 1 and December 31, 2023
  - Permanent, one-year continuous Medicaid eligibility for children under 19 years old (state mandatory) as well as pregnant and postpartum women and newborns (state optional)

- Mandatory Medicaid coverage for eligible juvenile inmates to receive health screenings, referrals and case management, starting in 2025
- Extension of current Medicare telehealth flexibilities through December 31, 2024.
- Medicare Part B coverage of marriage and family therapist services and mental health counseling services, starting in 2024
- Elimination of 4% cuts to Medicare payments in FY 2023 and FY 2024 that otherwise would have been required by the Pay-As-You-Go Act of 2010 (PAYGO) Act

- ***Governor Proposes FY 2023–24 State Budget***
  On January 10, Gov. Gavin Newsom released his proposed state budget for FY 2023–24, beginning July 1, 2023. The $297 billion budget proposal reflects a 9.8% decrease in overall spending from the FY 2022–23 Enacted Budget while still maintaining nearly all $35.6 billion in existing reserves. With an expected budget deficit of $22.5 billion this year due to reduced tax revenue, the state is in a different place than last year's record-high surplus. In the coming months, the State Legislature will hold committee hearings to review the governor's proposals as well as consider its own proposals. Then, Gov. Newsom will release a revised budget proposal (May Revise) by May 14, after which the Administration and Legislature must negotiate and enact a final budget by July 1. CalOptima Health will work closely with stakeholders and legislators to advance the agency's priorities. Below are highlights of the proposed budget:
  - Maintaining most investments in health care and homelessness — and even proposing some additional funding for Medi-Cal
  - Fully funding all CalAIM initiatives as well as expanding Medi-Cal to undocumented immigrants ages 26–49 by January 1, 2024
  - Increasing Medi-Cal rates for primary care providers, obstetricians and doulas
  - Adding a new Community Support for Transitional Rent, paying for up to six months of rent or temporary housing for those experiencing or at risk of homelessness who are transitioning out of certain institutional settings
  - Including a three-year renewal of the Managed Care Organization (MCO) tax, which recently expired on December 31, 2022, to partially compensate for the expected deficit. As proposed, the MCO tax would reactivate from January 1, 2024, through December 31, 2026, using the same model as the previous MCO tax, though the Administration indicates it will explore opportunities to increase the tax

d. <u>Public Health Emergency (PHE) Extended to April When Redetermination Begins</u>

The COVID-19 PHE has been extended into April. During the PHE, Medi-Cal members retained coverage regardless of any changes in circumstances. However, as part of FY 2023 federal budget, the continuous coverage requirements will end after March 31, 2023, regardless of when the PHE ends. Starting April 1, counties will then begin a process of redetermination to verify if members are still eligible for Medi-Cal. CalOptima Health members will receive a mailed letter asking to confirm their contact information as an initial step in this verification effort. We have been publicizing redetermination through our social media postings, publications, website and other channels, encouraging members who have changed addresses or other contact information during the PHE to notify the County of Orange Social Services Agency.

e. Homeless Health Services Remain Key Agency Focus

- ***Housing and Homelessness Incentive Program (HHIP) Funds Received***
  HHIP allows CalOptima Health to earn incentive funds for making investments and progress in addressing homelessness. On December 16, the Department of Health Care Services (DHCS) shared that CalOptima Health was awarded the maximum incentive amount of $8.37 million for the submission of our investment plan, a key deliverable in the multiyear effort. We will combine this funding with other committed dollars to make strategic investments throughout Orange County to help mitigate the homelessness crisis and ensure that members can access services needed to maintain their housing. This funding is in addition to $4.18 million we received for the submission of a local homelessness plan in June 2022. The remaining deliverables include two reports on progress made toward HHIP's goals, due in March and December 2023, with the potential to earn a total of $71.1 million.

- ***HHIP Funding Opportunity Offered to CBOs***
  Through the HHIP program, CalOptima Health can earn up to $83 million in funding for meeting specific program measures that fall under three priority areas: 1) infrastructure to coordinate and meet member housing needs; 2) partnerships and capacity to support referrals for services; and 3) delivery of services and member engagement. As part of this effort, CalOptima Health launched a funding opportunity offering $36.5 million in grants to community organizations that will advance these goals. Applications are due by January 31.

- ***Kelly Bruno-Nelson Joins Continuum of Care (CoC) Board***
  Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, was elected to the Orange County CoC Board as the designated health care representative. Since 1998, the County of Orange has operated a comprehensive CoC Board to develop and implement a strategy to address homelessness.

f. National Health and Nutrition Survey Comes to Orange County

Orange County is one of 15 counties nationwide selected to be part of the Centers for Disease Control and Prevention's (CDC) National Health and Nutrition Examination Survey (NHANES). The CHC is administering the survey at the NHANES Mobile Examination Center at the Orange County Fairgrounds from January 5 through March 13. CalOptima Health is helping raise awareness in the public and health care community about the NHANES effort. Chief Medical Director Richard Pitts, D.O., Ph.D. will participate in a media event alongside representatives from other Orange County agencies and the CDC on Friday, February 3.

g. OneCare Connect Transition Completed, OneCare Sees Membership Growth

On January 1, the OneCare Connect plan and its members automatically transitioned to OneCare (HMO D-SNP), a Medicare Medi-Cal Plan. As a result of that transition, the total OneCare membership increased from 3,000 to 17,381, including 477 new members who were enrolled because of efforts by outside sales agencies and our internal sales team.

h. Medical Audit to Begin in Late February

CalOptima Health is preparing for the DHCS routine medical audit of Medi-Cal. This year is considered a full-scope audit, and as such, many areas not audited in recent years are included (i.e., Cultural & Linguistics, Health Education, Privacy, Complex Case Management, etc.). The audit begins February 27 and will continue through March 10.

i. CalOptima Health Featured in Magazine's Companies That Care Issue

CalOptima Health was featured in the Orange County Business Journal's Companies That Care issue in December. The issue spotlighted companies that focus on mission-driven efforts and philanthropic programs to serve the Orange County community.

j. CalOptima Health Featured in Media Coverage

- On December 2, CBS News interviewed Chief Medical Officer Richard Pitts, D.O., Ph.D., on the benefits of Paxlovid for treating long-COVID.
- On December 5, the Orange County Breeze, Newsbreak and NewSantaAna.com covered CalOptima Health's $50.1 million investment in cancer prevention.
- On December 7, NewSantaAna.com ran an article about CalOptima Health's $5 million grant for a NAMI peer support program.
- On December 16, the Orange County Register interviewed Dr. Pitts about the cancer prevention program.
- On December 19, U.S. News interviewed PACE Director Monica Macias on coordinating care for elderly parents.
- On December 25, KROQ 106.7 interviewed NAMI OC President Steve Pitman who mentioned CalOptima Health's grant-funded peer support program. (mention starts at 8:00)
- On January 5, U.S. News published a slide show featuring tips by CalOptima Health's health coach Sara Bagheri about achieving better weight loss results.

CalOptima Health

Fast Facts
February 2023

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

Membership Data* (as of December 31, 2022)

Total CalOptima Health Membership

944,975

Program	Members
Medi-Cal	927,086
OneCare Connect	14,385
OneCare (HMO D-SNP)	3,067
Program of All-Inclusive Care for the Elderly (PACE)	437

*Based on unaudited financial reports and includes prior period adjustment. Data from prior to the OneCare Connect program end on January 1, 2023.

Operating Budget (for six months ended December 31, 2022)

	YTD Actual	YTD Budget	Difference
Revenues	$1,977,621,527	$2,012,577,662	($34,956,135)
Medical Expenses	$1,845,891,763	$1,887,619,046	$41,727,283
Administrative Expenses	$88,320,082	$105,075,379	$16,755,297
Operating Margin	$43,409,682	$19,883,237	$23,526,445
Medical Loss Ratio (MLR)	93.3%	93.8%	(0.5%)
Administrative Loss Ratio (ALR)	4.5%	5.2%	0.8%

Reserve Summary (as of December 31, 2022)

	Amount (in millions)
Board Designated Reserves	$568.6*
Capital Assets (Net of depreciation)	$67.5
Resources Committed by the Board	$451.8
Resources Unallocated/Unassigned	$382.4*
Total Net Assets	$1,470.2

Total of Board designated reserves and unallocated resources can support approximately 97 days of CalOptima Health's current operations.

Total Annual Budgeted Revenue **$4 Billion**

CalOptima Health Fast Facts

February 2023

Personnel Summary (as of January 20, 2023)

	Filled	Open	Vacancy %
Staff	1,342.6	144.8	9.74%
Manager	103.0	7.0	6.36%
Director	51.0	16.0	23.88%
Executive Director	10.0	3.0	23.08%
Chief	8.0	2.0	20.00%
Total FTE Count	1,514.6	172.8	10.24%

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

Provider Network Data (as of December 31, 2022)

	Number of Providers
Primary Care Providers	1,475
Specialists	9,292
Pharmacies	565
Acute and Rehab Hospitals	44
Community Health Centers	34
Long-Term Care Facilities	98

Treatment Authorizations (as of November 30, 2022)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	17.82 hours
Prior Authorization – Urgent	72 hours	16.14 hours
Prior Authorization – Routine	5 days	1.72 days

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

Member Demographics (as of December 31, 2022)

Member Age	
0 to 5	9%
6 to 18	25%
19 to 44	34%
45 to 64	20%
65 +	12%

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

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	40%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	9%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

December 1, 2022

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on December 1, 2022, at CalOptima Health, 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 Do called the meeting to order at 2:03 p.m., and Director Isabel Becerra led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chairman; Clayton Corwin, Vice Chair; Isabel Becerra; Supervisor Doug Chaffee (at 2:07 p.m.); Clayton Chau, M.D. (non-voting); Blair Contratto (at 2:09 p.m.); José Mayorga M.D.; Scott Schoeffel (left meeting at 2:38 p.m.); Nancy Shivers; Trieu Tran, M.D.

(All Board Members participated remotely except Chairman Do, Vice Chair Corwin, Director Becerra, and Director Contratto who participated in person)

Members Absent: None.

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

PRESENTATIONS/INTRODUCTIONS

None.

The Clerk noted for the record that staff is pulling Agenda Item 10 off the Consent Calendar and moving it to a Report Item. Agenda Item 10 will be heard at the top of the Reports/Discussion Items section of the agenda.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Michael Hunn, Chief Executive Officer (CEO), started his report with CalOptima Health's mission statement, which is to serve member health with excellence and dignity, respecting the value and needs of each person. Mr. Hunn noted that CalOptima Health has several important actions before the Board today and is requesting Board support of $242.5 million dollars, of which $232.5 million will come from reserves and all of which is focused on providers, members, and quality. In addition, CalOptima Health will undertake discussions on policies, including Agenda Item 10, which he moved from the Consent Calendar to the Reports agenda section to allow for discussion.

Mr. Hunn reviewed CalOptima Health's Fast Facts as of October 2022 and noted that CalOptima Health is ahead of budget for its operating margin at almost $18 million. Its administrative loss ratio (ALR) is at

4.1%, which means that 94.7% of every dollar is spent on member care, and approximately 5 cents is spent on administering the program.

CalOptima Health's reserves are about $1.4 billion. Of that amount, $444 million is unallocated and unassigned. Staff will be asking the Board to approve an allocation from those unallocated or unassigned reserves and noted that it will leave over 70 days of cash on hand. The remaining amount meets the Board's reserve policy that requires CalOptima Health to have one and half to two months of reserves at any given time.

Mr. Hunn also reviewed the CalOptima Health personnel data and noted there are 1,488 employees with a vacancy rate of about 11%. Mr. Hunn applauded the human resources team and the recruiting team for doing a great job in keeping open positions filled. He noted that CalOptima Health will always be undergoing a perpetual recruitment. There will always be about 200 positions that are constantly in motion due to people being recruited from outside agencies and people getting promoted.

Mr. Hunn reviewed the provider data, noting that CalOptima Health has over 10,000 providers, 1,500 primary care providers, and 9,000 specialists; almost 600 pharmacies; 45 acute and rehab hospitals; 34 community health centers; and about 100 long term care facilities.

Mr. Hunn also reviewed CalOptima Health's treatment authorizations. He noted that the Board set a goal in its vision that by 2027 CalOptima Health would achieve same day treatment authorizations, real-time claims payments, and annual assessments of members' social determinants of health. The treatment authorization summary speaks directly to the first vision goal of same-day treatment authorizations. For urgent inpatient treatment authorizations, the average approval is within 26.6 hours; the state-mandated response is 72 hours. For urgent prior authorizations the average approval is within 12 hours; the state-mandated response is 72 hours. And for routine prior authorizations the average approval is within one and half days; the state-mandated response is 5 days. Mr. Hunn thanked Kelly Giardina, Dr. Pitts, and their teams for their hard work to achieve these results.

Director Contratto complimented staff on an incredible report and noted that it is so nice to see at the top of each meeting all the meaningful work that CalOptima Health is doing for its members.

Mr. Hunn reported that CalOptima Health was the recipient of an Orange County Business Council (OCBC) award for the outstanding work that has been done between CalOptima Health and in partnership with the Health Care Agency. Mr. Hunn complimented and thanked those people who had the vision for CalOptima Health's participation in the public-private partnership, which was recognized by OCBC, and reiterated CalOptima Health's continued steadfast support for behavioral health, mental health and wellbeing, and members living healthy lives. Mr. Hunn noted that OCBC will come to a future meeting to present the award directly to the Board. Mr. Hunn added that he also wanted to thank the visionaries, Chairman Do, Director Chau, and others who have been instrumental in CalOptima Health having the work in place to deal with behavioral health issues in the public-private partnership.

Mr. Hunn also mentioned that the public health emergency (PHE) will likely be continued and reminded everyone that once the PHE ends, it will trigger the redetermination. CalOptima Health continues to work closely with the Social Services Agency to prepare for the redetermination. CalOptima Health intends to release a request for proposal to help with the annual assessment of the social determinants of health to better understand how best to care for members.

Back to Agenda

CEO Hunn also thanked U.S. Representative Lou Correa for hand-delivering a letter to Xavier Becerra, Secretary of the U.S. Department of Health and Human Services (HHS), regarding current barriers to the Program of All Inclusive Care for the Elderly (PACE) enrollment. CalOptima Health has asked for clarification on the Centers for Medicare & Medicaid Services (CMS) regulations that prevent PACE organizations from enrolling older adults who are not considered stably housed.

In closing, Mr. Hunn acknowledged the upcoming holiday season and the magnitude of stress that individuals feel during the holidays. He encouraged everyone to reach out for help when they are feeling stressed and to be kind to each other.

Chairman Do thanked Mr. Hunn for his update and provided details on a Board action, from about 4 years ago that narrowly passed, that approved $13 million dollars to help fund Be Well OC. With that investment came the building of the Anita Drive facility, which stands up, the first in the history of Orange County, as a mental health care system and is now expanding to the Irvine campus and others. This also started the mobile response system that is in place now in 6 cities in the county, which has proven to be a huge success and a great supplement to the mental health response in the county. Chairman Do added the reason he brought Be Well OC up is to show the role CalOptima Health plays as an agency. CalOptima Health is not just an agency that pays bills, it has the responsibility to stand up a system to address the health needs of the county and that responsibility must be kept in mind in what CalOptima Health does today and into the future.

2. Digital Transformation Update

Wael Younan, Chief Information Officer, provided an update on CalOptima Health's Digital Transformation, which included an update on the significant progress made in CalOptima Health's digital transformation goals. CalOptima Health has enrolled 99,000 members into its member portal; registered 15,000 providers into its provider portal; and transmitted 5.6 million patient care claims and 4.3 million patient encounters; and mounted 6.9 million admissions, discharges, and transfers. CalOptima Health has reduced manual data entry by 719 hours for pharmacy authorizations through automation and elimination of faxing by 75% year-to-date; an 80% reduction of pharmacy submissions from five days to one day. Mr. Younan added that CalOptima Health intends to complete 30 Information Technology Services security projects for better protection of member data and to protect against malicious attacks. Mr. Younan noted that these projects will not require any additional funding because staff is fully utilizing the solutions CalOptima Health currently owns.

Mr. Younan reported that CalOptima Health will begin migration to the Cloud starting in December 2022, noting that the process will run well into 2023. Staff is looking at several emerging solutions in partnership with CalOptima Health's clinical teams around redetermination intelligent texting and the creation of the first ever CalOptima Health mobile application. Mr. Younan also noted that CalOptima Health has been capturing portal usage and in the third quarter alone, there were 2 million searches for claims, 1.5 million member inquiries, 240,000 referral searches, and just under 50,000 referral submission searches. The usage illustrates the efficiency of providing quicker turnaround and accessibility to the data. It allows providers the ability to search for claims, labs, condition, history, medications, and referrals and gives members the ability to submit inquiries directly through the portal. Staff will continue to evaluate the types of calls that come into CalOptima Health to determine future enhancement for the provider portal.

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Mr. Younan reported that so far through digital transformation, CalOptima Health expects to save roughly $817,000. He also reviewed the list of in progress or approved systems and solutions with costs associated for each, a running total of spending, and total projected costs. Lastly, Mr. Younan reviewed the 2022 key planning milestones for quarters 1 through 4. He noted which milestones are complete and which remain to be completed in quarter 4. These include work on CalAIM and additional staffing for these projects.

The Board asked about the $17 million noted on slide 4 of the presentation and wondered if that will be deducted from the total of $100 million initially approved for the digital transformation. They also asked if staff anticipates needing all the $100 million budgeted for digital transformation or if there may be additional cost savings.

Mr. Younan responded that he believes CalOptima Health will realize savings as various projects get underway.

PUBLIC COMMENTS

1. Michelle Dytan – Oral re: Oncology and Kids and potential funding or resources for this organization.
2. Michael Weiss, M.D., CHOC Children's – Oral re: Agenda Item 10 – Oppose
3. David Gibbs, M.D., Children's Health of Orange County – Oral re: Agenda Item 10 – Oppose
4. Kate Williamson, American Academy of Pediatrics & CHOC Primary Care Network – Oral re: Agenda Item 10 – Oppose
5. Kerri Schiller, CHOC Children's – Oral re: Agenda Item 10 – Oppose
6. Karen Alvarez, American Cancer Society – Oral re: Agenda Item 28 – Support
7. Yoli Origel, Cancer Kinship – Oral re: Agenda Item 28 -- Support

CONSENT CALENDAR

3. Minutes

a. Approve Minutes of the November 3, 2022 Regular Meeting of the CalOptima Health Board of Directors
b. Receive and File Minutes of the September 15, 2022 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

4. Adopt Board Resolution No. 22-1201-01, 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)

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

6. Approve CalOptima Health's Calendar Year 2023 OneCare Member Health Rewards and Incentives

7. Authorize an Amendment to the Kaiser Foundation Health Plan Inc. Medi-Cal Health Maintenance Organization Contract for Health Care Services

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

8. Authorize Contract Amendment Related to CalOptima Health's Key Operational System Vendors for Office Ally Inc., Change Healthcare Technologies LLC, and Health Management Systems, Inc.
Director Schoeffel did not participate in this item due to potential conflicts of interest.

9. Approve New CalOptima Health Claims Administration Policy FF.1014p

10. Approve Updates to CalOptima Health Policy EE.1106: Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment
This item was moved from the Consent Calendar to Reports/Discussion Items section of the agenda.

11. Approve Modification to CalOptima Health Policy AA.1223: Participation in Community Events with External Entities
This item was pulled for discussion.

12. Approve CalOptima Health Board of Directors' Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee Policies and Procedures

13. Adopt Resolution No. 22-1201-02 Approving and Adopting Updated and New CalOptima Health Human Resources Policies

14. Adopt Resolution No. 22-1201-04 Approving Updated CalOptima Health Policy GA.8012

15. Adopt Resolution No. 22-1201-05 Approving and Adopting Updated CalOptima Health Policy GA.8058: Salary Schedule and Authorize the Chief Executive Officer to Implement Changes to Executive Level Job Titles

16. Adopt Resolution No. 22-1201-06 to Amend CalOptima Health's Conflict of Interest Code

17. Adopt Resolution No. 22-1201-03 Approving Revised 2023 CalOptima Health Compliance Plan, 2023 CalOptima Health Code of Conduct, 2023 CalOptima Health Anti-Fraud, Waste and Abuse Plan, and Authorizing Approval of Revised CalOptima Health Office of Compliance Policies and Procedures

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

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

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20. Receive and File:

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

Chairman Do noted for the record that Director Schoeffel will not be participating on Consent Calendar items 7 and 8 due to potential conflicts of interest.

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors approved the Consent Calendar Items 3 through 20, minus Consent Calendar Item 10, which was moved to Reports and Consent Calendar, and Item 11, which was pulled for discussion, as presented. (Motion carried 8-0-0; Director Schoeffel absent)***

11. Approve Modification to CalOptima Health Policy AA.1223: Participation in Community Events with External Entities

Director Contratto pulled this item for discussion and made an amended motion to increase the amount of funding that the Chief Executive Officer is authorized to approve for community event requests for these events from $10,000 to $25,000.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors approved the proposed modification to CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities and amended the dollar amount that the Chief Executive Officer is authorized to approve for community event requests up to $25,000 instead of $10,000 as originally included in the policy presented. (Motion carried 8-0-0; Director Schoeffel absent)***

REPORTS/DISCUSSION ITEMS

10. Approve Updates to CalOptima Health Policy EE.1106: Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment

Mr. Hunn briefly introduced this item, noting that this particular policy is regarding the minimum and maximum number of members an individual network can manage at any given time. He added that the current policy was set by CalOptima Health back in 1996 and states that no one network should have greater than 30% of the total membership. Mr. Hunn noted that Optum has about 21% of CalOptima Health's 940,000 members due the fact that three of CalOptima Health's networks combined under Optum. CHOC Health Alliance currently serves about half of the total number of children enrolled in CalOptima Health. Since CHOC Health Alliance only sees children and not adults, this policy proposes that the formula for auto assignment be based on the population served. Mr. Hunn reminded the Board that the member always has a choice and can choose their preferred provider.

Mr. Hunn noted that it is important for CalOptima Health to elevate all its networks, not only in their quality and outcomes, but also in their ability to provide services. Staff has been reaching out and speaking with networks, providers, and physicians and all of the networks want to be supported by CalOptima Health. As the insurance plan for the Medicaid population, it is incumbent upon CalOptima

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Health to have a diverse network that can withstand the pressures of any single major event.

Yunkyung Kim, Chief Operating Officer, added that with this policy CalOptima Health is proposing two substantive changes relating to the one-third member enrollment ceiling threshold. The first is that CalOptima Health is establishing that if multiple health networks share ownership, then they are treated as a single network and membership numbers are counted together. Ms. Kim added that the second change is that if a health network only enrolls a subset of members, then the denominator for calculating enrollment will be that subset population only. The network immediately impacted by this policy change would be CalOptima Health's pediatric network CHOC Health Alliance. CHOC Health Alliance is currently the only health network that enrolls a subset of membership. If this policy is approved, auto assignment for CHOC Health Alliance would now be turned off. The things that would not change are member choice and family linkages. Another part of auto assignment that will not change is the clinic-based auto assignment. So, for any network that is above the 30% threshold, auto assignment would cease for that network.

After hearing public comment on Agenda Item 10, Chairman Do asked if any Board members had questions or comments.

Director Becerra asked if CHOC sees adults. Ms. Kim responded that CHOC does not enroll adults.

Director Contratto asked two questions. First, whether staff can address Dr. Weiss' comments that only one health network is being negatively affected by this change as opposed to what was said earlier about how it negatively impacts other pediatric health networks and providers. Second, Director Contratto asked if CalOptima Health looked at LA Care and Inland Empire Health Plan (IEHP) to see if they are facing similar challenges.

For the first question, Ms. Kim responded that the direct network is subject to a 10% threshold and has already hit that maximum. The direct network continues to grow due to member choice. CHOC is the other affected network because they are currently above the one-third threshold. For the second question, Ms. Kim noted that other plans like LA Care and IEHP have a slightly different model where both invest heavily in their direct network. So, while CalOptima Health has set a threshold for its direct network at 10%, LA Care, for example, retains 50% in their direct network, and IEHP has taken a proactive policy approach of promoting a direct network and a smaller number of members distributed to their delegated network.

Director Mayorga had concerns regarding the message this policy is sending to the community. As a physician, he wants to ensure that patients have the highest level of care and quality of care. Director Mayorga noted that he has had a lot of experience working with every network in various settings and one of the things that is very clear is that all health networks currently have pediatric memberships, yet with smaller membership they are not performing as well as CHOC Health Alliance. He stated that CalOptima Health has provided those health networks the opportunity to do that with various incentives and motivation in regards to that and we see that CHOC Health Alliance with their magnitude of patient volumes still outperform many of them.

Vice Chair Corwin confirmed that CalOptima Health tracks members that choose a health network and those that are auto assigned. He also asked when it would be feasible to evaluate the performance of the health networks that will be taking on children and to ensure they are performing well.

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Mr. Hunn responded that CalOptima Health will continuously monitor and will report back to the Board when and as many times as the Board deems appropriate.

Director Tran stated that, as a practicing physician and from his experience, members do not know what health network they are seeing, they only know they have CalOptima Health or Medi-Cal. He added that it seems that CHOC Health Alliance is getting punished for going a good job. The reason that CHOC Health Alliance is successful and has grown is because they do a good job.

Mr. Hunn noted that the intent of this policy is not to penalize any network. He noted that he has the utmost respect for all the doctors who spoke today. This policy is about helping CalOptima Health's networks grow and ensuring it has a strong network with capacity for any health emergency that comes its way.

Chairman Do commented that with the rise of respiratory syncytial virus (RSV) cases CHOC Health Alliance went to the Board of Supervisors meeting recently with questions about initiating an emergency health declaration due to lack of capacity that would lower the regulation that a licensed hospital needs to treat pediatric patients to allow non-pediatric hospitals to provide pediatric care. The reason for this emergency declaration is that CHOC Health Alliance did not have the capacity. The current policy aims to build three things: capacity, resiliency, and competency. The emergency arose because of lack of capacity, so with this proposed policy we can begin to expand CalOptima Health's pediatric capacity.

After considerable discussion between the Board and staff, the Board took the following action.

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors approved recommended updates to CalOptima Health Policy EE.1106: Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment. (Motion carried 6-2-0; Director Mayorga and Director Tran voting no; Director Schoeffel absent)***

21. 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 CalOptima Health staff to develop and administer direct contracts or grants to the following entities: a.) Orange County Office of Care Coordination (as administrative entity for the Orange County Continuum of Care) for the Orange County point in time count and coordinated entry system evolution and CalAIM collaboration; b.) Pulse For Good to launch a kiosk-based member engagement and feedback system in local shelters (and other provider locations) for people experiencing homelessness; 2.) Authorized CalOptima Health staff to develop scopes of work to be used in a request for proposal or notice of funding opportunity process for the following projects: a.) Equity Grants for Programs Serving Underrepresented Populations; b.) Capital and Infrastructure Projects; and c.) The county-wide homeless***

continuum mapping and visualization project. (Motion carried 6-0-0; Supervisor Chaffee, Director Contratto and Director Schoeffel absent)

22. Approve Actions Related to the National Alliance for Mental Illness Orange County Peer Support Program

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors: 1.) Authorized the CalOptima Health Chief Executive Officer to develop and execute a grant agreement with the National Alliance for Mental Illness (NAMI) Orange County to administer a peer support program no earlier than January 1, 2023, for a five-year term; and 2.) Authorized expenditures in an amount up to $5 million from existing reserves to fund the grant agreement with NAMI Orange County. (Motion carried 7-0-0; Supervisor Chaffee and Director Schoeffel absent)***

23. Approve CalOptima Health's Measurement Year 2023 Medi-Cal and OneCare Quality Pay for Value Programs

Director Shivers did not participate in this item due to her affiliation with UnitedHealth Group and Optum.

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors: 1.) Approved modification of the measurement year 2023 Health Network Medi-Cal Pay for Value Performance Program for the measurement period effective January 1, 2023, through December 31, 2023; and 2.) Approved Measurement Year 2023 OneCare Pay for Value for the measurement period effective January 1, 2023, through December 31, 2023. (Motion carried 6-0-0; Director Shivers recused; Supervisor Chaffee and Director Schoeffel absent)***

24. Approve CalOptima Health's Five-Year Hospital Quality Program Beginning Measurement Year 2023

Director Contratto commented that she is very excited about this item and the two other actions that follow on this agenda. She noted that CalOptima Health has been listening to its providers and hospitals and has added incentives to support quality of care in its hospitals. Director Chau thanked CalOptima Health staff and echoed Director Contratto's comments.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Authorized CalOptima Health staff to implement the Hospital Quality Program for measurement years 2023 through 2027; 2.) Authorized appropriation of funds in an amount up to $150 million from existing reserves to fund the hospital incentive quality pool over the five (5)-year period; 3.) Authorized appropriation of funds in an amount up to $3.5 million from existing reserves to fund the hospital reporting incentive payments for calendar years 2023 through 2025; and 4.) Authorized the Chief Executive Officer to execute hospital contract amendments to include the Hospital Quality Program. (Motion carried 7-0-0; Supervisor***

Chaffee and Director Schoeffel absent)

25. Approve Actions Related to the Medi-Cal Annual Wellness Visit Initiative

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

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to establish a Medi-Cal Annual Wellness Visit Initiative for Medi-Cal members ages 45 years or older; and 2.) Authorized unbudgeted expenditures and appropriated funds in an amount up to $3.75 million from existing reserves to support the Medi-Cal Annual Wellness Visit Initiative from April 1, 2023, through June 30, 2023. (Motion carried 5-0-0; Directors Becerra and Mayorga recused; Supervisor Chaffee and Director Schoeffel absent)***

26. Authorize Actions Related to Improving Member Quality and Experience of Care Through Better Access to Skilled Nursing Facilities

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to develop and execute a three (3)-year skilled nursing facility Access Program, from July 1, 2023, through June 30, 2026; 2.) Authorized the Chief Executive Officer to amend contracts to implement the Skilled Nursing Facility Access Program; 3.) Authorized appropriation of funds in the amount of up to $10 million from existing reserves to fund the Skilled Nursing Facility Access Program over the three (3)-year period; and 4.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose. (Motion carried 7-0-0; Supervisor Chaffee and Director Schoeffel absent)***

27. Authorize In-Home Care Pilot Program with the University of California Irvine Family Health Center

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

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to develop and execute an agreement with the Regents of the University of California, on behalf of the University of California Irvine (UCI) Family Health Center, to conduct a twenty-four (24) month home-based care pilot to improve quality and cost effectiveness of care to CalOptima Health members; and 2.) Authorized unbudgeted expenditures and appropriated funds in an amount up to $2 million from existing reserves to fund the***

pilot program. (Motion carried 5-0-0; Directors Becerra and Mayorga recused; Supervisor Chaffee and Director Schoeffel absent)

28. Authorize Actions Related to the CalOptima Health Comprehensive Community Cancer Screening and Support Program for Medi-Cal Members

After hearing public comment on this item, the Board took the following action.

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors: 1.) Approved the recommended expenditure plan for the CalOptima Health Comprehensive Community Cancer Screening and Support Program for Medi-Cal Members in an amount not to exceed $50.1 million; and 2.) Authorized funding the program over the five-year period from: a.) A reallocation of $19,134,815 from Intergovernmental Transfer (IGT) 9 funds previously allocated for the Whole Child Model (WCM) program and the 24/7 Virtual Urgent Care Services After Hours Initiative; and b.) An allocation of the remaining IGT 10 funds, estimated at $31.0 million. (Motion carried 7-0-0; Supervisor Chaffee and Director Schoeffel absent)***

ADVISORY COMMITTEE UPDATES

29. OneCare Connect Member Advisory Committee Update

Patty Mouton, OneCare Connect Member Advisory Committee (OCC MAC) Chair, provided an update on the OCC MAC's recent activities. Ms. Mouton thanked the Board for their support of the committee throughout the years, noting that the OCC MAC's last meeting will be December 8, 2022, with the sunsetting of the Cal Medi-Connect Pilot Program.

30. Whole-Child Model Family Advisory Committee Update

Kristen Rogers, Whole-Child Model Family Advisory Committee (WCM FAC) Chair, provided an update on the WCM FAC's recent activities. Ms. Rogers also reminded the Board about the Committee's concerns regarding the upcoming redetermination and the importance of ensuring members have up-to-date information for navigating the redetermination.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Chairman Do thanked the Board for their dedicated service and level of engagement throughout 2022. He added that he knows the Board members have invested a lot of their time, personal time, to understand the subject matter and to delve into the nuances of CalOptima Health's operations. Chairman Do noted that he has the privilege of being a county Supervisor and has the support of full-time staff as CalOptima Health is part of his job, but for the non-Board of Supervisor Board members, the time and dedication they give to the agency is admirable. He also noted that he hopes that the Board members reflect on all the positive changes that the CalOptima Health Board undertook this year for its members in Orange County.

Director Contratto thanked staff for bringing the important actions the Board approved today, including allocating $235 million dollars to quality. She also noted that the Board has allocated a lot of dollars to digital transformation and now with these allocations to quality, she directed staff to provide a quarterly reporting that shows the total dollars authorized and an accounting of the dollars spent.

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CEO Hunn responded that CalOptima Health will absolutely provide quarterly reporting and noted that complete and full transparency and accountability are important to the agency.

Director Mayorga commented that he appreciates the amount of effort and work that the Board and the Executive Leadership has put into CalOptima Health. He noted that he is honored to serve on the CalOptima Health Board.

Director Becerra echoed the comments of other Board members and noted that it is a privilege to be on the Board at this time. In looking at what has been accomplished this year, CalOptima Health has moved from a significantly reactive position as a health plan to a proactive one.

Vice Chair Corwin commented that he certainly supports everything that his fellow Board members have said and had one minor request. In line with Director Contratto's comments, he noted that staff did not talk about the Chief Financial Officer's report but requested a quarterly update on the homeless health initiative dollars. It is important for the Board to understand where the dollars are allocated and the spending results for these various initiatives.

Dr. Pitts noted for the record that he would like to recognize the deputy sheriff in the back of the room, Officer Duarte. Dr. Pitts added that tomorrow is the seven-year anniversary of the terrorist attack in San Bernardino. He noted that he was in charge of the hospital that day when at 11:01 a.m. he received a phone call to lock down the hospital. The trauma that ensued after this attack is not easily forgotten. Unfortunately, there was no sheriff or officer in the San Bernardino facility that day. He thanked and recognized Officer Duarte for being present to ensure everyone's safety.

The CalOptima Health Board of Directors wished everyone a very happy holiday.

ADJOURNMENT
Hearing no further business, Chairman Do adjourned the meeting at 4:38 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: February 2, 2023

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

September 14, 2022

A Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee was held on September 14, 2022, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Zoom Webinar) in light of the COVID-19 public health emergency and of Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings.

Chair Trieu Tran called the meeting to order at 3:05 p.m., and Director Mayorga led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Trieu Tran, M.D., Chair; José Mayorga, M.D.; Nancy Shivers, R.N. (all members participated via teleconference except Director Mayorga who participated in person)

Members Absent: None

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

MANAGEMENT REPORTS

1. Chief Medical Officer Report

Richard Pitts, D.O., Ph.D., Chief Medical Officer, started the Chief Medical Officer Report off addressing the health network and hospital quality dashboards, which were included in the meeting materials. Dr. Pitts also reported that for the last couple of years the incentive dollars received by health networks and hospitals has gone down. In 2020, the payout of incentive dollars to health networks and hospitals dropped by 43% with only $16 million dollars paid out, which was also the height of the COVID-19 pandemic. Dr. Pitts reported that the payout of incentive dollars for 2021 is anticipated to be closer to $30 million dollars. He added that moving forward, CalOptima Health is planning on providing added incentives for certain key measures to improve patient quality and highlight areas of deficiency. Dr. Pitts used cervical cancer screening as an example, noting that only 62% of CalOptima Health members received the screening, which puts CalOptima Health in the 66th percentile for this HEDIS measure. Cervical cancer screening is one of several indicators where Dr. Pitts would like to see a marked improvement on the number of screenings. He added that breast cancer and blood pressure screenings are low and noted that, with all disease, early prevention is key to ensuring successful outcomes for the CalOptima Health population. Dr. Pitts also noted that this will take time and results will be seen incrementally.

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Chair Tran asked if CalOptima Health had results from pre-pandemic years to compare the results against current indicators. Dr. Pitts responded that he would get those numbers and provide the Committee with an update.

Director Mayorga noted that in the past there were incentives for members to go and get screenings done, such as cancer screenings, and asked if those incentives were successful. He also mentioned that it may be helpful to educate members and let them know that they can go directly to an imaging center to get screenings.

Dr. Pitts responded that incentives in terms of COVID-19 have been very successful and that he will follow up on the data regarding cancer screening incentive results.

PUBLIC COMMENTS
There were no requests for public comment.

CONSENT CALENDAR

2. Approve the Minutes of the June 8, 2022 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

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

REPORT ITEMS

3. Approve Modifications to CalOptima Health Policies AA.1207a and AA.1207b
Kelly Rex-Kimmet, Director, Quality Initiatives, introduced the item. Ms. Rex-Kimmet noted that these policies have not been updated for many years. The first policy, AA.1207a, is CalOptima Health's auto assignment policy outlining the process for how CalOptima Health assigns members. The second policy, AA.1207b, provides the methodology for health network assignment allocation and updates measures that have been heavily weighted towards pediatrics measures only. The recommendation is to update the measures and the scoring for those quality metrics, including establishing a minimum performance level.

Director Mayorga inquired if the action today included community health centers.

Yunkyung Kim, Chief Operating Officer, responded that this action is only for health networks, not community health centers.

Action: ***On motion of Chair Tran, seconded and carried, the Committee recommended that the Board of Directors: 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; and 2.) Policy AA.1207b: Performance based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology. (Motion carried 3-0-0)***

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INFORMATION ITEMS

4. Department of Health Care Services Comprehensive Quality Strategy

Marsha Choo, Director of Quality Improvement, provided an overview of the Department of Health Care Services (DHCS) 2022 Comprehensive Quality Strategy. Ms. Choo noted that the DHCS Comprehensive Quality Strategy outlines the ten-year quality vision that the state has shared with managed care plans (MCP) to improve quality of life and to eliminate health disparities. The quality vision integrates a whole system of person-centered care and a population health approach to care, as well as building partnerships with Medi-Cal members and organizations in the community to implement this vision. Ms. Choo added that the state is focusing on three target clinical areas: children's preventive care, behavioral health integration, and maternal health. The quality vision establishes a California Advancing and Innovating Medi-Cal (CalAIM) Population Health Management (PHM) strategy to address member needs across the continuum of care. Ms. Choo noted that the state is looking to close disparities by 50 percent by 2025. She also noted that California has many different health care models, and those MCPs have different contracts with the state. The state is exploring a standardized contract, with one boilerplate for all MCPs. This will include implementing value-based payments for provider incentives, focusing on a variety of measures. Ms. Choo reported that DHCS is looking to require that all MCPs be accredited by the National Committee for Quality Assurance (NCQA) – CalOptima Health is already accredited. But DHCS is also requiring that MCPs be Health Equity Accredited by NCQA. Ms. Choo noted that CalOptima Health is incorporating a lot of the elements from DHCS's 2022 Comprehensive Quality Strategy into its current and future work plans.

5. HEDIS Measurement Year 2021 Results

Kelly Rex-Kimmet, Director, Quality Analytics, presented the 2021 measurement year HEDIS results. Ms. Rex-Kimmet focused the presentation on CalOptima Health's performance for 2021 and the areas that the agency will need to focus on to meet goals outlined in the DHCS 2022 Comprehensive Quality Strategy.

For the HEDIS results, Ms. Rex-Kimmet noted that DHCS has a very specific set of measures called the managed care accountability set that all health plans are required to meet the minimum performance level of the 50th percentile. Failure to meet that percentile can result in financial sanctions or corrective actions. The HEDIS results are also used for NCQA accreditation and are used by the Centers for Medicaid and Medicare Services (CMS) for CalOptima Health's star rating. Ms. Rex-Kimmet noted that several health plans across the state did not make the 50th percentile for certain measures, including CalOptima Health. She reported that CalOptima Health saw improvements in childhood immunization, cervical cancer screening, asthma treatment, cardiovascular disease treatment, HbA1c contract, and antidepressant medications management measures. Conversely, CalOptima Health saw reduced performance in weight assessment, breast cancer screening, appropriate testing for Pharyngitis, and follow-up after ED visits for mental illness measures. She noted that only one measure did not achieve the minimum performance level set by DHCS, which is a new measure this year, well-child visits. Ms. Rex-Kimmet added that financial sanction or an improvement plan may be required by DHCS. For NCQA health plan rating, CalOptima Health is projected to maintain a 4.0 out of 5.0 rating. Ms. Rex-Kimmet reviewed in greater detail the HEDIS results as well as opportunities for improvement.

Ms. Rex-Kimmet noted that looking to the future, performance measurement is evolving with the DHCS Comprehensive Quality Strategy and NCQA's focus on health disparities and Health Equity

Accreditation, in addition to NCQA's goal to have all HEDIS measures digital in 5 years and the Department of Managed Health Care's health equity measures. She added that the new measures require access to expanded types of data sources, including social determinants of health, race/ethnicity, and hospital and admit and discharge data. CalOptima Health will need to invest in its ability to exchange data with electronic medical records (EMR) systems, and infrastructure to support EMR data exchange will be needed to meet the evolving needs of quality performance measurement requirements.

Director Mayorga commented that the sharing of information is critical.

Dr. Pitts thanked Ms. Rex-Kimmet for her service, noting that today's meeting will be Ms. Rex-Kimmet's last Quality Assurance Committee meeting.

Director Mayorga echoed Dr. Pitts comments, noting that he has worked with Ms. Rex-Kimmet for several years and appreciates all the great work she has done at CalOptima Health.

Chair Tran noted that not all providers are using EMR currently and there will be need for education.

Director Shivers asked if CalOptima Health follows up with patients that have been to the emergency room for mental illness.

Carmen Katsarov, Executive Director, Behavioral Health, responded yes, that care management staff follows up with the member once staff is aware there has been visit.

6. Quality Initiatives Update

Helen Lee Syn, Manager, Population Health Management, presented an update on CalOptima Health's quality initiatives. The update included an overview of CalOptima Health's general approach, the current quality initiatives and interventions, and the 2023 quality initiatives planning process. Ms. Syn noted that CalOptima Health uses a variety of strategies to raise awareness and engage members such as media outreach, texting, live calls, and targeted mailings. She also reviewed some of the adult preventive interventions, including breast cancer, cervical cancer, colorectal cancer, and high blood pressure with increased member engagement strategies like member health rewards. Ms. Syn reviewed several of the child and adolescent interventions, including immunizations, well-child and well-care visits, lead screening in children, and prenatal and postpartum care. In addition, CalOptima Health has been working closely with community providers to continue to provide culturally sensitive services for community-based education and patient advocacy.

Chair Tran asked if CalOptima Health is notifying members that members should get an updated vaccination.

Dr. Pitts responded that everyone should be keeping up to date with their vaccinations. He also shared that 98% of CalOptima Health PACE members have the two initial doses and 92% also have their booster shots.

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7. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update
Monica Macias, Director, PACE Program, provided an update on the recent activities of the PACE Member Advisory Committee (PMAC). Ms. Macias shared that the PMAC were able to meet in person again. She noted that when she reported at the last Quality Assurance Committee meeting, 32 participants were coming into the PACE center per day and added that PACE is now increasing that number to 60 participants per day. Ms. Macias noted that the participants are enjoying being back at the PACE Center.

Agenda Items 8.a. through 8.c. were accepted as presented.

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

COMMITTEE MEMBER COMMENTS
Director Shivers commented that she is impressed will all the ideas and initiatives and thanked staff for thinking out of the box and working towards getting the services that members need.

Chair Tran congratulated staff for their proactive approach to preventive care.

Director Mayorga commented that is it apparent that the investment the Board made in technology is going to be critical. He also noted that is important to support and invest in CalOptima Health's providers.

ADJOURNMENT
Hearing no further business, Chair Tran adjourned the meeting at 4:31 p.m. The next Quality Assurance Committee meeting is scheduled for December 14, 2022.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: December 14, 2022

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

4. Adopt Board Resolution No. 23-0202-01, 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. 23-0202-01, 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 September 23, 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. 23-0202-01.

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. 23-0202-01, 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. September 23, 2022, Orange County Health Officer's Orders and Strong Recommendations
4. Government Code section 54953, as amended by AB 361

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

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RESOLUTION NO. 23-0202-01

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;

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WHEREAS, on September 23, 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.

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APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 2nd day of February 2023.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

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

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

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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.

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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

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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

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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

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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 September 23, 2022)

In light of recent updated COVID-19 State Public Health Officer Orders on masking guidance, vaccine requirements and testing recommendations, 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 September 16, 2022. The Orders and Strong Recommendations issued on September 16, 2022, are no longer in effect as of September 23, 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

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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.
    - 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

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strongly recommended to end isolation upon negative results from the repeat test.

- 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.

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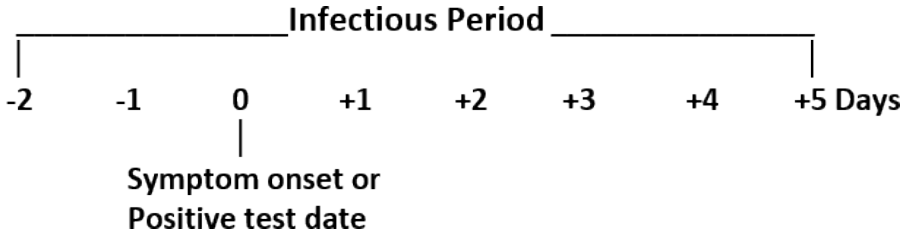
Timing for "Day 0" - As noted in CDPH Isolation and Quarantine Q&A, the 5-day clock for isolation period starts on the date of symptom onset or (day 0) for people who test positive after symptoms develop, or initial test positive date (day 0) for those who remain asymptomatic. If an asymptomatic person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

II. 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 September 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.

NOTE: For Correctional Facilities and Detention centers, when utilizing COVID-19 Community levels to determine masking requirements, an outbreak in these settings is defined as three suspected, probable, or confirmed COVID-19 cases within a 14-day period among residents and/or staff.

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.

In workplaces, employers and employees are subject to either the CalOSHA COVID-19 Emergency Temporary Standards (ETS) or the Cal/OSHA Aerosol Transmissible Diseases (ATD) Standard and should consult those regulations for additional applicable requirements.

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III. COVID-19 Vaccine Requirement Order

- **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 September 13, 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 September 13, 2022.

- **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 September 13, 2022, 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 "**C**" and can be found at the following link:

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C: 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 September 13, 2022, State Health Officer Order. 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-Adult-Care-Facilities-and-Direct-Care-Worker-Vaccine-Requirement.aspx

Individuals covered by this order include:

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

IV. Seasonal Flu Vaccination Order:

Seasonal Flu Vaccination for Certain County Residents.

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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

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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/stay-up-to-date.html and https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/specific-groups.html

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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

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.

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5. As of September 23, 2022, the County has reported a total of 664,185 recorded confirmed COVID-19 cases and 7,432 of COVID-19 related deaths.

6. Safe and effective authorized COVID-19 vaccines and updated booster vaccines are recommended by the CDC for eligible individuals. 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/vaccines/stay-up-to-date.html and 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 been widely available, but certain populations have been hesitant to get 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.

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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: September 23, 2022

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

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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 February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Ratify an Amendment to CalOptima Health's Primary Agreement with the California Department of Health Care Services

Contact

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

Recommended Action

Ratify an amendment between the California Department of Health Care Services (DHCS) and CalOptima Health related to the Calendar Year 2023-A Contract Amendment.

Background

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

Discussion

Calendar Year (CY) 2023-A Contract Amendment to the Primary Agreement (January 1, 2023, through December 31, 2023)

On June 3, 2022, DHCS provided managed care plans (MCPs), including CalOptima Health, with a draft version of the CY 2023-A Contract Amendment and notified MCPs that DHCS will submit the amendment to the Centers for Medicare & Medicaid Services (CMS) in December 2022. This amendment will bring MCP agreements, including CalOptima Health's MCP agreement, into alignment with requirements effective January 1, 2023.

DHCS provided the finalized amendment to CalOptima Health on December 13, 2022, and requested the signed amendment by December 23, 2022. Staff procured the Chair's signature and promptly returned the CalOptima Health-signed amendment to DHCS for countersignature to ensure timely filing with CMS. *Please see* Attachment 3 for the details on the changes contained within the finalized amendment.

DHCS has generally already implemented the requirements of the CY 2023-A Contract Amendment by issuing sub-regulatory guidance such as All Plan Letters (APLs). Simultaneously, DHCS has been working with CMS to formalize the requirements in DHCS's agreements with MCPs, including CalOptima Health. DHCS's implementation of these requirements via sub-regulatory guidance prior to the formal inclusion of the requirements in MCP agreements is largely due to the lengthy CMS review process. While the contractual obligations are retroactive, CalOptima Health staff has implemented the required operational

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changes and other contractual requirements by following the DHCS APL and sub-regulatory guidance.

The amendments do not contain any rate changes or otherwise set any rates. Staff received draft CY 2023 rates from the DHCS in September 2022 and will request authority from the Board of Directors upon receipt of the final CY 2023 rates. Staff recommends that the CalOptima Health Board of Directors ratify the CY 2023-A Contract Amendment to the DHCS Primary Contract.

Fiscal Impact

The recommended action to ratify the CY 2023-A Contract Amendment is expected to be budget neutral. Staff projects that estimated Medi-Cal revenue assumptions included in the Fiscal Year (FY) 2022-23 Operating Budget will be sufficient to cover anticipated member medical costs through June 30, 2023. Management will include medical expenses for July 1, 2023, through December 31, 2023, in the FY 2023-24 Operating Budget.

Rationale for Recommendation

CalOptima Health's execution of the CY 2023-A Contract Amendment to its Primary Agreement with DHCS is necessary for the continued operation of CalOptima Health's Medi-Cal program.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Appendix summary of amendments to Primary Agreements with DHCS
2. CalOptima Health Contract Amendment_A-63
3. Additional CY 2023-A Contract Amendment Detail

/s/ Michael Hunn — *01/26/2023*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 5

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

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

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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

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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

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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
A-59 incorporates new Calendar Year (CY) 2022 capitation rates and benefit changes implemented in CY 2022	August 5, 2021 March 3, 2022 August 4, 2022
A-62 extends the Primary Agreement with DHCS to December 31, 2023.	May 5, 2022
A-63 incorporates new benefits changes for Calendar Year (CY) 2023.	February 2, 2023

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)

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	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
Agreement 22-20494 incorporates both Hyde services ("Private Services") and the new Unsatisfactory Immigration Status members from January 1, 2023 to December 31, 2023.	December 1, 2022

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

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

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

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

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IV. Exhibit A, Attachment 3, MANAGEMENT INFORMATION SYSTEM, is amended to read:

1. Management Information System (MIS) Capability

A. Contractor shall implement and maintain MIS system that shall be fully compliant with 42 CFR section 438.242 requirements and can process and provide all Medi-Cal eligibility, membership enrolled with Contractor, Provider claims payment and status, Encounter-level health care services delivery, Provider Network, financial, Program Data, **Data Sources specified in DHCS policies and guidance, including All Plan Letters (APLs), the Enhanced Care Management (ECM) Policy Guide, Community Supports Policy Guide, and the Population Health Management (PHM) Program Guide,** and any other data necessary to carry out all processes and procedures needed by Contractor to perform and administer all of the functions required under this Contract. All data shall be available to DHCS and to the Centers for Medicare and Medicaid Services (CMS) upon request. Request for data shall be in writing and specify the timeframe, format, and method required for submission.

C. Contractor's MIS must have the capability to transmit and consume data files with and from DHCS, Subcontractors and sub-Subcontractors, Network Providers, other State, federal, and local governmental agencies, and other sources as needed to support Care Coordination and the overall administration of the Medi-Cal program. Contractor must have processes in place for utilizing all data made available to meet the Care Coordination requirements and other administrative functions of this Contract. Data that Contractor's MIS must be able to transmit and consume include, but are not limited to:

1) Encounter Data,

2) Medi-Cal Fee-For-Service (FFS) claims data,

3) Carved-out claims data, including state plan services carved out of the contract and data available from partner organizations, including but not limited to the

Local Education Agency Medi-Cal Billing Option Program (LEA BOP) and incarceration in-reach services,

4) Dental claims data,

5) Specialty mental health data,

6) Substance use disorder data,

7) Medi-Cal FFS treatment authorization request data

8) California Children's Services (CCS) program data

9) Targeted Case Management (TCM) data;

10) Pharmacy claims data;

11) Risk Tier assignment data;

12) Authorization and referral data; and

13) Electronic Health Record or Health Record information, including case notes.

V. Exhibit A, Attachment 9, ACCESS AND AVAILABILITY, is amended to read:

12. Cultural and Linguistic Services Program

Contractor shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. ~~Contractor shall review and update their cultural and linguistic services consistent with the population needs assessment (PNA) requirements stipulated below.~~

C. Population Needs Assessment (PNA)

~~Contractor shall ensure that the Health Education, Cultural and Linguistic PNA, as described in Exhibit A, Attachment 10, Provision 8, Paragraph A.3) includes identification of the cultural and linguistic needs of Members. Contractor shall demonstrate, upon request by the State, how the PNA findings and conclusions are utilized by the plan to provide contractually required cultural and linguistic services for Members.~~

Contractor must review and update its cultural and linguistic services programs to align with the Population Needs Assessment (PNA). Contractor must ensure its Network Providers', Subcontractors', and sub-Subcontractors' cultural and Health Equity linguistic services programs also align with the PNA.

VI. Exhibit A, Attachment 10, SCOPE OF SERVICES, is amended to read:

3. Initial Health ~~Assessment~~ Appointment (IHA)

~~An Initial Health Assessment (IHA) consists of a history, physical and mental status examination, an Individual Health Education Behavioral Assessment (IHEBA), identified diagnoses, and plan of care. The IHA enables a Provider of primary care services to comprehensively assess and manage the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this Contract.~~ **Contractor must ensure the provision of an Initial Health Appointment (IHA) in accordance with 22 CCR sections 53851(b)(1) and 53910.5(a). An IHA, at a minimum, must include: a history of the Member's physical and mental health; an identification of risks; an assessment of the need for preventive screens, services, and health education; a physical examination; and the diagnosis and plan for treatment of any diseases. An IHA may be waived if the Member's Primary Care Provider determines that the Member's health record contains complete information, updated within the previous 12 months, consistent with the assessment requirements.**

A. Contractor shall cover and ensure the provision of an IHA ~~(comprehensive history and physical examination) in conformance with Title 22 CCR Section 53851(b)(1) to~~ **for** each new Member within timelines stipulated in Provision ~~5~~**4, Services for Members under Twenty-One (21) Years of Age,** and Provision ~~6~~**5, Services for Adults,** below.

B. Contractor shall ensure that ~~the IHA includes an IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A using an age appropriate DHCS-approved assessment tool.~~ **a Member's completed IHA is documented in their Health Record and that appropriate assessments from the IHA are available during subsequent health visits**.

D. ~~Contractor shall ensure that Member's completed IHA and IHEBA tool are contained in the Member's Medical Record and available during subsequent health visits.~~

~~E.~~**D.** Contractor shall make repeated attempts, if necessary, to contact a Member ~~and~~ **to** schedule an IHA.

1) Contractor shall make at least three (3) documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA. Contact methods must include at least one (1) telephone and one (1) mail notification.

2) Contractor must document all attempts to perform an IHA at subsequent office visit(s) until all components of the IHA are completed.

3) Contractor may delegate these activities, but Contractor remains ultimately responsible for all delegated functions.

~~**4. Health Risk Stratification and Assessment for SPD Beneficiaries**~~

~~Contractor shall apply a DHCS approved health risk stratification mechanism or algorithm to identify newly enrolled SPD beneficiaries with higher risk and more complex health care needs within 44 days of enrollment. Based on the results of the health risk stratification, Contractor shall also administer the DHCS approved health risk assessment survey within 45 days for SPD beneficiaries deemed to be at a higher health risk, and 105 days for those determined to be a lower health risk. The health risk stratification and assessment shall be done in accordance with W & I Code Sections 14182 (c)(11) to (13) and APL 17-013.~~

~~5~~4. Services for Members under Twenty-One (21) Years of Age

Contractor shall cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age required under the EPSDT benefit described in 42 USC Section 1396d(r), and W&I Code section 14132(v). The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments and other measures listed in 42 USC Section 1396d(a), whether or not covered under the State Plan. All EPSDT services are Covered Services, unless excluded under this Contract. Contractor shall inform Members that EPSDT services are available for Members under 21 years of age, as well as how to access services.

A. Provision of IHAs for Members under Age 21

3) The IHA must include, or arrange for provision of, all immunizations necessary to ensure that the child is up-to-date **for their age**~~.~~ ~~See PL 13-001 for specific IHEBA requirements~~ **an Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings**.

B. Preventive Services for members under Age 21

3) Where a request is made for children's preventive services by the Member, the Member's parent(s) or guardian or through a referral ~~from the local Child Health and Disability Prevention (CHDP) program~~, an appointment shall be made for the Member to be examined within two (2) weeks of the request.

H. Local Education Agency (LEA) Services

Contractor must reimburse Local Education Agencies, as appropriate, for the provision of school-linked EPSDT services, including but not limited to BHT as specified in Paragraph E, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services, of this Provision.

~~6~~5. Services for Adults 21 Years of Age and Older

A. Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

Contractor shall ensure that the ~~performance of the initial comprehensive history and physical exam~~ **IHA** for adults includes, but is not limited to~~:~~ **, an evaluation of applicable preventive services provided in accordance with the United States Preventive Services Taskforce (USPSTF) "A" and "B" recommendations.**

~~1) A comprehensive history including, but not limited to, mental and physical systems, and social and past medical history.~~

~~2) Status of currently recommended preventive services.~~

~~3) Comprehensive physical and cognitive exam sufficient to assess and diagnose acute and chronic conditions.~~

~~4) Diagnoses and plan of care including follow-up activities.~~

Contractor is responsible for assuring that arrangements are made for follow-up services and plan of care that reflect the findings and risk factors determined during the IHA.

Contractor shall ensure that Member's completed IHA is contained in the Member's Medical Record and available during subsequent health visits.

~~For all Adults, Contractor shall ensure that the IHA includes the IHEBA, as described in Exhibit A, Attachment 10, Provision 8, Paragraph A.~~

B. Adult Preventive Services

Contractor shall cover and ensure **the provision of** all preventive **services** and Medically Necessary diagnostic and treatment services for adult Members~~. Preventive services should be provided in accordance with evidence based guidelines.~~ **as follows:**

1) Contractor shall ensure ~~that plans provide at a minimum preventive services based on the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult Members [age 21 or older]. All~~ **the provision of all applicable** preventive services identified as USPSTF "A" and "B" recommendations ~~must be provided. For tobacco use prevention and cessation services, Contractor may use either the USPSTF recommendations or the latest edition of the US Public Health Service "Treating Tobacco Use and Dependence: A Clinical Practice Guideline." As a result of the IHA or other examination, discovery of the presence of risk factors or disease conditions will determine the need for further follow-up, diagnostic, and/or treatment services. In the absence of the need for immediate follow-up, the core preventive services identified in the requirements for the IHA for adults described above shall be offered in the frequency required by~~ **in accordance with** the USPSTF Guide to Clinical Preventive Services.

~~2) Contractor shall cover and ensure the provision of all Medically Necessary services based on the findings or risk factors identified in the IHA or during routine, urgent, or emergent health care visits. Contractor shall ensure that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up.~~

~~7~~6. Perinatal Services

~~8~~7. Services for All Members

A. Health Education

7) Contractor shall maintain a health education system that provides educational interventions addressing ~~the following~~ health categories and topics ~~and ensure that these programs are available and~~

~~accessible to Members upon referral by Providers and also upon the Member's request~~ **that align with Contractor's Population Health Management (PHM) Strategy, in accordance with Exhibit A, Attachment 23, Provision 2, Population Health Management Strategy (PHMS) and Population Needs Assessment (PNA), including education regarding the appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions.**

~~a) Effective use of Managed Health Care Services: Educational interventions designed to assist Members to effectively use the managed health care system, preventive and primary healthcare services, obstetrical care, and health education services; and appropriately use complementary and alternative care.~~

~~b) Risk-Reduction and Healthy Lifestyles: Educational interventions designed to assist Members to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes, including programs for tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases, HIV/AIDS, and unintended pregnancy; nutrition, weight control, and physical activity; and parenting.~~

~~c) Self-Care and Management of Health Conditions: Educational interventions designed to assist Members to learn and follow self-care regimens and treatment therapies for existing medical conditions, chronic diseases or health conditions, including programs for pregnancy, asthma, diabetes, and hypertension.~~

~~9) Contractor shall ensure that all new Members complete the IHEBA within 120 calendar days of enrollment as part of the IHA; and that all existing Members complete the IHEBA at their next non-acute care visit, but no later than their next scheduled health screening exam.~~

~~Contractor shall ensure that:~~

~~a) The Staying Healthy Assessment (DHCS Form 7098) and bilingual translations, or alternative tools approved by DHCS, are used by Primary Care Providers to satisfy the IHEBA requirement;~~

~~b) The IHEBA is administered and reviewed by the Primary Care Provider during an office visit;~~

~~c) The IHEBA is reviewed at least annually by the Primary Care Provider with Members who present for a scheduled visit;~~

~~d) The IHEBA is re-administered by the Primary Care Provider at the appropriate age-intervals utilized by the Staying Healthy Assessment (0-3 years, 4-8 years, 9-11 years, 12-17 years, and 18 years and older). This should occur at the patient's first scheduled health screening exam upon changing into the next age group.~~

~~e) The IHEBA requires documentation and follow-up at initial and subsequent visits, of risk factors identified and addressed (brief counseling or referral to appropriate health education services) date and Primary Care Provider's signature or initials.~~

~~f) The completed IHEBA tool is included along with the medical history and problem list as a permanent part of the Member's Medical Record. Documentation shall be entered in the Member's Medical Record which shall indicate the voluntary refusal to complete the IHEBA. A declination of services may be in the form of a signed statement by the Member (if an emancipated minor or age 18 or older) or the parent(s) or guardian of the Member, or dated documentation of Member's response to an in-person or telephone contact. Declination of services shall be noted in the Member's Medical Record. A nonresponse may be documented via the absence of a form or recipient response.~~

~~g) Assistance is provided to Members in completing the assessment tool, if needed.~~

~~h) Interventions are conducted and arrangements are made for follow-up services to address the needs identified by the IHEBA.~~

~~Contractor is responsible to assist Primary Care Providers in the development and delivery of culturally and linguistically appropriate health education interventions and assure provisions for low-literate, illiterate and visually and hearing impaired Members.~~

~~10~~**9**) Contractor shall ensure education and training of contracting medical Providers, practitioners, and Allied Health Care Personnel to support delivery of effective health education services for Members. Education and training must cover at least the following topics:

~~11~~**10**) Contractor shall adopt and maintain appropriate health education program standards/guidelines and-policies/procedures, and conduct appropriate levels of evaluation, e.g. formative, process, impact and outcome evaluation, to ensure access, availability and effectiveness in achieving health education program goals and objectives. Contractor shall maintain documentation that demonstrates
effective implementation of all DHCS health education requirements under this Contract.

~~12~~**11**) Contractor shall monitor the performance of Subcontractors that deliver health education programs and services to Members, and implement strategies to improve performance and effectiveness.

~~13~~**12**) Contractor shall monitor access and availability of health education programs and services, and implement strategies to remove barriers to Member participation including, but not limited to, distance barriers (program location), availability barriers (frequency and timing of program offerings), and cultural and linguistic barriers.

~~14) Contractor shall cover and ensure provision of comprehensive case management including coordination of care services as described in Exhibit A, Attachment 22.~~

~~15) The Health Information Form (HIF)/Member Evaluation Tool (MET). Contractor shall use data from a Health Information Form (HIF)/Member Evaluation Tool (MET) to help identify newly enrolled Members who may need expedited services. In accordance with 42 CFR section 438.208(b), Contractor shall, at a minimum, comply with the following:~~

~~a) Mail a DHCS-approved HIF/MET to all new Members as a part of Contractor's welcome packet and include a postage paid envelope for response.~~

~~b) Within 90 days of each new Member's effective date of enrollment:~~

~~i. Make at least two (2) telephone call attempts to~~

~~remind new Members to return the HIF/MET and/or collect the HIF/MET information from new Members. This outreach can be done through head of household for Members under the care of parents, custodial parents, legal guardians, or other authorized representatives in accordance with applicable privacy laws.~~

~~ii. Conduct an initial screening of the Member's needs as identified in the HIF/METs received. To meet this requirement, Contractor may build upon any existing screening process currently used to meet requirements in Exhibit A, Attachment 10, Scope of Services, or Exhibit A, Attachment 11, Case Management and External Coordination of Care.~~

~~c) Upon a Member's disenrollment, Contractor shall make the HIF/MET assessment results available to their new Medi-Cal Managed Care Health Plan upon request.~~

~~16~~**13**) Contractor develop a referral policy to ensure the Member is seen by a dental Provider following an initial dental health screening. The Member shall be referred to a dental Provider to address any immediate dental needs and for comprehensive dental care which will include a comprehensive oral exam.

D. Behavioral Health Services

2) Contractor ~~shall~~ **must** cover and pay for all Medically Necessary Mental Health Covered Services for the Member, including the following services:

i) Dyadic Care Services and the Family Therapy Benefit for Members ages 0-J years and/or their caregivers in an outpatient setting.

J. Asthma Prevention Services (APS)

K. Community Health Workers (CHW) Services

L. CHW Provider Capacity

M. Identifying Members for CHW

N. Long-Term Care (LTC) Services

Contractor must authorize and cover LTC. Contractor must ensure that Members in need of LTC services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs, unless the Member has elected hospice care.

1) LTC services are covered under this Contract. Contractor must ensure that Members, other than Members requesting hospice services, in need of LTC services are placed in a LTC facility that provides the level of care most appropriate to the Member's medical needs. Contractor must make Member placement decisions based on the appropriate level of care, as set forth in the definitions in 22 CCR sections 51118, 51120, 51120.5, 51121, 51123, 51124, 51124.5, and 51124.6 and the criteria for admission set forth in 22 CCR sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR section 51003(e).

2) Hospice Services as defined in 22 CCR section 51180 rendered in a Skilled Nursing Facility or Intermediate Care Facility are not LTC services consistent with 22 CCR section 51544(h).

3) Contractor must place Members in LTC facilities that are licensed and certified by the CDPH. Contractor must ensure that contracted LTC facilities have not been decertified by CDPH or otherwise excluded from participation in the Medi-Cal Program.

4) Contractor must provide continuity of care, as set forth in APL 18-008, to Members through continued placement in the LTC facility in which the Member is residing at time of Enrollment for up to 12 months. During this time, Contractor may attempt to place Members at LTC facilities within its Provider Network

only with approval from the Member or individual authorized to make health care decisions on their behalf.

5) Contractor must cover a Member stay in a facility with availability regardless of Medical Necessity if placement in a Medically Necessary appropriate lower level of care is not available, unless otherwise provided by this Contract. Contractor must continue to attempt to place the Member in a facility with the appropriate level of care, including by offering to contract with facilities within and outside of the Service Area.

O. Care Management and Care Coordination

1) Contractor must provide all Members with Care Coordination services as specified in Exhibit A, Attachment 23, Provision 8, Basic Population Health Management.

2) Contractor must provide care management services to all Members as specified in Exhibit A, Attachment 23, Provision 8, Basic Population Health Management, and Exhibit A, Attachment 23, Provision 7, Care Management Programs. Care management services include, Basic Population Health Management (Basic PHM), Complex Care Management (CCM), and Enhanced Care Management (ECM).

VII. Exhibit A, Attachment 11, CASE MANAGEMENT AND EXTERNAL COORDINATION OF CARE, Provision 18, is amended to read:

1. Targeted Case Management (TCM) Services

~~Contractor is responsible for determining whether a Member requires Targeted Case Management (TCM) services, and must refer Members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services.~~

~~If a Member is receiving TCM services as specified in Title 22 CCR Section 51351, Contractor shall be responsible for coordinating the Member's health care with the TCM Provider and for determining the Medical Necessity of diagnostic and treatment services recommended by the TCM Provider that are Covered Services under the Contract.~~

A. Contractor must identify the target populations for Targeted Case Management (TCM) programs within their Service Area, and maintain

procedures to refer Members to TCM services. If upon notification from DHCS that a Member is receiving TCM services and Contractor is not already aware, Contractor must reach out to Local Government Agencies (LGAs) to coordinate care, as appropriate.

B. Contractor must have MOUs with LGAs to facilitate coordination of TCM services for its Members in accordance with the MOU requirements in Exhibit A, Attachment 12, Provision 2.

C. Contractor must coordinate with LGAs to provide Care Coordination for all Medically Necessary Covered Services identified by TCM Providers in their Member care plans, including referrals and Prior Authorization for Out-of-Network medical services. Coordination with LGAs must continue for Members receiving TCM services until the LGA notifies Contractor that TCM services are no longer needed for the Member.

D. Because TCM can be a direct duplication of services such as Basic PHM, CCM, ECM, and Community Supports, Contractor must have processes to ensure Members receiving TCM are not receiving duplicative services.

E. Contractor must designate a representative responsible for coordinating TCM services with LGAs for the Member. Contractor representative's responsibilities include, but are not limited to, sharing the appropriate Member Provider(s) information and PCP and/or Care Manager assignment with LGAs and resolving all related operational issues.

F. Contractor must also notify Members' PCPs and/or Care Managers when Members are receiving TCM services and provide them with the appropriate LGA contact information.

G. For Members under 21 years of age, Contractor must ensure that all Medically Necessary services are provided timely as required in Exhibit A, Attachment 10, Provision 5, Services for Members under Twenty-One (21) Years of Age. Notwithstanding medical services recommended in TCM care plans or arranged by LGAs or TCM providers for Members less than 21 years of age, Contractor remains responsible for the provision of the EPSDT benefit, as described in Exhibit A, Attachment 10, Provision 5, Paragraph F.

4. ~~Specialty~~ Mental Health Services

Contractor must use DHCS-approved screening tools as identified in DHCS

guidance to ensure Members seeking mental health services, and who are not currently receiving Non-specialty Mental Health Services (NSMHS) or Specialty Mental Health Services (SMHS), receive referrals to the appropriate delivery system for mental health services, either in Contractor's Network or the county mental health plan network, in accordance with the No Wrong Door policies set forth in W&I Code section 14184.402(h) and specified in Exhibit A, Attachment 20, Provision 6, No Wrong Door for Mental Health Services.

A. Non-Specialty Mental Health Services (NSMHS)

Contractor must provide timely NSMHS for Members consistent with the No Wrong Door policies, including under the following circumstances:

1) When NSMHS are provided in the following instances;

a) During the assessment process;

b) Prior to determination of a diagnosis; or

c) Prior to determination of whether NSMHS criteria set forth in W&I Code section 14184.402(b)(2) are met.

2) When NSMHS were not included in a Member's individual treatment plan;

3) When a Member has a co-occurring mental health condition and substance use disorder; or

4) When NSMHS are provided to a Member concurrently with SMHS, if those services are not duplicative and coordinated between Contractor and the county mental health plan.

~~A~~**B**. Specialty Mental Health Services **(SMHS)**

1) ~~All Specialty Mental Health Services (inpatient and outpatient) are excluded from this Contract.~~ **Contractor must maintain policies and procedures to refer Members who meet the criteria for SMHS to the MHP in accordance with the No Wrong Door policies.**

2) ~~Contractor shall make appropriate referrals for Members needing Specialty Mental Health Services as follows:~~ **If a Member receiving**

NSMHS is determined to meet the criteria for SMHS due to a change in the Member's condition, Contractor must use DHCS-approved standardized transition tools as specified by DHCS, and continue to provide NSMHS to the Member concurrently receiving SMHS when those services are not duplicative and coordinated between Contractor and the MHP.

~~a) For those Members with a tentative psychiatric diagnosis which meets eligibility criteria for referral to the county mental health plan, as defined in PL 00-001 Revised and APL 13-021, the Member shall be referred to the county mental health plan in accordance with the Memorandum of Understanding (MOU) between Contractor and the county mental health plan and APL 13-018.~~

~~b) For those Members whose mental health diagnosis is not covered by the county mental health plan because the adult Member's level of impairment is mild to moderate, or the recommended treatment for adult and child Members do not meet the criteria for Specialty Mental Health Services, the Member shall be referred to an appropriate Medi-Cal mental health Provider within Contractor's Provider Network. Contractor shall consult with the county mental health plan as necessary to identify other appropriate community resources and to assist the Member to locate available non-covered mental health services.~~

C. Mental Health Services Disputes

~~3~~**1)** Disputes between Contractor and the county mental health plan regarding this section shall be addressed collaboratively within the Contract as specified by the MOU to achieve a timely and satisfactory resolution. **Disputes between the Contractor and MHP shall not delay the provision of Medically Necessary services by the Contractor or MHP.**

2) If Contractor and the county mental health plan cannot agree **on the appropriate place of care**, **then** disputes shall be resolved pursuant to **APL 21-013** **and** ~~Title~~ 9~~,~~ CCR~~,~~ ~~S~~**s**ection 1850.505. **Specifically, as set forth in APL 21-013, Contractor and county mental health plans must complete the plan-level dispute resolution process within 15 Working Days of identifying the dispute.**

3) Contractor and the county mental health plan may seek to

enter into an expedited dispute resolution process if a Member has not received a disputed service(s) and Contractor and/or the county mental health plan determine that the routine dispute resolution process timeframe would result in serious jeopardy to the Member's life, health, or ability to attain, maintain, or regain maximum function. Under this expedited process, Contractor and the county mental health plan will have one (1) Working Day after identification of a dispute to attempt to resolve the dispute at the plan level. All terms and requirements established in APL 21-013 apply to disputes between Contractor and the county mental health plan.

~~B~~**D**. County Mental Health Plan Coordination

Contractor shall execute a Memorandum of Understanding (MOU) with the county mental health plan as stipulated in Exhibit A, Attachment 12, Local Health Department Coordination, Provision 3. County Mental Health Plan Coordination for the coordination of Specialty Mental Health Services to Members**, to ensure services for its Members are properly coordinated and provided in a timely and non-duplicative manner**.

5. Alcohol and Substance Use Disorder Treatment Services

Alcohol and substance use disorder treatment services available under Drug Medi-Cal program as defined in Title 22 CCR 51341.1, and outpatient heroin detoxification services defined in Title 22 CCR 51328 are excluded from this Contract. These Excluded Services include all medications used for the treatment of alcohol and substance use disorders covered by DHCS, as well as specific medications not currently covered by DHCS, but reimbursed through the Medi-Cal FFS Program.

A. Contractor shall identify ~~individuals~~ **Members** requiring alcohol and or substance use disorder treatment services and refer the ~~individuals~~ **Members** to the county department responsible for substance use treatment, or other community resources when services are not available through counties, and to outpatient heroin **and other opioid** detoxification Providers available through the Medi-Cal FFS program, ~~for~~ **as** appropriate ~~services~~. Contractor shall assist Members in locating available treatment service sites. To the extent that treatment slots are not available within Contractor's Service Area, Contractor shall ~~pursue placement~~ **coordinate with the county department responsible for substance use disorder treatment to refer Members to available treatment** outside the **Service** ~~a~~**A**rea. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the alcohol and substance use disorder treatment and coordinate services between ~~the its~~ Network

Providers and the treatment programs.

B. Contractor shall execute a MOU with ~~the~~ **each** county department **responsible** for alcohol and substance use disorder treatment services **within Contractor's Service Area in accordance with the MOU requirements in Exhibit A, Attachment 12, Provision 2, Network Provider Agreements, Subcontractor Agreements or Memoranda of Understanding**. **The MOU must delineate the roles and responsibilities between Contractor and county departments for coordinating care, and ensuring non-duplication of services and timeliness of care for the Members.**

C. Prescribing and medication management of buprenorphine and other prescribed medications for substance use disorder treatment, also known as medication- assisted treatment or MAT, are the responsibility of Contractor when they are provided in Primary Care offices, departments, hospitals or other contracted medical facilities.

8. Services for Persons with Developmental Disabilities (DD)

A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities **(DD)**.

B. Contractor shall provide all screening, preventive, Medically Necessary, and therapeutic Covered Services to Members with developmental disabilities. Contractor shall refer Members with ~~developmental disabilities~~ **DD** to a ~~Regional Center for the developmentally disabled~~ **regional center** for evaluation and for access to those non-medical services provided through the ~~Regional Centers~~, such as but not limited to, respite, out-of-home placement, and supportive living. ~~Contractor shall monitor and coordinate all medical services and Medically Necessary Outpatient Mental Health Services with the Regional Center staff, including identification of all appropriate services, which need to be provided to the Member.~~

D. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of services for Members with ~~developmental disabilities~~ **DD to ensure the non-duplication of services and to coordinate and work with the regional centers in the development of the individual development services plan required for all Members with DD, which includes identification of the Member's medical needs and the provision of Medically Necessary services such as medical care, NSMHS, and Behavioral Health Treatment (BHT)**.

10. ~~Local Education Agency~~ School-Based Services

Local Education Agency (LEA**)** assessment services are services specified in Title 22, CCR Section 51360(b) and provided to students who qualify based on Title 22 CCR Section 51190.1. LEA services provided pursuant to an Individual Education Plan as set forth in Education Code, Section 56340 et seq. or Individual Family Service Plan as set forth in Government Code Section 95020 are not covered under this Contract. However, Contractor is responsible for providing a PCP and all Medically Necessary Covered Services for the Member, and shall ensure that the Member's PCP cooperates and collaborates in the development of the Individual Education Plan **(IEP)** or the Individual Family Service Plan **(IFSP)**. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary diagnostic, preventive and treatment services identified in the Individual Education Plan developed by the LEA, with Primary Care Provider participation.

A. Contractor must have a MOU in place with all LEAs in its Service Area in accordance with Exhibit A, Attachment 12, Provision 2, Network Provider Agreements, Subcontractor Agreements or Memoranda of Understanding, to ensure that there are processes that account for facilitating cooperation and collaboration between the Member's PCP and the LEA in the development of the Member's IEP or the IFSP. Contractor must provide case management and Care Coordination to the Member, or the parent, legal guardian or authorized representative, to ensure the provision of all Medically Necessary Covered Services identified in the IEP developed by the LEA, with PCP participation.

B. Contractor must cover Medically Necessary mental health and substance use disorder services as specified by DHCS when delivered at school sites. Contractor must execute Network Provider Agreements and/or Subcontractor Agreements, as appropriate, with LEAs, FQHCs, and community-based Providers in each county in Contractor's Service Area to directly reimburse for the provision of mental health and substance use disorder services in accordance with H&S Code section 1374.722.

1) Contractor must include in all Network Provider Agreements and/or Subcontractor Agreements with school-based Providers the following information, at a minimum:

a) Guidelines for sharing of Protected Health Information;

b) Guidelines specifying coordination of services;

c) Standards for quality and quality assurance;

d) Processes for notification to the Member, Member's parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons on where to receive initial and follow-up services;

e) Referral procedures; and

f) Processes to ensure services are not duplicated.

2) Contractor must ensure that Network Provider Agreements and Subcontractor Agreements with school-based Providers meet the requirements contained in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements.

C. Contractor must implement interventions that increase access to preventive, early intervention, and behavioral health services by school- affiliated behavioral health Providers for children in publicly funded childcare and preschool, and TK-12 children in public schools, in accordance with the interventions, goals, and metrics set forth in W&I Code section 5961.3(b).

13. Dental

A. Contractor shall cover and ensure that dental screenings and oral health assessments for all Members are included as a part of the IHA. ~~For Members under 21 years of age, Contractor is responsible for ensuring that a dental screening/oral health assessment shall be performed as part of every periodic assessment~~ by a medical Provider or coordinated with a dental Provider, ~~with annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first.~~ Contractor shall ensure that **all** Members are referred to appropriate Medi-Cal dental Providers. Contractor shall provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish, **and** dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental providers are not covered under this Contract.

B. For Members under 21 years of age, Contractor is responsible for ensuring that a dental screening or oral health assessment is performed as part of every periodic assessment by a medical Provider or coordinated with a dental Provider, with annual dental

referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first.

C. Contractor shall ensure the provision of ~~covered medical services related to~~ **Medically Necessary** dental**-related Covered** ~~s~~**S**ervices that are not **exclusively** provided by dentists or dental anesthetists. **Contractor must also have an identified Contractor liaison available to Medi-Cal dental Providers to assist with referring Members to other Covered Services. Other** Covered ~~medical s~~**S**ervices include**, but are not limited to**: laboratory services; and, pre-admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). Contractor may require Prior Authorization for medical services required in support of dental procedures.

D. If ~~the~~ Contractor requires Prior Authorization for ~~these~~ **dental procedures**, Contractor shall develop and publish the **policies and** procedures for obtaining Prior Authorization to ensure that services for the Member are not delayed. Contractor shall ~~submit such procedures to~~ **coordinate with the DHCS Dental Services Division in the development of their policies and procedures for Prior Authorization of dental services, and must submit them to** DHCS for review and approval.

14. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

~~A. DOT is offered by LHDs and is not covered under this Contract.~~
Contractor shall assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis drug therapy.

A. The following groups of individuals are at risk for non-compliance for the treatment of TB:

1) Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin);

2) Members whose treatment has failed or who have relapsed after completing a prior regimen;

3) Members with mental health conditions or substance use disorders;

4) Elderly, children**,** and adolescents~~s~~ **Members;**

5) **Members with unmet housing needs;**

6) **Members with language and/or cultural barriers**; and,

7) ~~individuals~~ **Members** who have demonstrated noncompliance (those who failed to keep office appointments).

B. Contractor shall refer Members with active TB and who have ~~any of these~~ **treatment resistance or non-compliance issue** risks to the TB Control Officer of the LHD for DOT. ~~Contractor shall assess the following groups of Members for potential noncompliance and for consideration for DOT: substance users, persons with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers.~~ If~~, in the opinion of Network~~ **a** Provider~~,~~ **finds that** a Member ~~with one (1) or more of these risk factors~~ is at risk for **treatment resistance or** noncompliance, **Contractor must refer** the Member ~~shall be referred~~ to the LHD for DOT.

~~Contractor shall provide all Medically Necessary Covered Services to the Member with TB on DOT and shall ensure joint case management and coordination of care with the LHD TB Control Officer.~~

~~B~~**C**. Subject to Exhibit A, Attachment 12, Provision 4, Contractor shall execute a Memorandum of Understanding (MOU) with the LHD as stipulated in Exhibit A, Attachment 12, Provision 2, ~~for the provision of~~ **to ensure joint case management and Care Coordination with the LHD TB Control Officer. Contractor must provide all Medically Necessary Covered Services to Members with TB on** DOT.

15. Women, Infants, and Children (WIC) Supplemental Nutrition Program

B. Contractor, as part of its IHA of Members, or, as part of the initial evaluation of pregnant Members, shall refer and document the referral of pregnant, breastfeeding, or postpartum Members or a parent/guardian of a child under the age of five (5) to the WIC program as mandated by Title 42 CFR 431.635(c) **and PL 98-010**.

~~B~~**C**. Subject to Exhibit A, Attachment 12, Provision 4, Contractor shall execute a Memorandum of Understanding (MOU) with the WIC program as stipulated in Exhibit A, Attachment 12, Provision 2, for services provided to Members through the WIC program.

19. In-Home Support Services (IHSS)

A. Contractor must maintain policies and procedures for identifying and referring eligible Members to the county In-Home Support Services (IHSS) program. Contractor's procedures must address the following requirements, at a minimum:

1) Processes for coordinating with the county IHSS agency that ensures Members do not receive duplicative services through ECM, Community Supports, and other services;

2) Track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until IHSS notifies Contractor that IHSS is no longer needed for the Member;

3) Outreach and coordinate with the county IHSS agency for any Members identified by DHCS as receiving IHSS;

4) Upon identifying Members receiving, referred to, or approved for IHSS, conduct a reassessment of Members' Risk Tier, per the population RSS and Risk Tiering requirements in this Section; and

5) Continue to provide Basic PHM and Care Coordination of all Medically Necessary services while Members receive IHSS.

B. To facilitate coordination, Contractor must have MOUs with each county IHSS agency within Contractor's Service Area in accordance with the MOU requirements in Exhibit A, Attachment 12, Provision 2, Network Provider Agreements, Subcontractor Agreements or Memoranda of Understanding. The MOU must delineate the roles and responsibilities of Contractor and IHSS in providing IHSS to the Members.

20. American Indian Health Services (AIHS)

Contractor must have an identified Contractor liaison dedicated to working with each American Indian Health Service (AIHS) Facility in its Service Area, and responsible for coordinating referrals and payment for services provided to American Indian Members who are qualified to receive services from an AIHS Facility, in accordance with the requirements in Exhibit A, Attachment 8, Provision 7, Federally Qualified Health Center (FQHC), Rural Health Center (RHC), and American Indian Health Service Programs.

VIII. Exhibit A, Attachment 18, IMPLEMENTATION PLAN AND DELIVERABLES, is amended to read:

10. Scope of Services

H. Submit policies and procedures for the provision of:

6) Long-Term Care

IX. Exhibit A, New Attachment 23, POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE, adds the following language:

**Exhibit A, Attachment 23
POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE**

1. Population Health Management (PHM) Program Requirements

A. Contractor must develop and maintain a Population Health Management (PHM) program that ensures all Members have equitable access to necessary wellness and prevention services, Care Coordination, and care management. Contractor must assess each Member's needs across the continuum of care based on Member preferences, data-driven risk stratification, identified gaps in care, and standardized assessment processes. Contractor must maintain a PHM program that seeks to improve the health outcomes of all Members consistent with the requirements set forth in this Section and DHCS guidance.

B. Contractor must ensure its PHM program meets all National Committee for Quality Assurance (NCQA) PHM standards, as well as applicable federal and State requirements. Contractor must conduct a Population Needs Assessment (PNA) as described in Provision 2 of this Attachment, and submit to DHCS for approval a Population Health Management Strategy (PHMS) that details all components of its PHM program activities in accordance with the requirements of this Attachment and the DHCS Comprehensive Quality Strategy.

C. Contractor must engage Local Health Departments (LHDs), Local Education Agencies (LEAs), Local Government Agencies (LGAs), and other stakeholders identified in Provision 2 of this Attachment to develop its PNA.

2. Population Health Management Strategy (PHMS) and Population Needs Assessment (PNA)

In accordance with 42 CFR sections 438.206(c)(2), 438.330(b)(4), and 438.242(b)(2), 22 CCR sections 53876(a)(4), 53876(c), 53851(b)(2), 53851(e), 53853(d), and 53910.5(a)(2), and applicable DHCS guidance, Contractor must conduct a PNA every three (3) years. The first submission under this new structure will be due to DHCS in Calendar Year 2025. Contractor must use the PNA to identify population-level health and social needs, including health disparities, and to provide and maintain culturally competent and linguistically appropriate services and translations. Contractor must implement health equity, health education, and continuous Quality Improvement (QI) programs and services, and determine relevant subpopulations for targeted, person-centered interventions. Contractor must develop the PNA in accordance with the following requirements:

A. Contractor's PNA must evaluate, at a minimum, the following factors for its entire Member population:

1) General characteristics and health needs;

2) Health status, behaviors and utilization trends, including use of Emergency Services;

3) Health education, and cultural and linguistic needs;

4) Health disparities;

5) Social drivers of health (SDOH); and

6) Any gaps in services and resources even if they are not Covered Services under this Contract.

B. Contractor's PNA must consider all relevant data for its entire Member population, including, but not limited to:

1) Data from Subcontractors and sub-Subcontractors; and

2) Needs assessments conducted by other entities and community-based organizations within Contractor's Service Area.

C. Contractor must use reliable data sources, including Subcontractor and sub-Subcontractor level data, to conduct and update the PNA at least annually every three (3) years. Reliable data sources must include the most recent results from the Member satisfaction survey and DHCS Health Disparities data.

D. In order to assess Member needs in Contractor's Service Area, Contractor must conduct broad community engagement as specified in DHCS policies and guidance, including the PHM Program Guide, and engage representatives of LHDs, LEAs, LGAs, Safety Net Providers, community based organizations, county mental health plans, Drug Medi-Cal and Drug Medi-Cal Organized Delivery System (DMC- ODS) plans, community mental health programs, PCPs, social service providers, regional centers, California Department of Corrections and Rehabilitation, county jails and juvenile facilities, Child Welfare Agencies as well as stakeholders from special needs groups, including Seniors and Persons with Disabilities (SPD), Children with Special Health Care Needs (CSHCN), Members with Limited English Proficiency (LEP), and other Member subgroups from diverse cultural and ethnic backgrounds.

F. Contractor must produce its PNA in writing, make it available to the public, and post it on its website.

G. Contract must submit an annual PHM Strategy that is aligned with NCQA requirements and DHCS policies and guidance, including the PHM Program Guide, and includes the following:

1) All components of the PHM Strategy and approach

2) Strategies and initiatives that address the Comprehensive Quality Strategy's Clinical Focus Areas and achieve the Bold Goals, in addition to specific health disparities and conditions identified in the PNA.

3. Data Integration and Exchange

In accordance with the CMS Interoperability and Patient Access final rule (CMS- 9115-F) and applicable federal and state data exchange requirements, Contractor must integrate its PHM data by expanding its Management Information System (MIS) capabilities outlined in Exhibit A, Attachment 3, Management Information Systems, as follows:

A. Integrate additional data sources in accordance with all NCQA PHM standards to ensure the ability to assess the needs and characteristics of all Members;

B. Enhance interoperability of its MIS to allow for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks as specified by DHCS;

C. Enhance interoperability of the PHM Service, in support of population health principles, integrated care, and Care Coordination across delivery systems;

D. Provide DHCS with administrative, clinical, and other data requirements as specified by the DHCS; and

E. Comply with all data sharing agreements, including data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with Health & Safety Code section 130290.

4. PHM Service

Contractor must use the PHM Service in accordance with all applicable federal and State laws and regulations, and in a manner specified by DHCS, as follows:

A. Contractor must use the PHM Service, when applicable functionality is fully defined and deemed available by DHCS, at a minimum, to:

1) Perform Risk Stratification and Segmentation (RSS) activities using PHM Service's RSS methodologies, including identifying and assessing Member-level risks and needs through use of the PHM Service's Risk Tiering functionalities, which places Members into standardized tiers.

2) Inform and enable Member screening and assessment activities, including using pre-populating screening and assessment tools; and

3) Support Contractor's Basic PHM program, including wellness and prevention, Member engagement and health education activities.

5. Population Risk Stratification/Segmentation (RSS) and Risk Tiering

A. Contractor must meet all of the requirements for RSS listed in this Provision. Contractor must use the PHM Service, in a manner specified by DHCS, or their own RSS approach, to meet the requirements contained in this Provision, including:

1) Considering findings from the PNA and all Members' behavioral, developmental, physical, and oral health, Long-Term Services and Supports (LTSS) needs as well as health

risks, rising-risks, and health-related social needs due to SDOH;

2) Complying with NCQA PHM standards;

3) Risk stratify and/or segment all Members at least annually and during each of the following timeframes:

a) Upon each Member's Enrollment;

b) Annually after each Member's Enrollment;

c) Upon a significant change in the health status or level of care of the Member; and

d) Upon the occurrence of events or new information that Contractor determines as potentially changing a Member's needs, including but not limited to, referrals for Complex Care Management (CCM), Enhanced Care Management (ECM), and Transitional Care Services.

4) Submitting its processes to DHCS upon request regarding how it identifies significant changes in Members' health status or level of care and how it is monitoring appropriate re-stratification.

5) Use integrated data that includes data sources, specified in DHCS policies and guidance, including the PHM Program Guide.

6) Avoid and reduce biases in its RSS approach by using evidence-based methods to prevent further exacerbation of Health Disparities. Only using utilization data would not meet standards to reduce bias.

B. Contractor must use RSS and PHM Service Risk Tiers, when available, to:

1) Connect all Members, including those with rising risk, to an appropriate Contractor-identified level of service within parameters outlined in Paragraph B.3) of this Provision, including but not limited to, care management programs, Basic PHM, and Transitional Care Services;

2) Monitor and improve the penetration rate of PHM programs

and services, including, but not limited to, the percentage of Members who require additional assessments who complete them as well as the connection of Members to the programs and services they are eligible for.

3) In line with NCQA PHM requirements, prior to PHM Service being deemed by DHCS to be operational, assess specific Members identified as High or Medium-Rising risk as outlined in DHCS guidance, including the PHM Program Guide, to determine care management needs.

C. Contractor must ensure that its RSS and Risk Tiering approach is submitted to DHCS for review and approval in a form and method prescribed by DHCS, and includes the following element, at a minimum:

1) Description of its RSS and Risk Tiering approach;

2) Description of how RSS and Risk Tiers are used to connect Members to appropriate services;

3) The number of Members in each Risk Tier and the programs or services for which they are eligible;

4) The penetration rate of PHM programs or services by Risk Tier:

a) The number of Members, by Risk Tier, who needed further assessment and received it;

b) The number of Members, by Risk Tier who were enrolled in programs they were eligible for; and

5) Method(s) for discovering and reducing bias within the RSS and Risk Tiering approach.

6. Screening and Assessments

A. In accordance with 42 CFR section 438.208, Contractor must conduct an initial screening of each Member's needs within 90 days of Enrollment and share that information with DHCS and other managed care health plans or Providers serving the Member, to prevent duplication of those activities. Contractor must make at least three (3) attempts to contact a Member to conduct the initial screening using available modalities.

B. Contractor must conduct necessary screenings to gain timely information on the health and social needs of all Members, in accordance with applicable State and federal laws and regulations, and NCQA PHM standards.

C. Contractor must abide by DHCS guidance for Member screening and assessment, including the PHM Program Guide, which will include guidance for how to use the PHM Service for the screening and assessment process.

D. Contractor must monitor what percentage of required screenings and assessments are completed per the specifications above.

7. Care Management Programs

Contractor must maintain a PHM delivery infrastructure to ensure that the needs of its entire Member population are met across the continuum of care. The infrastructure must provide Members with the appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. The care management interventions described in this Provision are intended for specific segments of the population that require more intensive engagement than the Basic PHM described in Provision 8 of this Attachment. Members receiving care management must have an assigned Care Manager and a Care Management Plan (CMP).

A. Enhanced Care Management (ECM) and Complex Care Management (CCM)

1) ECM is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and consistently apply comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. This benefit is intended for the highest risk Medi-Cal managed care health plan Members who meet the Populations of Focus criteria. ECM is described further in Exhibit A, Attachment 22.

2) Complex Care Management, which equates to Complex Case Management as defined by NCQA and in this Contract, is an approach to comprehensive care management that meets differing needs of high and rising-risk Members through both ongoing chronic Care Coordination and interventions for

episodic, temporary needs. The overall goal of CCM is to help Members regain optimum health or improved functional capability, in the right setting, and in a cost-effective manner.

3) Contractor must consider CCM to be an opt-out program, i.e. all eligible Members have the right to participate or to decline to participate.

4) Both ECM and CCM are inclusive of Basic PHM, which Contractor must provide to all Members. Care Managers conducting ECM or CCM must integrate all elements of Basic PHM into their ECM or CCM approach.

B. Care Management Programs

Contractor must operate and administer ECM as described in Exhibit A, Attachment 22, and CCM as stated in this Paragraph.

1) Contractor must operate and administer CCM in accordance with all NCQA CCM standards and requirements, and coordinate services for high and medium-rising risk Members through Contractor's CCM approach. To the extent NCQA's standards are updated, Contractor must comply with the most recent standards. Contractor must maintain and provide DHCS with policies and procedures that, at a minimum, include the following details regarding its CCM program:

a) Must be designed and implemented to help Members gain or regain optimum health or improved functional capability in the right setting;

b) Must include comprehensive assessment of the Member's condition, determination of available benefits and resources, and development and implementation of a CMP with performance goals, monitoring and follow-up;

c) Must have an opt-out approach wherein Members meeting the criteria for CCM have the right to decline to participate;

d) Must include a variety of interventions for Members that meet the differing needs of high and medium-rising risk populations, including longer-term chronic care coordination and interventions for episodic, temporary

needs; and

e) Must incorporate disease-specific management programs, including but not limited to asthma and diabetes, that include self-management support and health education.

2) Contractor must assess Members for the need for Community Supports as part of its CCM program and provide Community Supports, if available and medically appropriate and cost effective.

C. CCM Care Manager Role

1) Assignment of Care Manager

a) Contractor must identify and assign a Care Manager for every Member receiving CCM. PCPs may be assigned as Care Managers when they are able to meet all the requirements specified in this Paragraph C.

b) When a Care Manager other than the Member's PCP is assigned, Contractor must provide to the Member's PCP with the identity of the Member's assigned Care Manager and a copy of the Member's CMP.

c) When multiple Providers perform separate aspects of Care Coordination for a Member, Contractor must:

i. Identify a lead Care Manager and communicate that lead to all treating Providers and the Member; and

ii. Maintain policies and procedures to ensure compliance and non-duplication of Medically Necessary services, and the delegation of responsibilities between Contractor and the Member's Providers in meeting all care management requirements.

2) Care Manager Responsibilities

a) Contractor is responsible for ensuring Care Managers comply with all of the Basic PHM requirements in Provision 8 of this Attachment, and all NCQA CCM

standards.

b) Contractor must ensure that the Care Manager performs the following duties:

i. Conduct Member assessments as needed to identify and close any gaps in care and address the Member's physical, mental health, substance use disorder, developmental, oral health, dementia, palliative care, chronic disease and LTSS needs as well as needs due to SDOH;

ii. Complete a CMP for all Members receiving CCM, consistent with the Member's goals in consultation with the Member. The CMP must:

a. Address a Member's health and social needs, including needs due to SDOH;

b. Be reviewed and updated at least annually, upon a change in Member's condition or level of care, or upon request of the Member;

c. Be in an electronic format and a part of the Member's Medical Record, and document all of the Member's services and treating Providers;

d. Be developed using a person-centered planning process that includes identifying, educating and training the Member's parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons, as needed; and

e. Include referrals to community-based social services and other resources even if they are not Covered Services under this Contract.

iii. Ensure continuous information sharing and communication with the Member and their treating Providers; and

iv. Specify the responsibility of each Provider that provides services to the Member.

c) Ensure Members receive all Medically Necessary services, including Community Supports, to close any gaps in care and address the Member's mental health, substance use disorder, developmental, physical, oral health, dementia, and palliative care needs, as well as needs due to SDOH;

d) Support and assist the Member in accessing all needed services and resources, including across the physical and behavioral health delivery systems;

e) Communicate to Members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

f) Refer to Community Health Workers (CHWs), peer counselors, and other community-based social services including, but not limited to, personal care services, LTSS, Community Supports, and local community organizations;

g) Assess the Member's understanding of the referral instructions and follow-up to determine whether the referral instructions were completed or whether the Member needs further assistance to access the services, and if so, provide such assistance;

h) Review and/or modification of Member's CMP, when applicable, to address unmet service needs;

i) Facilitate and encourage the Member's adherence to recommended interventions and treatment; and

j) Ensure timely authorization of services to meet the Member's needs in accordance with the Member's CMP.

8. Basic Population Health Management (PHM)

A. Contractor must provide Basic PHM to all Members, in accordance with 42 CFR section 438.208. Contractor must maintain policies and

procedures that, at a minimum, meet the following Basic PHM requirements:

1) Ensure that each Member has an ongoing source of care that is appropriate, ongoing and timely to meet the Member's needs;

2) Ensure Members have access to needed services including Care Coordination, navigation and referrals to services that address Members' developmental, physical, mental health, SUD, dementia, LTSS, palliative care, and oral health needs;

3) Ensure that each Member is engaged with their assigned PCP and that the Member's assigned PCP plays a key role in the Care Coordination functions described in this Subsection, in partnership with the Contractor;

4) Ensure that each Member receives all needed preventive services in partnership with the Member's PCP;

5) Ensure efficient Care Coordination and continuity of care for Members who may need or are receiving services and/or programs from Out-of-Network Providers;

6) Review Member utilization reports to identify Members not using Primary Care; stratify such reports, at minimum, by race and ethnicity to identify Health Disparities that result from differences in utilization of outpatient and preventive services; and develop strategies to address differences in utilization;

7) Facilitate access to care for Members by, at a minimum, helping to make appointments, arranging transportation, ensuring Member health education on the importance of Primary Care for Members who have not had any contact with their assigned Medical Home/PCP or have not been seen within the last 12 months, particularly Members less than 21 years of age;

8) Ensure all services are delivered in a culturally and linguistically competent manner in alignment with NCLAS standards that promotes health equity for all Members;

9) Coordinate health and social services between settings of care, across other Medi-Cal Managed Care Health Plans, delivery systems, and programs such asTargeted Case

Management and SMHS, with external entities outside of Contractor's Network, and with Community Supports and other community-based resources, even if they are not Covered Services under this Contract, to address Members' needs and to mitigate impacts of SDOH;

10) Coordinate a warm hand-off to other public benefits programs, including but not limited to, California Work Opportunity and Responsibility to Kids (CalWORKs), CalFresh, the Women, Infants and Children (WIC) Supplemental Nutrition Program, Early Intervention Services, Supplemental Security Income (SSI), and all other programs requiring Memorandums of Understanding (MOUs) per Exhibit A, Attachment 12, Provision 2, Network Provider Agreements, Subcontractor Agreements or Memoranda of Understanding;

11) Assist Members, Members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons with navigating health delivery systems, including Contractor's Subcontractor and sub-Subcontractor Networks, to access Covered Services as well as services not covered under this Contract;

12) Provide Members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes;

13) Communicate to Members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

14) Ensure that Providers furnishing services to Members maintain and share, as appropriate, Members' Medical Records in accordance with professional standards and state and federal law;

15) Facilitate exchange of necessary Member information in accordance with any and all state and federal privacy laws and regulations, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable;

16) Maintain processes to ensure no duplication of services occurs; and

17) Provide evidence-based disease management programs in line with NCQA requirements and DHCS Comprehensive Quality Strategy (CQS) Bold Goals, including, but not limited to, programs for diabetes, cardiovascular disease, asthma, and depression that incorporate health education interventions, target members for engagement, and seek to close care gaps for Members participating in these programs.

B. In order to ensure that Basic PHM is provided to all Members, Contractor must provide the following resources to Providers, at minimum:

1) Establish a system to electronically track and monitor Network Provider referrals not requiring Prior Authorization, including referrals for care management services, and the outcomes of referrals;

2) Develop or provide access to a current and continuously updated community resource directory to the Network Providers; and

3) Provide a toll-free telephone number for Network Providers to obtain Contractor assistance in arranging referrals.

a) Telephone referral assistance must address referrals for mental health and substance use disorder treatment, developmental services, dementia, palliative care, dental, personal care services, and LTSS; and

b) Contractor must communicate the availability of the telephone referral assistance by providing the toll-free number on the home page of Contractor's website and in materials supplied to Network Providers, including Contractor's Provider Manual.

C. Wellness and Prevention Programs

Contractor must provide comprehensive wellness and prevention programs to all Members and in accordance with DHCS guidance.

1) Contractor must provide wellness and prevention programs that meet NCQA PHM standards, including for the provision of evidence-based self-management tools;

2) Contractor must ensure that the wellness and prevention

programs align with the DHCS Comprehensive Quality Strategy;

D. Contractor must provide wellness and prevention programs in a manner specified by DHCS, and in collaboration with LGAs as appropriate, that include the following, at a minimum:

1) Identification of specific, proactive wellness initiatives and programs that address Member needs as identified in the PNA;

2) Initiatives, programs and evidence-based approaches to improving access to preventative health visits, developmental screenings and services for Members less than 21 years of age, as described in Exhibit A, Attachment 10, Provision 4, Services for Members Under 21 Years of Age;

3) Initiatives, programs and evidence-based approaches on improving pregnancy outcomes for women, including through 12 months post-partum;

4) Initiatives, programs and evidence-based approaches on ensuring adults have access to preventive care, as described in Exhibit A, Attachment 10, Provision 5, Services for Adults, and in compliance with all applicable State and federal laws;

5) A process for monitoring the provision of wellness and preventive services by PCPs as part of Contractor's Site Review process, as described in Exhibit A, Attachment 4, Provision 10, Site Review;

6) Health education materials, in a manner that meets Members' health education and cultural and linguistic needs, in accordance with Exhibit A, Attachment 10, Provision 7, Services for All Members, and in alignment with NCLAs standards; and

7) Initiatives and programs that implement evidence-based best practices that are aimed at helping Members set and achieve wellness goals.

8) Special preventive services as required by EPSDT, in accordance with Exhibit A, Attachment 10, Provision 4, Services for Members Under 21 Years of Age.

E. Contractor must ensure that its wellness and prevention programs

are submitted to DHCS for review and approval in a form and method prescribed by DHCS.

F. Contract must report annually through the PHMS on how community-specific information and stakeholder input from the PNA is used to design and implement evidence-based wellness and prevention strategies.

9. Other Population Health Requirements for Children

For Members who are less than 21 years of age, Contractor must provide as part of care management and Basic PHM the following services for children:

A. EPSDT Case Management Responsibilities

1) Contractor must provide case management to assist Members under 21 years of age in gaining access to all Medically Necessary medical, behavioral health, dental, social, educational serves, and other services, as defined in 42 USC sections 1396d(a), 1396d(r), and1396n(g)(2), and W & I Code section 14059.5(b). Case management services for Members under 21 years of age also includes the data exchange necessary for the provision of services as well as the coordination of non-covered services such as social support services.

2) Contractor must also provide EPSDT case management services as Medically Necessary for Members less than 21 years of age, as required in Exhibit A, Attachment 10, Provision 4, Services for Members Under 21 Years of Age, and must ensure that all Medically Necessary services for Members under 21 years of age are initiated within timely access standards whether or not the services are Covered Services under this Contract.

B. Children with Special Health Care Needs (CSHCN)

Contractor must develop and implement policies and procedures to provide services for CSHCN. CSHCN are defined as having, or being at an increased risk for, a chronic physical, behavioral, developmental, or emotional condition, and who require health or related services of a type or amount beyond what is generally required by children. Contractor must ensure that the policies and procedures include the following information, at a minimum, to

encourage CSHCN Member participation:

1) Methods for ensuring and monitoring timely access to pediatric Specialists, sub-Specialists, ancillary therapists, transportation Providers, and DME and supplies. These may include assignment to a Specialist as a PCP, Standing Referrals, or other methods;

2) Methods for monitoring and improving the quality, health equity and appropriateness of care for CSHCN; and

3) Methods for ensuring Care Coordination with California Department of Developmental Services (DDS) and local CCS Programs, as appropriate.

C. Early Intervention Services

1) Contractor must develop and implement systems to identify Members who may be eligible to receive services from the Early Start program, and refer them to the local Early Start program. These Members include those with a condition known to lead to a developmental delay, those in whom a developmental delay is suspected, or whose early health history places them at risk for delay. Contractor must collaborate with the local regional center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for such Members.

2) Contractor must provide case management and Care Coordination to the Member to ensure the provision of all Medically Necessary Covered Services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.

10. Transitional Care Services

A. Contractor must provide Transitional Care Services to all Members transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and State laws and regulations, and DHCS guidance, including the PHM Program Guide. Transferring from one setting, or level of care, to another includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and SNFs to home or community-based settings, Community Supports, post-acute care facilities, or

LTC settings.

B. If the Member is receiving CCM or ECM, Contractor must ensure that the Member's assigned Care Manager provides all Transitional Care Services. If the Member is not receiving CCM or ECM, the Contractor must assign a care manager who is required to ensure all transitional care services are complete, including making appropriate referrals and ensuring no gaps in care.

C. Contractor must implement transitional care processes that meet the following requirements, at minimum:

1) Implement a standardized discharge risk assessment that is to be completed prior to discharge, to assess a Member's risk of re-institutionalization, re-hospitalization, and risk of mental health and/or substance use disorder relapse;

2) Obtain permission from Members, Members' parents, legal guardians, or authorized representatives, as appropriate, to share information with Providers to facilitate transitions, in accordance with federal and state privacy laws and regulations;

3) Ensure that medication reconciliation is conducted pre- and post-transition;

4) Refer to Community Supports and coordination with county social service agencies and waiver agencies for IHSS and other HCBS;

5) Ensure all Prior Authorizations required for the Member's discharge are processed within timeframes consistent with the urgency of the Member's condition, not to exceed five (5) Working Days for routine authorizations, or 72 hours for expedited authorizations, in accordance with Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization. This includes Prior Authorizations for therapy, home care, medical supplies, prescription medications for which Contractor is responsible, and DME that are processed in accordance with 42 CFR section 438.210, Health and Safety Code section 1367.01, and Exhibit A, Attachment 5, Provision 1, Utilization Management Program;

6) Ensure all Network Provider hospitals, institutions, and facilities educate their Discharge Planning staff on the

services, supplies, medications, and DME needing Prior Authorization;

7) Ensure that mutually agreed upon policies and procedures for Discharge Planning and Transitional Care Services exist between Contractor and each of its Network Provider and Out-of-Network Provider hospitals within its Service Area;

8) Prevent delayed discharges of a Member from a hospital, institution, or facility due to circumstances such as, but not limited to, Contractor authorization procedures or transitions to a lower level of care, by determining and addressing the root causes of why delays occur;

9) Ensure each Member is evaluated for all care settings appropriate to the Member's condition, needs, preferences and circumstances. Members must not be discharged to a setting that does not meet their medical and/or LTSS needs; and

10) Ensure Members with substance use disorder and mental health needs receive treatment for those conditions upon discharge.

D. Contractor must provide a Discharge Planning document to Members, Member's parents, legal guardians, or authorized representatives, as appropriate, when being discharged from a hospital, institution or facility. Contractor's Discharge Planning document must include the following information, at a minimum:

1) Pre-admission status, including living arrangements, physical and mental function, SUD needs, social support, DME uses, and other services received prior to admission;

2) Pre-discharge factors, including the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge;

3) The hospital, institution or facility to which the Member was admitted;

4) Specific agency or home recommended by the hospital, institution or facility after the Member's discharge based upon Member needs and preferences; specific services needed after the Member's discharge; specific description of the type of placement preferred by the Member, specific description of

type of placement agreed to by the Member, specific description of agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling;

5) Summary of the nature and outcome of participation of Member, Member's parents, legal guardians, or authorized representatives in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital, institution or facility to be included in the Member's Medical Record;

6) Information regarding available care, services, and supports that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.

7) The name and contact information of the assigned care manager responsible for transitional care services.

E. Nursing Facility Transitions

When transitioning Members to and from SNFs, Contractor must ensure timely Member transitions that do not delay or interrupt any Medically Necessary services or care by meeting the following requirements, at a minimum:

1) Coordinate with facility discharge planners, care or case managers, or social workers to provide case management and transitional care services during all transitions;

2) Assist Members being discharged or Members' parents, legal guardians, or authorized representatives by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with IHSS, Community Supports, LTSS, and other HCBS;

3) Maintain contractual requirements for SNFs to share Minimum Data Set (MDS) Section Q, have appropriate systems to import and store MDS Section Q data and incorporate MDS Section Q data into transition assessments;

4) Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge;

5) Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; and

6) Follow-up with Members, Members' parents, legal guardians, or authorized representatives, as appropriate, regarding the new care setting to ensure compliance with transitional care services requirements.

X. Exhibit B, BUDGET DETAIL AND PAYMENT PROVISIONS, is amended to read:

16. Special Contract Provisions Related to Payment

A. Contractor must reimburse Network Providers pursuant to the terms of each applicable Directed Payment Initiative in accordance with 42 CFR section 438.6(c), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS shall make the terms of each Directed Payment Initiative available on the **DHCS website at www.dhcs.ca.gov** ~~DHCS website~~.

C. Contractor must comply with the terms of any Incentive Arrangements approved by CMS under 42 CFR section 438.6(b)(2), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Incentive Arrangement available on the **DHCS website at www.dhcs.ca.gov** ~~DHCS website~~.

D. To participate in Member direct incentive programs approved in the Public Assistance Cost Allocation Plan (PACAP) by the U.S. Department of Health and Human Services Division of Cost Allocation Services, with CMS concurrence, Contractor must comply with the terms of those programs as set forth in the PACAP in a form and manner specified by DHCS through APLs or other technical guidance. For Rating Periods in which Member direct incentive programs are effective, commencing with the Rating Period starting January 1, 2021, DHCS shall make the terms of each approved Member direct incentive program available on the **DHCS website at www.dhcs.ca.gov** ~~DHCS website~~**.**

E. Contractor must comply with the terms of any Risk Sharing Mechanisms instituted in accordance with 42 CFR section 438.6(b)(1), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS

will make the terms of each approved Risk Sharing Mechanism available on the DHCS website at www.dhcs.ca.gov.

XI. Exhibit E, Attachment 1, DEFINITIONS, is amended to read:

Dyadic Care Services means a family and caregiver-focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified.

Eligible Beneficiary means any Medi-Cal beneficiary who is residing in Contractor's Service Area with one (1) of the following aid codes:

Aid Group	Mandatory Aid Codes
Adult and Family/Optional Targeted Low-Income Child	01, 02, 03, 04, 06, 07, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 43, 45, 46, 47, 49, 54, 59, 72, 76, 82, 0A, 0E, 2P, 2R, 2S, 2T, 2U, 2V, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4A, **4C,** 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U**,** 4W, 5V, 7A, 7J, 7S, 7W, 8E, 8P, 8R, 8U, K1, M3, M7, M9, P5, P7, P9, R1, 5C, 5D, 5K, 5L, H1, H2, H3, H4, H5, E6, E7, M5, R1, T1, T2, T3, T4, T5
SPD	10, 14, 16, 1E, 1H, 20, 24, 26, 27, 36, 60, 64, 66, 67, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y, L6
Adult	81, 86, 87
Long Term Care/Full Dual Eligible	13, 23, 53, 63
Long Term Care/Non-Full Dual Eligible	13, 23, 53, 63
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U, 0W
Adult Expansion	L1, M1, 7U
Adult & Family/Optional Targeted Low-Income Child (Dual)	**0A,** 2V, 30, 32, 33, 34, 35, 38, 39, **3A, 3C,** 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, **5C, 5D,** 5V, 47, 54, 59, 72, 7A, 7J, 7S, 7W, 7X, 82, 8E, 8P, 8R, **E6, E7, H1, H2, H3, H4, H5,** K1, M3, **M5,** M7, M9, P5, P7, P9, **T1, T2, T3, T4, T5**
SPD/Dual	10, 14, 16, 1E, 1H, 1X, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6X

Long-Term Care (LTC) means **specialized rehabilitative services and care** provided in a ~~s~~**S**killed ~~n~~**N**ursing ~~f~~**F**acility**,** ~~and subacute c~~are ~~services~~ **and beginning July 1, 2023, subacute facility, pediatric subacute facility, or ICF/DD, ICF/DD-H and ICF-DD-N homes,** that lasts longer than ~~60 days~~ **the remainder of the month of admission plus one (1) month**.

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

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

CY 2023-A Contract Amendment Detail

Category	Requirement	Sub-Regulatory Guidance
Management Information System (MIS) Capability	-MCPs must have MIS capabilities to transmit and consume data files from state, federal, and local government entities to support care coordination and administration of the Medi-Cal program.	
Covered Services	-Revised Initial Health Assessment (IHA) requirements. -Addition of dyadic care services for members ages 0 -20 years and/or their caregivers in an outpatient setting.	
Care Management and Care Coordination	-MCPs must identify the target populations for Targeted Case Management (TCM) programs within their service areas and maintain procedures to refer members for TCM services. -MCPs must have Memorandums of Understanding (MOU) with Local Governmental Agencies (LGAs) to facilitate coordination of TCM services. -MCPs must designate a representative responsible for coordinating TCM services with the LGAs for the member. - MCPs must use DHCS-approved screening tools to ensure members receive referrals to either the Non-Specialty Mental Health Services (NSMHS) or Specialty Mental Health Services (SMHS) delivery system. -Outlines requirements for MCPs and Mental Health Plans (MHPs) regarding mental health services disputes. -Execution of various MOUs for care management and care coordination purposes.	DHCS All – Plan Letter (APL) 21-013: Dispute Resolution Process Between Mental Health Plans (MHPs) and Managed Care Plans (MCPs)
Population Health Management (PHM)	-Maintain a health education system that provides educational interventions that align with the MCP's PHM Strategy. -MCPs must implement the PHM Program Guide requirements outlined in the contract amendment and DHCS sub – regulatory guidance.	DHCS APL 22-024: PHM Program Guide CalAIM PHM Policy Guide
Risk Sharing	-MCPs must comply with the terms of any risk sharing mechanism in accordance with federal requirements in a form and manner specified by DHCS.	
Aid Codes	-Addition of covered aid codes to CalOptima's Health Contract with DHCS.	
Terminology Changes	-Update terms and definitions used in the agreement.	

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CalOptima Health Board Action Agenda Referral

Action To Be Taken February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
6. Approve Modifications to CalOptima Health Budget Approval and Budget Reallocation Policy

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

Recommended Action
Pursuant to CalOptima Health's policy review process, approve modifications to CalOptima Health Policy GA.5003: Budget Approval and Budget Reallocation.

Background
CalOptima Health regularly reviews its policies and procedures to ensure they are up to date and align with federal and state health care program requirements, contractual obligations, laws, and CalOptima Health operations.

Discussion
The table below outlines a list of substantive changes to CalOptima Health Policy GA.5003: Budget Approval and Budget Reallocation (Policy), which are reflected in the attached redline policy. The list does not include non-substantive change that may also be reflected in the redline (e.g., formatting, spelling, punctuation, capitalization, minor clarifying language, and/or grammatical changes).

CalOptima Health last revised the Policy on March 1, 2012. The policy provides guidance on the budget approval and budget reallocation process for the operating budget and capital budget for each line of business and at the consolidated level.

Section	Proposed Change	Rationale
Title	Changed Policy title to Budget Approval and Budget Reallocation.	Changed to reflect the main purpose of the Policy.
III.A	Deleted language "present the proposed capital budget by major asset type (e.g., hardware, software, tenant improvements, equipment)"	Deleted to enhance the efficiency of CalOptima Health's operations and governance.
III.B	Increased CEO authority on budget reallocation, within certain parameters, from $100,000 to $250,000.	Increase CEO authority to enhance the efficiency of CalOptima Health's operations and governance.

Fiscal Impact
There is no fiscal impact.

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Rationale for Recommendation

Updates to Policy GA.5003: Budget Approval and Budget Reallocation will enhance the efficiency of CalOptima Health's operations and governance.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Policy GA.5003: Budget Approval and Budget Reallocation

/s/ Michael Hunn *01/26/2023*

Authorized Signature **Date**

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Policy:	GA.5003
Title:	**Budget Approval and ~~Operations Forecasting~~Budget Reallocation**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2010
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes ~~the~~CalOptima Health's budget approval and ~~operations forecasting~~budget reallocation process ~~agency-wide and for all lines of business.~~.

II. POLICY

A. CalOptima Health shall develop ~~a yearly operating budget~~ an annual Operating Budget for each line of business and at the consolidated ~~agency~~level.

B. CalOptima Health shall ~~prepare a yearly capital budget~~develop an annual Capital Budget for the purchase of Fixed Assets.

C. The development of all budgets shall reflect ~~CalOptima's~~CalOptima Health's short-term and long-term strategic objectives and based on the best information available.

D. ~~CalOptima's~~The CalOptima Health Board of Directors (Board) shall review and approve ~~all budgets~~the annual Operating Budget and Capital Budget prior to implementation.

E. CalOptima Health shall ~~compare financial results to the operating budget each month as part of the~~ provide a monthly financial report to the Board ~~of Directors.~~that compares financial performance to the Operating Budget and Capital Budget.

F. CalOptima ~~shall~~Health may reforecast revenue and expenditures periodically throughout the year~~.~~, as necessary. Any budget reallocation up to but less than, the amounts allowed within this policy, requires approval by the Chief Executive Officer (CEO).

III. PROCEDURE

A. Operating Budget and Capital ~~Budgets~~Budget

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1. ~~CalOptima's~~The Finance ~~Department~~Departments, in collaboration with other departments, shall develop ~~an operating budget for each Line of Business and agency-wide,~~ on an annual basis~~.~~:

~~2. CalOptima's Finance Department, in collaboration with other departments, shall develop an agency-wide capital budget, on an annual basis.~~

~~3. CalOptima's Finance Department shall reference the Annual Operational Plan for strategic guidance in the development of operating and capital budgets.~~

a. ~~Presentation of Proposed Budgets to~~An Operating Budget for each line of business and at the consolidated level; and

b. An agency-wide Capital Budget.

~~4.~~2. Budget Review by the Finance and Audit Committee of the Board ~~of Directors~~

a. ~~CalOptima's~~The Chief Financial Officer (CFO) or Designee shall present ~~the proposed operating budget~~ to the Finance and Audit Committee of the Board:

i. The ~~of Directors. The report shall include~~proposed Operating Budget, including a discussion of major assumptions and a comparison ~~with the~~to current ~~year forecast.~~and prior budget years; and

~~b. CalOptima's CFO or Designee shall present the proposed capital budget by major asset type (e.g., hardware, software, tenant improvements, equipment). The report shall reference the Depreciation expense impact.~~

ii. The proposed Capital Budget, including use of Fixed Assets and allocation within Capital Budget categories.

~~c.~~ The Finance and Audit Committee of the Board ~~of Directors~~ shall review ~~and approve the proposed budgets and~~, propose any changes, as necessary~~.~~

~~d.~~b. ~~The Finance Department shall analyze the Finance and Audit Committee's proposed changes~~, and ~~incorporate such changes, as necessary~~recommend approval of the proposed Operating Budget and Capital Budget to the full Board.

c. If changes are recommended by the Finance and Audit Committee of the Board, the Finance Departments shall analyze the proposed changes and incorporate such changes into the proposed budget documents.

~~5.~~ Budget Review and Approval by the Board: After the Finance and Audit Committee of the Board recommends approval of ~~Directors approves~~ the proposed ~~operating~~Operating Budget and ~~capital budgets, CalOptima's~~ Capital Budget, the CFO or Designee shall present the proposed ~~budgets~~budget documents to the Board ~~of Directors prior to beginning of each fiscal year.~~

~~6. The Board of Directors shall approve all budgets prior to implementation.~~

~~7. If unknown assumptions are utilized in the development of budgets (e.g. state program funding, rates), the Board of Directors may approve an interim budget to ensure that CalOptima has~~

conditional appropriation funding. The Finance Department shall propose a revised budget when funding and rate information is confirmed.

8. CalOptima shall make all reasonable efforts to present proposed budgets for approval prior to the beginning of each fiscal year. In the case that CalOptima is unable to present proposed budgets prior to the beginning of the fiscal year, the CFO or Chief Executive Officer (CEO) shall request extension of the current year budget into the new fiscal year as a temporary measure, until key information is available.

B. Budget Allocation Changes

1. Medical Services. To the extent that there are unexpended budgeted funds approved for a specific supplemental program in the medical services budget (e.g., quality incentive programs), the CEO may make a budget substitution under a cumulative one hundred thousand dollars ($100,000) into or out of any supplemental program under the Medical Services Budget, subject to the conditions and limitations set forth below. Any budget substitution of one hundred thousand dollars ($100,000) or more is subject to the approval of the Board. Payments for supplemental programs are not for base rate payments (e.g. per diems, capitation rate, etc.) but are targeted to address a specific need or activity (quality incentives, incentive grants, etc.). Substitutions the CEO may make shall be:

   i. For a program or activity that has been explicitly approved by the Board for their review and ;

   b. Limited to the same line of business, e.g., OneCare expenditure cannot be moved to Medi-Cal;

   c. Budget neutral in the context of the Medical Services Budget for the line of business, which establishes targets or estimates of the provider payment portion of the overall Budget; and

   d. Reported monthly to the Board as part of the Financial Report and reported to the Finance and Audit Committee with analysis on a quarterly basis.

9.3. Capital Budget. The CEO may make a substitution of a capital item for a different capital item under one hundred thousand dollars ($100,000) in the approved Capital Budget subject to the conditions and limitations set forth below. Any budget substitution of one hundred thousand dollars ($100,000) or more is subject to the approval of the Board. Substitutions the CEO may make shall be:.

   e. For a program or activity that has been explicitly approved by the Board;

C.B. Budget neutral in the overall Capital Budget;Reallocation

1. Reported monthly to Administrative or Medical Management Budget

   a. The CEO may approve a reallocation of funds within the Board as part of the Financial Report and reported to the Finance and Audit Committee with analysis on a quarterly basis; and

   b. Within the same capital-approved Operating Budget from a budgeted administrative or medical management expense category, which to an existing budget line item or for purposesan unbudgeted initiative. The total amount of the Capital Budgetbudget

reallocation to an existing budget line item or unbudgeted initiative shall be ~~defined as follows:~~

~~i. Information Systems Hardware;~~

~~ii. Information Systems Software, or~~

~~iii. Furniture, Fixtures and Equipment (FF&E).~~

~~c.~~a. ~~Administrative Budget. The CEO may make a substitution of an administrative expense~~ up to but less than ~~one~~two hundred and fifty thousand dollars ($~~100~~250,000~~)~~), in ~~the approved Administrative Budget for another subject to the conditions and limitations below. Any budget substitution of one hundred thousand dollars ($100,000) or more is subject to the approval of the Board. Examples of programs or activities would be: ICD-10, National Committee on Quality Assurance (NCQA), MSI Transition, Health Care Reform analysis, Long-Term Care Integration, Behavioral Health integration, etc. These are in addition to maintenance of business for CalOptima's existing lines of business. The administrative portion of the Medical Services Budget (i.e., expenses for medical management, utilization management, etc.) shall have the same substitutions policy as outlined above for the Administrative Budget. Substitutions the CEO may make shall be:~~aggregate, per fiscal year.

~~d. For a program or activity that has been explicitly approved by the Board;~~

b. Each budget reallocation shall be subject to the following conditions and limitations:

i. Limited to the same line of business;

~~i.~~ii. Limited to the same ~~,~~budget expense category, e.g., ~~OneCare expenditure cannot be moved to Medi-Cal;~~Salary, Wages & Employee Benefits, Non-Salary Operating Expenses, Depreciation & Amortization, and Indirect Cost Allocation, Occupancy Expense; and

~~ii.~~iii. Budget neutral in the context of the Administrative or Medical Management Budget~~; and~~.

~~e.~~c. ~~Reported~~ The CFO or Designee shall provide information on budget reallocations as part of the monthly financial report to the Board ~~as part of the Financial Report~~ and ~~reported~~ quarterly analysis to the Finance and Audit Committee ~~with analysis on a quarterly basis~~of the Board.

d. ~~No changes~~Any budget reallocation in the ~~budget exceeding one~~amount of two hundred and fifty thousand dollars ($~~100~~250,000~~), or that would provide funding for a program~~) or ~~activity not~~ more, in aggregate, per fiscal year, to an existing budget line item or an unbudgeted initiative requires separate Board consideration and approval.

2. Capital Budget

a. The CEO may approve a reallocation of funds within the Board-approved ~~by the Board, may~~ Capital Budget from a budgeted capital project to a different existing budgeted capital project or for an unbudgeted capital project. The total amount of budget reallocation to an existing budgeted or unbudgeted capital project shall be ~~made without the prior approval of~~

~~the Board of Directors~~up to but less than two hundred and fifty thousand dollars ($250,000), in aggregate, per fiscal year.

b. ~~-~~Each budget reallocation shall be subject to the condition of budget neutrality in the overall Capital Budget.

c. Any budget reallocation in the amount of two hundred and fifty thousand dollars ($250,000) or more, in aggregate, per fiscal year, to an existing budgeted or unbudgeted capital project requires separate Board consideration and approval.

~~D.~~C. Reporting and Analysis

1. On a monthly basis, ~~CalOptima's~~the Accounting and Finance ~~Department~~Departments shall prepare, at the minimum, the following standard financial reports for internal presentation to the ~~CalOptima~~ Executive Officers and at the Board ~~of Directors~~ meeting:

   a. Financial highlights;

   b. Enrollment summary and trend;

   c. Balance Sheet;

   d. Income Statement;

   ~~d.~~e. Capital project summary; and

   ~~e.~~f. Statement of Cash Flows.

~~2. CalOptima's Finance Department shall compare actual capital spending against the budget on a monthly basis and shall report the results quarterly to the Finance and Audit Committee of the Board of Directors.~~

~~3.~~2. ~~CalOptima's~~The Accounting and Finance Departments may present additional financial reports and updates to the Finance and Audit Committee of the Board ~~of Directors~~ and other ~~associated~~advisory committees, as requested or necessary.

~~D. Re-forecasting~~

D. ~~CalOptima's~~Reforecasting

1. The Finance ~~Department shall~~ Departments may prepare periodic ~~re-forecasts~~reforecasts of the current fiscal year by line of business for internal review, as necessary.

~~2.~~ If there are significant changes due to enrollment, ~~rates,~~ revenue, or expenses, ~~CalOptima's~~the CFO or Designee shall report this information to the Finance and Audit Committee of the Board ~~of Directors and Board of Directors.~~

~~3.~~2. ~~CalOptima's Finance Department may perform forecasts and re-forecasts for the upcoming two (2) to three (3) years, both for internal planning and discussion with~~and the Board ~~of Directors and other associated committees.~~ .

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/01/2012	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	01/01/2010	GA.5003	Budget and Operations Forecasting	Administrative
Revised	03/01/2012	GA.5003	Budget and Operations Forecasting	Administrative
Revised	TBD	GA.5003	Budget Approval and Budget Reallocation	Administrative

IX. GLOSSARY

Term	Definition
~~Operating Budget~~	~~Expenses associated with maintenance of business.~~
Asset	A tangible or intangible item of value.
Capital Budget	~~Amounts~~The annual forecast of amounts spent to acquire or improve ~~a~~ long-term ~~asset~~Assets such as equipment or Buildings, approved by the CalOptima Health Board of Directors.
Depreciation	An expense recorded to allocate a tangible Asset's Cost over its useful life.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Fixed Assets	Fixed Assets or capital Assets are tangible Assets with a value greater than or equal to the Capitalization Threshold and a useful life in excess of one (1) year. Fixed Assets include Buildings, machinery and equipment, computer equipment, vehicles, Improvements, and Land.
Medical Services Budget	Expenses associated with providing care for ~~members~~CalOptima Health Members.
Member	~~An Enrollee -~~A beneficiary ~~of~~enrolled in a CalOptima Health program.
Operating Budget	The annual forecast of revenue and expenses associated with the maintenance of business, approved by the CalOptima Health Board of Directors.

Policy:	GA.5003
Title:	**Budget Approval and Budget Reallocation**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2010
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes CalOptima Health's budget approval and budget reallocation process.

II. POLICY

A. CalOptima Health shall develop an annual Operating Budget for each line of business and at the consolidated level.

B. CalOptima Health shall develop an annual Capital Budget for the purchase of Fixed Assets.

C. The development of all budgets shall reflect CalOptima Health's short-term and long-term strategic objectives and based on the best information available.

D. The CalOptima Health Board of Directors (Board) shall review and approve the annual Operating Budget and Capital Budget prior to implementation.

E. CalOptima Health shall provide a monthly financial report to the Board that compares financial performance to the Operating Budget and Capital Budget.

F. CalOptima Health may reforecast revenue and expenditures periodically throughout the year, as necessary. Any budget reallocation up to but less than, the amounts allowed within this policy, requires approval by the Chief Executive Officer (CEO).

III. PROCEDURE

A. Operating Budget and Capital Budget

1. The Finance Departments, in collaboration with other departments, shall develop on an annual basis:

   a. An Operating Budget for each line of business and at the consolidated level; and

   b. An agency-wide Capital Budget.

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2. Budget Review by the Finance and Audit Committee of the Board

   a. The Chief Financial Officer (CFO) or Designee shall present to the Finance and Audit Committee of the Board:

      i. The proposed Operating Budget, including a discussion of major assumptions and a comparison to current and prior budget years; and

      ii. The proposed Capital Budget, including use of Fixed Assets and allocation within Capital Budget categories.

   b. The Finance and Audit Committee of the Board shall review, propose any changes, as necessary, and recommend approval of the proposed Operating Budget and Capital Budget to the full Board.

   c. If changes are recommended by the Finance and Audit Committee of the Board, the Finance Departments shall analyze the proposed changes and incorporate such changes into the proposed budget documents.

3. Budget Review and Approval by the Board: After the Finance and Audit Committee of the Board recommends approval of the proposed Operating Budget and Capital Budget, the CFO or Designee shall present the proposed budget documents to the Board prior to the beginning of each fiscal year for their review and approval.

B. Budget Reallocation

1. Administrative or Medical Management Budget

   a. The CEO may approve a reallocation of funds within the Board-approved Operating Budget from a budgeted administrative or medical management expense to an existing budget line item or for an unbudgeted initiative. The total amount of budget reallocation to an existing budget line item or unbudgeted initiative shall be up to but less than two hundred and fifty thousand dollars ($250,000), in aggregate, per fiscal year.

   b. Each budget reallocation shall be subject to the following conditions and limitations:

      i. Limited to the same line of business;

      ii. Limited to the same budget expense category, e.g., Salary, Wages & Employee Benefits, Non-Salary Operating Expenses, Depreciation & Amortization, and Indirect Cost Allocation, Occupancy Expense; and

      iii. Budget neutral in the context of the Administrative or Medical Management Budget.

   c. The CFO or Designee shall provide information on budget reallocations as part of the monthly financial report to the Board and quarterly analysis to the Finance and Audit Committee of the Board.

   d. Any budget reallocation in the amount of two hundred and fifty thousand dollars ($250,000) or more, in aggregate, per fiscal year, to an existing budget line item or an unbudgeted initiative requires separate Board consideration and approval.

2. Capital Budget

a. The CEO may approve a reallocation of funds within the Board-approved Capital Budget from a budgeted capital project to a different existing budgeted capital project or for an unbudgeted capital project. The total amount of budget reallocation to an existing budgeted or unbudgeted capital project shall be up to but less than two hundred and fifty thousand dollars ($250,000), in aggregate, per fiscal year.

b. Each budget reallocation shall be subject to the condition of budget neutrality in the overall Capital Budget.

c. Any budget reallocation in the amount of two hundred and fifty thousand dollars ($250,000) or more, in aggregate, per fiscal year, to an existing budgeted or unbudgeted capital project requires separate Board consideration and approval.

C. Reporting and Analysis

1. On a monthly basis, the Accounting and Finance Departments shall prepare, at the minimum, the following standard financial reports for internal presentation to the Executive Officers and at the Board meeting:

a. Financial highlights;

b. Enrollment summary and trend;

c. Balance Sheet;

d. Income Statement;

e. Capital project summary; and

f. Statement of Cash Flows.

2. The Accounting and Finance Departments may present additional financial reports and updates to the Finance and Audit Committee of the Board and other advisory committees, as requested or necessary.

D. Reforecasting

1. The Finance Departments may prepare periodic reforecasts of the current fiscal year by line of business for internal review, as necessary.

2. If there are significant changes due to enrollment, revenue, or expenses, the CFO or Designee shall report this information to the Finance and Audit Committee of the Board and the Board.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/01/2012	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	01/01/2010	GA.5003	Budget and Operations Forecasting	Administrative
Revised	03/01/2012	GA.5003	Budget and Operations Forecasting	Administrative
Revised	TBD	GA.5003	Budget Approval and Budget Reallocation	Administrative

IX. GLOSSARY

Term	Definition
Asset	A tangible or intangible item of value.
Capital Budget	The annual forecast of amounts spent to acquire or improve long-term Assets such as equipment or Buildings, approved by the CalOptima Health Board of Directors.
Depreciation	An expense recorded to allocate a tangible Asset's Cost over its useful life.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Fixed Assets	Fixed Assets or capital Assets are tangible Assets with a value greater than or equal to the Capitalization Threshold and a useful life in excess of one (1) year. Fixed Assets include Buildings, machinery and equipment, computer equipment, vehicles, Improvements, and Land.
Medical Services Budget	Expenses associated with providing care for CalOptima Health Members.
Member	A beneficiary enrolled in a CalOptima Health program.
Operating Budget	The annual forecast of revenue and expenses associated with the maintenance of business, approved by the CalOptima Health Board of Directors.

CalOptima Health Board Action Agenda Referral

Action To Be Taken February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Approve New CalOptima Health Policy GA.7110p: Street Medicine

Contact

Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Action

Approve new CalOptima Health Policy GA.7110p: Street Medicine.

Background/Discussion

In November 2022, the California Department of Health Care Services (DHCS) All Plan Letter (APL) 22-023: Street Medicine Provider: Definitions and Participation in Managed Care provided guidance to Medi-Cal managed care health plans (MCPs) on opportunities to utilize street medicine providers to address clinical and non-clinical needs of their Medi-Cal members experiencing unsheltered homelessness through administration of Street Medicine programs.

Per DHCS, Street Medicine is "a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment."

With the anticipated launch of CalOptima Health's own Street Medicine program in April 2023, staff have drafted a policy for Board approval. The policy addresses the following elements: provider participation requirements (e.g., primary care provider, direct contract, Community Supports provider or Enhanced Care Management provider), general qualifications, facility site review procedures, credentialing, provider enrollment, billing and claims submission, and data sharing.

Fiscal Impact

The recommended action to approve CalOptima Health Policy GA.7110p is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation

CalOptima Health staff recommends that the Board approve and adopt policy GA.7110p: Street Medicine to ensure CalOptima Health can effectively launch a Street Medicine program that aligns with the requirements set forth by DHCS.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Entities Covered by this Recommended Action
2. New CalOptima Health Policy GA.7110p: Street Medicine
3. Department of Health Care Services All Plan Letter (APL) 22-023: Street Medicine Provider: Definitions and Participation in Managed Care

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

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Attachment to the February 2, 2023 Board of Directors Meeting – Agenda 7

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Healthcare In Action (HIA)	3800 Kilroy Airport Way, Suite 100	Long Beach	CA	90806

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Policy:	GA.7110p
Title:	**Street Medicine**
Department:	Operations Management
Section:	CalAIM
CEO Approval:	*/s/*
Effective Date:	04/01/2023
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes CalOptima Health's and Provider responsibilities for the overall administration and implementation of a Street Medicine program, to include services for Members experiencing unsheltered homelessness pursuant to California Department of Health Care Services (DHCS) requirements.

II. POLICY

A. CalOptima Health is responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, DHCS Contract requirements, and other DHCS guidance, including All Plan Letters (APL) and Policy Letters.

B. CalOptima Health shall reimburse eligible providers for the provision of medical services for Members experiencing unsheltered homelessness, in accordance with CalOptima Health's policies and procedures, consistent with DHCS and other regulatory requirements.

C. Street Medicine Provider refers to a licensed medical provider (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas).

1. For a non-physician medical practitioner (PA, NP, and CNM), CalOptima Health shall ensure compliance with state law and DHCS Contract requirements regarding physician supervision of non-physician medical practitioners.

D. Contracted Street Medicine Providers may choose to serve as the Member's assigned Primary Care Provider (PCP) upon Member election, similar to how Obstetrician-Gynecologist (OB/GYN) Providers can elect to serve as PCPs.

1. In order to serve as a PCP, the Street Medicine Provider must meet CalOptima Health's eligibility criteria for being a PCP, be qualified and capable of treating the full range of health care issues served by PCPs within their scope of practice and agree to serve in a PCP role.

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2. Street Medicine Providers willing to serve in the Member's assigned PCP capacity shall be enrolled and credentialed as a PCP, in accordance with DHCS APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment

    a. Street Medicine Providers serving as an assigned PCP and are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV shall undergo a full site review process of the street medicine Provider and affiliated facility in accordance with DHCS APL 22-017: Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review.

    b. Street Medicine Providers serving as an assigned PCP and are not affiliated with a brick-and-mortar facility or mobile unit/RV shall undergo a condensed Facility Site Review (FSR) and Medical Record Review (MRR) of the street medicine Provider to ensure Member safety.

E. CalOptima shall contract with a provider that meets DHCS's Street Medicine Provider requirements in at least one of the pathways, as defined by in DHCS APL 22-023: Street Medicine Provider: Definitions and Participation in Managed Care.

1. As Member's assigned PCP:

    a. Providers elected as a Member's assigned PCP are exempt from PCP time and distance standards as the Member does not have a permanent residential address and the Street Medicine Provider is meeting the Member at their lived environment.

2. Through a direct contract with the Provider:

    a. Providers will be subject to the same MCP administrative processes (e.g., billing protocols, credentialing requirements, authorization guidelines, etc.) rather than multiple processes and requirements under each subcontracting entity.

    b. Prior authorization to see a Street Medicine Provider will not be needed if the Member seeks services directly from a Street Medicine Provider related to the Member's primary care.

4. As an Enhanced Care Management (ECM) Provider:

    a. Provider can be contracted to provide both PCP and ECM services to a Member.

5. As a Community Supports (CS) Provider.

6. As a referring or treating contracted Provider:

    a. Providers have the right to decline the additional responsibilities of an assigned PCP, and instead, care for Members in a non-PCP capacity as a referring or treating contracted Provider working with individuals experiencing unsheltered homelessness.

    b. Providers in this capacity must be communicative about and responsive to care coordination and monitoring activities with other care service entities.

F. Street Medicine Providers shall verify Medi-Cal or Medicare Member eligibility of individuals they encounter in the provision of health care services. Medi-Cal eligible individuals will be covered by either the Medi-Cal Fee-for-Service (FFS) or Medi-Cal managed care with CalOptima Health delivery system.

G. The Street Medicine Provider must be affiliated with a brick-and mortar facility (e.g., primary care medical office, Federally Qualified Health Center (FQHC), clinic, etc.) if the Street Medicine Provider does not have the capability to provide Primary Care services on the street.

1. CalOptima Health shall assign Members to the affiliated brick and-mortar facility to which the Street Medicine Provider is affiliated.

2. CalOptima Health may assign their Members to the Street Medicine Provider as the assigned PCP directly, or to the Street Medicine Provider's affiliated brick-and-mortar location but must make clear the Member's care is being overseen by a Street Medicine Provider PCP.

H. Street Medicine Providers are required to enroll as a Medi-Cal Provider if there is a state-level enrollment pathway for them to do so.

1. To include Street Medicine Providers in their Networks when there is no state-level Medi-Cal enrollment pathway, CalOptima Health is required to vet the qualifications of the Street Medicine Provider to ensure they can meet the CalOptima Health's standards of participation.

III. PROCEDURE

A. Street Medicine Provider Requirements and Qualifications

1. Street Medicine Providers are required to enroll as a Medi-Cal Provider if there is a state-level enrollment pathway for them to do so. The Credentialing requirements outlined in DHCS APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment only apply to Street Medicine Providers with a state-level pathway for Medi-Cal enrollment.

a. If there is not a state-level enrollment pathway, the Street Medicine provider is not required to meet the credentialing requirements in DHCS APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment in order to become an "in-network" Provider.

b. Street Medicine Providers with no state-level Medi-Cal enrollment pathway shall be vetted for qualifications, in accordance with CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers, to ensure they can meet the CalOptima Health's standards of participation, similar to the credentialing process and requirements mentioned above.

2. If the Street Medicine Provider is willing to be the Member's assigned PCP:

a. The Street Medicine Provider must initiate the request via telephone call to CalOptima Health with the Member on the line, and both parties must confirm to CalOptima Health the Member's choice in selecting the Street Medicine Provider to be their assigned PCP.

b. CalOptima Health is responsible for enrolling and Credentialing the Street Medicine provider, in accordance with DHCS APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment.

c. CalOptima Health shall conduct the full review process in accordance with DHCS APL 22-017: Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review.

i. Street Medicine Providers serving as an assigned PCP and are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV shall undergo a full site review process of the street medicine Provider and affiliated facility in accordance with DHCS APL 22-017: Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review.

ii. Street Medicine Providers serving as an assigned PCP and are not affiliated with a brick-and-mortar facility or mobile unit/RV shall undergo a condensed Facility Site Review (FSR) and Medical Record Review (MRR) of the street medicine Provider to ensure Member safety.

d. CalOptima Health shall make clear that the Street Medicine Provider is the Member's assigned PCP or is overseeing the Member's care.

e. CalOptima Health shall inform Street Medicine Providers of PCP responsibilities, as well as credentialing and review requirements, as applicable.

f. Street Medicine Providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care, including but not limited to:

i. Basic Case Management (with transition to Basic Population Health Management when effective);

ii. Care coordination and health promotion;

iii. Support for Members, their families, and their authorized representatives;

iv. Referral to specialists, including behavioral health, community, and social support services, when needed;

v. The use of health information technology to link services, as feasible and appropriate; and

vi. Provision of primary and preventative services to assigned Members.

g. Street Medicine Providers elected as a Member's assigned PCP are exempt from PCP time and distance standards as the Member does not have a permanent residential address and the Street Medicine Provider is meeting the Member at their lived environment.

i. Service location requirement for PCPs is not applicable to Street Medicine Providers serving as PCPs, as these Street Medicine Providers are not rendering services at a brick-and-mortar location.

3. CalOptima Health has the option to directly contract with Street Medicine Providers.

a. Street Medicine Providers will be subject to the same administrative processes as CalOptima Health (e.g., billing protocols, credentialing requirements, authorization guidelines, etc.).

b. Payment arrangements will be between the CalOptima Health and the Street Medicine Provider.

c. Street Medicine Providers that meet all of CalOptima Health's required administrative processes, could provide services to a Member, and receive payment for those services, even if the Member is assigned to a Subcontractor, such as a medical group or IPA.

d. Under a direct contracting arrangement, the Street Medicine Provider must have the ability to refer Members to Medically Necessary Covered Services within the proper CalOptima Health network, and must coordinate care with CalOptima Health, Subcontractor, and/or IPA as appropriate.

e. CalOptima Health shall ensure Members have access to all Medically Necessary Covered Services and have appropriate referral and authorization mechanisms in place to facilitate access to needed services in CalOptima Health's Network.

4. The contracted Street Medicine Provider has the right to decline the additional responsibilities of an assigned PCP, and instead, care for Members in a non-PCP capacity as a referring or treating contracted Provider working with individuals experiencing unsheltered homelessness.

   a. Street Medicine Providers must have processes in place to work with CalOptima Health, the Member's PCP, and ECM Care Manager to ensure the Member has referrals to primary care, Community Supports, behavioral health services, and other social services as needed.

5. Providers shall meet the minimum staffing requirements, as defined in the final contract with CalOptima Health.

6. Requirements for canvassing and provision of medical services in the field include having a mobile medical unit that includes all the necessary equipment to provide services outside a traditional medical facility, and in accordance with Provider contract with CalOptima Health.

7. Providers shall be able to connect or refer individuals experiencing unsheltered homelessness to/for ECM and/or CS, as applicable; non-emergency medical transportation; other specialty care, as deemed necessary by the provider; and other social supports necessary to address the individual's social determinants of health.

8. Partnership Development Requirements

   a. Partner with local homeless services providers and emergency responders to identify encampments, hotspots, and key areas where people experiencing unsheltered homelessness have established residence.

   b. Coordinate with local homeless services providers to set a schedule for visiting these key sites during the week.

   c. Be able to refer individuals to a physical clinic location in the services area or to the Member's assigned PCP provider.

   d. Collaborate with street outreach teams to coordinate response and referrals, and to connect individual to the existing continuum of care and housing.

9. Billing and Claims Submission

a. Providers shall submit timely claims in accordance with CalOptima Health's Claims policies, in alignment with the service pathways indicated in DHCS APL 22-023: Street Medicine Provider: Definitions and Participation in Managed Care.

i. Place of Services (POS) codes to Fee-for-Service Medi-Cal or CalOptima Health when rendering medical services for Street Medicine, of which include Homeless Shelter – POS code 04, Mobile Unit – POS code 15, and Temporary Lodging – POS code 16.

b. Providers shall submit other reports to CalOptima Health, as defined in the final contract.

c. For managed care Members, Street Medicine Providers must comply with the billing provisions for Street Medicine Providers as applicable to CalOptima Health's policies and procedures.

10. Data Sharing and Reporting

a. Contracted Street Medicine Providers must comply with all applicable CalOptima Health data sharing and reporting requirements in accordance with federal and state laws and the contract based on provider contracting type.

b. CalOptima Health shall ensure Street Medicine Providers receive appropriate provider training and manuals and have adequate systems in place to adhere to data sharing, reporting requirements, such as for encounter, claims, and care coordination data, administration requirements, such as grievances and appeals, referrals, after-hours and timely access, prior authorizations, quality improvement, performance measures, and electronic health records.

B. CalOptima Health Responsibilities

1. CalOptima Health shall ensure Street Medicine Providers are credentialed and contracted as Medi-Cal providers consistent with DHCS APL 22-023: Street Medicine Provider: Definitions and Participation in Managed Care.

2. CalOptima Health shall ensure Street Medicine Providers with a state-level pathway for Medi-Cal enrollment are credentialed or vetted according DHCS APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment and CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers.

3. CalOptima Health shall manage the process for Providers who serve in an assigned PCP capacity to ensure appropriate level of site review process, which is either a full or condensed review, is rendered in a manner consistent with DHCS and other regulatory requirements.

4. CalOptima Health shall ensure non-duplication of services provided through ECM and any other covered benefit, program, and/or delivery system.

5. CalOptima Health shall ensure that the Provider has access to CalOptima Connect, and other related software required for the billing and reporting process.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
B. CalOptima Health Policy GG.1353: Enhanced Care Management Service Delivery
C. CalOptima Health Policy GG.1354: Enhanced Care Management – Eligibility and Outreach
D. CalOptima Health Policy GG.1355: Community Supports
E. CalOptima Health Policy GG.1356: Enhanced Care Management Administration
F. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
G. CalOptima Health Policy MA.3101: Claims Processing
H. CalOptima Health Policy EE.1103: Provider Network Training
I. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
J. Department of Health Care Services All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment
K. Department of Health Care Services All Plan Letter (APL) 22-017: Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review
L. Department of Health Care Services All Plan Letter (APL) 22-023: Street Medicine Provider: Definitions and Participation in Managed Care

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
TBD	Department of Health Care Services	TBD

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
Effective	04/01/2023	GA.7110	Street Medicine	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Case Management	Medi-Cal: A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation. OneCare: A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a Member's health needs through communication and available resources to promote quality cost-effective outcomes.
Community Supports (CS)	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima Health's capitation rate and count toward the medical expense component of CalOptima Health's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima Health and the Member and must be approved by DHCS.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of PCPs and high-volume Specialty Care Provider offices.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain, or maintain functional capacity, or improve, support, or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Term	Definition
Member	Medi-Cal: 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. OneCare: Member: A beneficiary enrolled in the CalOptima Health OneCare program
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
Street Medicine	Street Medicine is a set of health and social services designed to specifically address the unique needs and circumstances of individuals experiencing unsheltered homelessness, to be delivered directly to them in their own environment, and more specifically, places that are not intended for human habitation.
Street Medicine Provider	Street Medicine Provider refers to a licensed medical provider (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas.

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

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: November 8, 2022

ALL PLAN LETTER 22-023

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: STREET MEDICINE PROVIDER: DEFINITIONS AND PARTICIPATION IN MANAGED CARE

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) on opportunities to utilize street medicine providers to address clinical and non-clinical needs of their Medi-Cal Members experiencing unsheltered homelessness.

BACKGROUND AND DEFINITION:
Street medicine refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment. The fundamental approach of street medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through.[1] Typically, and for the purposes of this APL, street medicine is provided to an individual experiencing unsheltered homelessness in their lived environment, places that are not intended for human habitation. Health care services provided at shelters, mobile units/recreational vehicles (RV), or other sites with a fixed, specified location does not qualify as street medicine, it is considered mobile medicine, as it requires people experiencing unsheltered homelessness to visit a health care provider at the provider's fixed, specified location. Please note that mobile units/RVs that go to the individual experiencing unsheltered homelessness in their lived environment ("on the street") is considered street medicine.

Street medicine directly aligns with California Advancing and Innovating Medi-Cal's (CalAIM) primary goal to identify and manage comprehensive needs through whole person care approaches and social drivers of health. Street medicine offers an opportunity to provide needed services to individuals who are experiencing unsheltered homelessness by meeting them where they are and utilizing a whole person, patient-centered approach to provide Medically Necessary health care services, as well as address social drivers of health that impede health care access. The Department of

[1] Street Medicine Institute: https://www.streetmedicine.org/.

Health Care Services (DHCS) considers street medicine to be a harm reduction tool and integral to avoiding an emergency department visit or hospitalization, providing access to Medically Necessary health care services, and connecting MCP Members to Community Supports that they may not otherwise access. DHCS recognizes the benefit that street medicine can provide, and with this in mind, encourages MCPs to adopt requirements for street medicine providers that allow for maximum provider participation while maintaining high quality care. It is DHCS' responsibility to ensure that access, quality, and equity of care is provided to all Medi-Cal beneficiaries. DHCS recognizes that providers of varying types may choose not to participate in the Medi-Cal program for a variety of reasons. DHCS strongly encourages all street medicine providers to consider participating in the Medi-Cal program to further elevate and innovate street medicine. Additionally, although mobile medicine does provide health and social services to individuals experiencing homelessness, DHCS envisions and expects the majority of these services provided to individuals experiencing unsheltered homelessness to be delivered in their lived environment via street medicine.

POLICY:
MCPs may cover the provision of medical services for their Members experiencing unsheltered homelessness through street medicine providers in the role of the Member's assigned Primary Care Provider (PCP), through a direct contract with the MCP, as an ECM Provider, as a Community Supports Provider, or as a referring or treating contracted Provider. Since utilization of street medicine providers is voluntary for MCPs, there is no required effective start date for the operations of an MCP street medicine program. MCPs may operate a street medicine program once it has fulfilled all requirements as outlined in this APL and/or other guidance and as approved by DHCS. DHCS does not require a street medicine provider to be affiliated with a brick-and-mortar facility, and has outlined various provisions under each scenario below. DHCS does not prescribe any particular contracting type for MCPs and street medicine providers.

Street Medicine Provider as a Member's Assigned PCP
Street medicine provider refers to a licensed medical provider (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas). For a non-physician medical practitioner (PA, NP, and CNM), MCPs must ensure compliance with state law and Contract requirements regarding

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physician supervision of non-physician medical practitioners.[2] Additionally, given the unique and specialized nature of street medicine, a supervising Physician must be a practicing street medicine provider, with knowledge of and experience in street medicine clinical guidelines and protocols. Contracted street medicine Providers may choose to serve as the Member's assigned PCP upon Member election, similar to how Obstetrician-Gynecologist (OB/GYN) Providers can elect to serve as PCPs. In order to serve as a PCP, the street medicine Provider must meet the MCP's eligibility criteria for being a PCP, be qualified and capable of treating the full range of health care issues served by PCPs within their scope of practice, and agree to serve in a PCP role. Street medicine Providers, when elected by Members to act as their assigned PCP, are responsible for providing the full array of Primary Care services, including but not limited to, preventive services, and the treatment of acute and chronic conditions. Thus, street medicine Providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care, including but not limited to:[3]

- Basic Case Management (with transition to Basic Population Health Management when effective);
- Care coordination and health promotion;
- Support for Members, their families, and their authorized representatives;
- Referral to Specialists, including behavioral health, community, and social support services, when needed;
- The use of Health Information Technology to link services, as feasible and appropriate; and
- Provision of primary and preventative services to assigned Members.

If the street medicine Provider does not have the capability to provide Primary Care services on the street, the street medicine Provider must be affiliated with a brick-and-mortar facility (e.g., primary care medical office, Federally Qualified Health Center (FQHC), clinic, etc.). In this case, MCPs must assign Members to the affiliated brick-and-mortar facility to which the street medicine Provider is affiliated. MCPs may assign their Members to the street medicine Provider as the assigned PCP directly, or to the street medicine Provider's affiliated brick-and-mortar location, but must make clear the Member's care is being overseen by a street medicine Provider PCP.

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[2] See Sections 51240 and 51241 of Title 22 of the California Code of Regulations (CCR); Sections 3516, 2836.1, and 2507 of the California Business and Professions Code (B&P); and the MCP Contract. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index. State law is searchable at: https://leginfo.legislature.ca.gov/faces/codes.xhtml.
[3] See the MCP Contract Exhibit E, Definitions, Medical Home.

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If the street medicine Provider is willing to serve in the Member's assigned PCP capacity, the MCP is responsible for enrolling and credentialing the street medicine Provider, in accordance with APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment.[4]

Site Review and Medical Record Review Requirements
Street medicine Providers who are serving in an assigned PCP capacity are required to undergo the appropriate level of site review process, which is either a full or a condensed review.

- For street medicine Providers serving as an assigned PCP, and that are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV, the MCP must conduct the full review process of the street medicine Provider and affiliated facility in accordance with APL 22-017: Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review.

- For street medicine Providers serving as an assigned PCP, and that are not affiliated with a brick-and-mortar facility or mobile unit/RV, the MCP must conduct a condensed Facility Site Review (FSR) and Medical Record Review (MRR) of the street medicine Provider to ensure Member safety. The requirements for the condensed FSR and MRR that MCPs must adhere to as part of their review processes is forthcoming, and will be limited to FSR and MRR requirements that would apply only to a street medicine Provider under this scenario. The condensed FSR and MRR requirements will be based on and reflective of the full FSR and MRR requirements as outlined in APL 22-017.

MCPs that use street medicine Providers as PCPs must develop and maintain protocols for identifying and transferring Members to a higher level of care if needed when the Member's service needs are beyond the capabilities and/or qualifications of the street medicine Provider. MCPs must ensure protocols include providing access to urgent and emergency care, specialty care, mental health and substance use disorder treatment, ancillary services, and appropriate Non-Emergency Medical and Non-Medical Transportation services. MCPs must also ensure their street medicine protocols allow for expeditious referrals to ECM and Community Supports.

Process for Street Medicine Provider to Become Member's Assigned PCP
If an MCP has street medicine Providers willing to serve in a PCP capacity, MCPs must inform Members through the Member Handbook that contracted street medicine Providers may be elected to be the Member's assigned PCP so that the Member and

[4] APLs can be found at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

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the street medicine Provider can discuss whether this arrangement is appropriate. Additionally, MCPs may distribute population-specific communications (pamphlets, brochures, fact sheets, etc.) approved through the DHCS file and use process. Street medicine Providers are advised to assess and examine the level and quality of the establishment of the treatment relationship at the time of initial engagement when considering an agreement to be a Member's assigned PCP, as DHCS envisions dynamic and exceptional Provider-Member patient interactions. Street medicine Providers should also be committed in ensuring that the Member patient is transferred to another PCP in a timely manner in the event the street medicine Provider is no longer able or willing to serve as the assigned PCP. If the street medicine Provider is willing to be the Member's assigned PCP, the street medicine Provider must initiate the request via telephone call to the MCP with the Member on the line, and both parties must confirm to the MCP the Member's choice in selecting the street medicine Provider to be their assigned PCP. MCPs must make clear that the street medicine Provider is the Member's assigned PCP or is overseeing the Member's care. MCPs must inform street medicine Providers of PCP responsibilities, as well as credentialing and review requirements, as applicable.

Provider Enrollment and Credentialing

MCP Network Providers, including street medicine Providers, are required to enroll as a Medi-Cal Provider if there is a state-level enrollment pathway for them to do so.[5] The credentialing requirements outlined in APL 22-013 only apply to street medicine providers with a state-level pathway for Medi-Cal enrollment. If there is not a state-level enrollment pathway, the street medicine provider is not required to meet the credentialing requirements in APL 22-013 in order to become an "in-network" Provider. To include street medicine Providers in their Networks when there is no state-level Medi-Cal enrollment pathway, MCPs are required to vet the qualifications of the street medicine Provider to ensure they can meet the MCP's standards of participation, similar to the credentialing process and requirements mentioned above. MCPs must create and implement their own processes to do this. Criteria that MCPs may want to consider as part of their vetting processes include, but is not limited to:

- Sufficient experience providing similar services within the service area;
- Ability to submit claims or invoices using standardized protocols;
- Business licensing that meets industry standards;
- Capability to comply with all reporting and oversight requirements;
- History of fraud, waste, and/or abuse;

[5] Please see APL 22-013: Frequently Asked Questions at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-013-FAQ.pdf.

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- Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and
- History of liability claims against the provider.

Access Requirements
Street medicine Providers elected as a Member's assigned PCP are exempt from PCP time and distance standards as the Member does not have a permanent residential address and the street medicine Provider is meeting the Member at their lived environment. Further, MCPs are not expected to contract with street medicine Providers in order to meet time and distance standards as part of Annual Network Certification requirements. Additionally, the Service Location requirement for PCPs, as specified in the MCP Contract, is not applicable to street medicine Providers serving as PCPs, as these street medicine Providers are not rendering services at a brick-and-mortar location. MCPs must submit Policies and Procedures (P&Ps) detailing at a minimum: 1) process for street medicine Providers to contract with the MCP as a PCP, if desired, and not requiring contracted street medicine Providers to be PCPs; 2) process to ensure timely access to traditional PCPs and Specialists in the MCP's Network; and 3) process to provide transportation to a traditional PCP that is outside of time or distance standards, upon the Member's request.

Direct Contracting Arrangement
To facilitate direct access, DHCS encourages MCPs to contract directly with street medicine Providers. Even if the MCP delegates the provision of health care services to a Subcontractor, MCPs have an option to directly contract with street medicine Providers. Direct contracts with street medicine Providers can allow ready access to health care services for individuals experiencing unsheltered homelessness and would reduce contracting complexity for street medicine Providers. For example, rather than having to contract with each subcontracted Independent Physician/Provider Association (IPA) in the MCP's Network, the street medicine Provider could directly contract with the MCP. In addition, the street medicine Provider would be subject to the same MCP administrative processes (e.g., billing protocols, credentialing requirements, authorization guidelines, etc.) rather than multiple processes and requirements under each subcontracting entity. The payment arrangement would be between the MCP and the street medicine Provider. Moreover, Prior Authorization to see a street medicine Provider would not be needed if the Member seeks services directly from a street medicine Provider related to the Member's primary care. This means that an MCP-contracted street medicine Provider, that meets all MCP-required administrative processes, could provide services to an MCP Member and receive payment for those services, even if the Member is assigned to a Subcontractor, such as a medical group or IPA.

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Under a direct contracting arrangement, the street medicine Provider must have the ability to refer Members to Medically Necessary Covered Services within the proper MCP network, and must coordinate care with the MCP, Subcontractor, and/or IPA as appropriate. MCPs would need to ensure Members have access to all Medically Necessary Covered Services and have appropriate referral and authorization mechanisms in place to facilitate access to needed services in the MCP's Network.

Street Medicine Provider as an ECM Provider
ECM is delivered primarily by community-based ECM Providers that enter into contracts with MCPs. MCPs may contract with street medicine Providers to become an ECM Provider. A street medicine Provider can be contracted to provide both PCP and ECM services to a Member. ECM is primarily in-person based, and as such, ECM Providers are poised to build trust and facilitate coordinated care management with individuals experiencing unsheltered homelessness. Street medicine Providers that are also ECM Providers are required to enroll in Medi-Cal if there is a state-level enrollment pathway; fulfill all ECM requirements; have the capacity to provide culturally appropriate and timely in-person care management activities; and have formal agreements, data systems, and processes in place with entities across sectors to support care coordination and care management.[6] MCPs are responsible for ensuring non-duplication of services provided through ECM and any other covered benefit, program, and/or delivery system.

Street Medicine Providers Serving Solely as Referring or Treating Contracted Provider
The contracted street medicine Provider has the right to decline the additional responsibilities of an assigned PCP, and instead, care for Members in a non-PCP capacity as a referring or treating contracted Provider working with individuals experiencing unsheltered homelessness. To provide care in this capacity, street medicine Providers must have processes in place to work with the MCP, the Member's PCP, and ECM Care Manager to ensure the Member has referrals to primary care, Community Supports, behavioral health services, and other social services as needed.

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[6] Please refer to the Enhanced Care Management and Community Supports Provider Standard Terms and Conditions (please see: https://www.dhcs.ca.gov/services/Documents/MCQMD/ECM-and-Community-Supports-Standard-Provider-Terms-and-Conditions.pdf), the CalAIM Enhanced Care Management Policy Guide (please see: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide-April-2022.pdf), APL 21-012: Enhanced Care Management Requirements, and the CalAIM Enhanced Care Management and Community Supports Contract Template Provisions (please see: https://www.dhcs.ca.gov/Documents/MCQMD/MCP-ECM-and-ILOS-Contract-Template-Provisions.pdf) for further details.

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Street medicine Providers in this capacity need to be communicative about and responsive to care coordination and monitoring activities with other care service entities.

Medi-Cal Eligibility
Street medicine Providers are required to verify the Medi-Cal eligibility of individuals they encounter in the provision of health care services. Medi-Cal eligible individuals will be covered by either the Medi-Cal Fee-for-Service (FFS) or Medi-Cal managed care (with a corresponding MCP) delivery system. For those individuals without Medi-Cal coverage, the Hospital Presumptive Eligibility (HPE) program is one pathway for qualified HPE Providers to determine Medi-Cal eligibility. HPE provides qualified individuals immediate access to temporary Medi-Cal services while individuals apply for permanent Medi-Cal coverage. DHCS allows qualified HPE Providers to determine presumptive eligibility under the HPE program off the premises of hospitals and clinics, such as in mobile clinics, street teams, or other locations.[7] Street medicine Providers are not required to participate in the HPE program, but may do so if they meet and fulfill all qualifications and requirements of the HPE program.

Billing/Reimbursement
Street medicine Providers rendering services to Medi-Cal eligible individuals are to bill Medi-Cal FFS, or the MCP if contracted, based on the eligibility of the individual, for appropriate and applicable services within their scope of practice.[8] Street medicine Providers must comply with the billing provisions for street medicine Providers as applicable in FFS, including but not limited to, the Medi-Cal Provider Manual. For managed care Members, street medicine Providers must comply with the billing provisions for street medicine Providers as applicable to MCP policies and procedures.

If the street medicine Provider is an FQHC, they can still be reimbursed at their applicable Prospective Payment System (PPS) rate when such services are being provided outside the four walls and where the Member is located. The FQHC would be paid their applicable PPS rate when the street medicine Provider is a billable clinic provider.

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[7] For additional information on HPE Off-Premise flexibilities, please see Medi-Cal NewsFlash: HPE Off-Premise Flexibilities at: https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_31240.aspx.
[8] Providers may bill Place of Service (POS) codes to Fee-for-Service Medi-Cal or MCPs when rendering medical services for street medicine, which include a homeless shelter (POS code 04), mobile unit (POS code 15), and temporary lodging (POS code 16). Please see Medi-Cal NewsFlash: Clarification on Billing Guidelines for Medi-Cal Providers for Street Medicine at: https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_31526.aspx.

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Street medicine Providers can also be reimbursed for providing State Plan benefits, including the use of Community Health Worker (CHW) services as defined in 42 CFR 440.130(c) and APL 22-016. MCPs are responsible for ensuring non-duplication of services provided by a CHW and any other covered benefit, program, and/or delivery system.

Data Sharing, Reporting and Administration Requirements
Contracted street medicine Providers must comply with all applicable MCP data sharing and reporting requirements in accordance with federal and state laws and the MCP Contract based on provider contracting type. MCPs are to ensure street medicine Providers receive appropriate provider training and manuals, and have adequate systems in place to adhere to data sharing and reporting requirements, such as for encounter, claims, and care coordination data.[9] Additionally, street medicine Providers must comply with all applicable MCP administration requirements in accordance with federal and state laws and the MCP Contract based on provider contracting type. MCPs are to ensure street medicine Providers receive appropriate provider training and manuals, and have adequate systems in place to adhere to administration requirements, such as grievances and appeals, referrals, after-hours and timely access, prior authorizations, quality improvement, performance measures, and electronic health records.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required P&Ps, the MCP must submit its 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.

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.[10] These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

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[9] Please see the DHCS CalAIM Data Sharing Authorization Guidance at: https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance.pdf and the MCP Contract.
[10] 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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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

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Authorize Amendment of Federal Advocacy Services Contract with Potomac Partners DC, LLC and Proposed Budget Allocation Change in the CalOptima Health Fiscal Year 2022-23 Operating Budget

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima Health's contract with Potomac Partners DC, LLC (PPDC) for federal advocacy services, effective February 1, 2023, as follows:
    a. Increase payment terms in Exhibit B from $12,500 per month to $27,000 per month;
    b. Revise the scope of work in Exhibit A to reflect the commitment of additional time, personnel, and resources to services performed on behalf of CalOptima Health; and
2. Authorize the reallocation of budgeted but unused funds of $72,500 from Fiscal Year 2022-23 Medi-Cal: Medical Management Budget – Purchased Services line item to Fiscal Year 2022-23 Medi-Cal: Administrative Budget – Professional Fees line item to fund the increased payment terms in the amended contract through June 30, 2023.

Background

CalOptima Health retains a lobbying firm in Washington, DC to assist with tracking, analysis, and advocacy regarding federal legislation, regulations, and appropriations. In addition, the firm develops and maintains relationships with members and staff of the U.S. Congress, as well as officials in the White House and applicable federal departments and agencies.

On May 6, 2021, following CalOptima Health's standard procurement process, the CalOptima Health Board of Directors (Board) authorized the CEO to contract with PPDC to provide federal advocacy services for a term of May 21, 2021, through June 30, 2024, with two one-year extension options each exercisable at CalOptima Health's sole discretion. PPDC's current contract is priced at $12,500 per month, with no more than $5,000 per year in out-of-the-ordinary expenses authorized in advance by CalOptima Health. *See* Attachment B.

Discussion

As part of its contract, PPDC subcontracts with Strategic Health Care (SHC) to provide subject matter expertise on specific health care issues. Together, PPDC and SHC have substantial knowledge and experience on issues important to CalOptima Health, including Medicaid, Medicare, and the Affordable Care Act, as well key relationships with Congressional leadership and federal officials at the U.S. Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS). In the past year, PPDC and SHC have secured a $2 million federal earmark for CalOptima Health's Care Traffic Control initiative, enhanced

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relationships with Orange County's Congressional delegation, and set meetings with high-ranking HHS/CMS officials and key members and staff in Congressional leadership to discuss CalOptima Health's top priorities. However, due to limited capacity and resources, several legislative and regulatory priorities were not pursued to their desired extent.

Given the higher levels of advocacy needed to advance CalOptima Health's federal policy priorities and defeat proposals with harmful impacts to members, staff recommends that the Board increases the payment terms of PPDC's current contract from $12,500 per month to $27,000 per month, effective February 1, 2023. The new rate will allow PPDC and SHC to dedicate additional staff time, including that of firm principals, to CalOptima Health in order to achieve current and expected future goals set by the Board.

Accordingly, staff also recommends that the Board delegate authority to the CEO to revise the contract's scope of work to reflect the increased commitment of resources to CalOptima Health, effective February 1, 2023. Examples of additional deliverables will include, but are not limited to, developing a more robust, proactive advocacy strategy in the new 118th Congress, expanding relationships with key influencers in Congress and federal agencies, blocking proposed Medicaid waivers that may negatively impact CalOptima Health members, and coordinating a national health equity symposium hosted by CalOptima Health. All other contract terms will remain the same. Consistent with CalOptima Health's standard practice, staff will continue to monitor the performance of PPDC to ensure objectives outlined in the amended contract are achieved.

In order to fund the increased payment terms in Exhibit B of the amended contract for the remainder of Fiscal Year (FY) 2022-23, staff recommends that the Board authorize the reallocation of $72,500 in budgeted but unused funds from FY 2022-23 Medi-Cal: Medical Management Budget – Purchased Services to FY 2022-23 Medi-Cal: Administrative Budget – Professional Fees.

Fiscal Impact

The recommended action to increase payment terms to PPDC is an unbudgeted item. The fiscal impact for the period of February 1, 2023, through June 30, 2023, is budget neutral. A budget reallocation from FY 2022-23 Medi-Cal: Medical Management Budget – Purchased Services to FY 2022-23 Medi-Cal: Administrative Budget – Professional Fees will fund this action. Management will include updated administrative expenses in future operating budgets.

Rationale for Recommendation

Federal advocacy efforts continue to be a priority for CalOptima Health given the level of activity on health care issues in Washington, DC. CalOptima Health anticipates that several important issues will require focus, attention, involvement and advocacy.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Current PPDC Contract No. 21-10013

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

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Attachment to the February 2, 2023 Board of Directors Meeting – Agenda Item 8

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Potomac Partners DC, LLC	700 Pennsylvania Ave SE, Suite 320	Washington	DC	20003

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CONTRACT NO. 21-10013
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
POTOMAC PARTNERS DC, LLC
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of May 21, 2021, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and Potomac Partners DC, a LLC, hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a CONTRACTOR to provide National Legislative Services, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

C. CONTRACTOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services; and

D. CONTRACTOR desires to perform these services for CalOptima; and

E. CalOptima and CONTRACTOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto; (ii) CalOptima's Request for Proposal ("RFP"), 21-018, inclusive of any revisions, amendments and addenda thereto; and (iii) CONTRACTOR's proposal dated January 6, 2021. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 17, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference. CONTRACTOR shall also perform in accordance with its Proposal dated January 6, 2021.

2.2 CONTRACTOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract. No person named in this Section 2, or his/her successor approved by CalOptima, shall be removed or replaced by CONTRACTOR, nor shall his/her agreed-upon function or level of commitment hereunder be changed without the prior written consent of CalOptima.

Name	Function/Title
Rick Alcalde	Founder & President, Project Manager
Dan Felix	Managing Partner
Adam Cross	Legislative Specialist
Paul Lee	Sr. Partner and Founder of Strategic Health Care, (Subcontractor)
David Introcaso, Ph.D.	VP, Regulatory Policy for Strategic Health Care, (Subcontractor)

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 This policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per occurrence: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property, with the following minimum limits of $1,000,000 per occurrence:

3.1.5.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Privacy and Network Liability: $1,000,000

b) Internet Media Liability: $1,000,000

c) Business Interruption & Expense: $1,000,000

d) Data Extortion: $1,000,000

e) Regulatory Proceeding: $1,000,000

f) Data Breach Notification & Credit Monitoring: $1,000,000

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

3.2.3 The Insurance Company agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this clause. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9 Thirty (30) days prior written notice of cancellation be given to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

3.6 "Occurrence," as used herein, means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any liability whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Indemnitors under this Contract. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation, California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.3 CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except Claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.4 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including but not limited to those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.5 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control, and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees in connection with this Contract, and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%)

of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima Policies relating to services under the Contract that are in effect when this Contract is signed or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

9.1 During the performance of this Contract, CONTRACTOR and its subcontractor(s) shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. CONTRACTOR and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict of interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; and

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR, and any person designated by CONTRACTOR to make or participate in making a governmental decision on behalf of CalOptima, is considered a "Consultant" pursuant to CalOptima's Conflict of Interest Code, and shall be required to file a statement of economic interests (Fair Political Practices Commission Form 700) with CalOptima annually.

10.5 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.6 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict of Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit I, attached hereto and incorporated by this reference:

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. Equal Opportunity.

12.1 CONTRACTOR and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("DHCS"), setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

12.2 CONTRACTOR and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

12.3 CONTRACTOR and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of CONTRACTOR and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

12.4 CONTRACTOR and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

12.5 CONTRACTOR and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

12.6 In the event of CONTRACTOR and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

12.7 CONTRACTOR and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event CONTRACTOR and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or CONTRACTOR as a result of such direction by DHCS, CONTRACTOR and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Standard of Performance; Warranties.

13.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

13.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified, and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR, CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage to other parts of the system resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. In the event that CONTRACTOR fails to make adjustments, repairs, corrections, or other work made necessary by such defects, CalOptima may do so and charge CONTRACTOR the costs incurred.

13.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's

inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

13.5 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

13.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair and replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

14.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

14.1.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed

and pay them to the appropriate taxing authority, and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR agrees to abide by the terms of the CalOptima Travel Policy, attached hereto as Exhibit C, and incorporated herein by this reference.

15. Term. This Contract shall commence May 21, 2021 and shall continue in full force and effect through 6/30/2024, ("Initial Term"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to two (2) additional consecutive one (1) year terms ("Extended Terms"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term, the remaining option(s) shall automatically lapse. As used in this Contract, the word "Term" shall include the Initial Term and any and all Extended Term(s), to the extent CalOptima exercises its option pursuant to this paragraph.

16. Termination.

16.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

16.2 Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

16.2.1 CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

16.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

16.2.3 In the event of Termination for Unavailability of Funds, as provided in this Section, and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify CONTRACTOR in writing and CalOptima shall have the right to reinstate this Contract for that period for which funds are received by CalOptima or the unexpired term of this Contract as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Contract two (2) times during the Term of this Contract.

16.3 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

16.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 24, (Confidentiality).

16.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

16.5.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise), and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

16.5.2 CalOptima may take over the services, and may award another party a contract to complete the services under this Contract.

16.5.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

17. Modifications. CalOptima reserves the right to modify the Contract at any time should such modification be required by CMS or applicable law or regulation. Modifications shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for its performance.

18. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

19. Confidential Material.

19.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans or other information,

materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

19.2 For the purposes of this Section 19, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

19.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

19.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

19.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access, use and disclosure of Protected Health Information is referenced below in Section 24, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

20. Record Ownership and Retention.

20.1 The originals of all letters, documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract shall be delivered to, and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights.

CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

20.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

20.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

20.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

20.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

21. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

22. Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other in any press release, advertising, promotional, marketing or similar publicly disseminated material without first submitting such material to the other Party and obtaining the other Party's express written approval of the material and consent to such use.

23. Business Associate Protected Health Information Disclosure Agreement. This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit Protected Health Information. As such, no Business Associate Agreement is required for this Contract.

24. Confidentiality of Member Information.

24.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

24.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its Subcontractors, CONTRACTOR:

24.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

24.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

24.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

24.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

24.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

25. Medicare Advantage Program. CONTRACTOR agrees to abide by the terms of "Addendum 1, Medicare Advantage Program," attached hereto as Exhibit G and incorporated herein by this reference.

26. Time is of the Essence. Time is of the essence in performance of this Contract.

27. CalOptima Designee. The Chief Executive Officer of CalOptima, or his designee, shall have the authority to act for and exercise any of the rights of CalOptima, as set forth in this Contract, subsequent to and in accordance with the authority granted by the Board of Directors.

28. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

29. Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. In the event any party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

30. Force Majeure. When satisfactory evidence of a cause beyond a party's control is presented to the other party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the party not performing, a party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including, but not limited to, any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local government, or a material act or omission by the other party.

31. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

To CONTRACTOR:	To CalOptima:
Potomac Partners DC, LLC	CalOptima
700 Pennsylvania Ave SE, Suite 320	505 City Parkway West
Washington, DC 20003	Orange, CA 92868
Attention: Rick Alcalde	Attention: Ryan Prest, MBA, CPSM, CPPB

32. Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima. CONTRACTOR shall insert the substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Contract.

33. Unavoidable Delays.

33.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

33.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5)

working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

33.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

34. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the parties hereto acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

35. Attorneys' Fees. Should either party to this Contract institute any action or proceeding to enforce or interpret this Contract or any provision hereof, or for damages by reason of any alleged breach of this Contract, otherwise arising under this Contract, or for a declaration of rights hereunder, the prevailing party in any such action or proceeding shall be entitled to receive from the other party all costs and expenses, including, without limitation, reasonable attorneys' fees incurred by the prevailing party in such action or proceeding.

36. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

37. Headings. The section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

38. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power, or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

39. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that

potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

40. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

41. Debarment and Suspension Certification.

41.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

41.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

41.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

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

41.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 41.2.2 herein;

41.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

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

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

41.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

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

41.5 If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

42. Lobbying Restrictions and Disclosure Certification.

42.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

42.2 Certification and Disclosure Requirements.

42.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit E, Part 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 42.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

42.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit E, Part 2, entitled "Certification Regarding Lobbying") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 42.3 of this provision if paid for with appropriated funds.

42.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 42.2.2herein. An event that materially affects the accuracy of the information reported includes:

42.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

42.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

42.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

42.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 42.2.1of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

42.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 42.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

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

43. Air and Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR § 15.5. CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 et seq.), as amended.

44. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

45. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

46. Third Party Beneficiaries. There are no intended third party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

47. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

48. Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

49. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

[Remainder of page left intentionally blank. Signatures on following page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 21-10013 on the day and year last shown below which shall commence as of the date in Section 15.

Potomac Partners DC, LLC	CalOptima
By: Rick Alcalde	By: DocuSigned by: Nancy Huang D22E3B87032946F...
Print Name: Rick Alcalde	Print Name: Nancy Huang
Title: President, Potomac Partners DC Date: 04/09/2021	Title: CFO, CalOptima Date: 05/17/2021

By: Dan Feliz	By: DocuSigned by: Richard Sanchez 234AD421BDEC4D9...
Print Name: Dan Feliz	Print Name: Richard Sanchez
Title: Managing Partner, Potomac Partners DC Date: 04/09/2021	Title: CEO, CalOptima Date: 05/17/2021

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required

Exhibit A

SCOPE OF WORK

A. Purpose:
CONTRACTOR shall represent CalOptima's interests in Washington D.C. and have the responsibility of monitoring and influencing legislative and regulatory policies, building and maintaining positive and mutually beneficial relationships, and providing CalOptima with necessary advocacy services.

B. Reporting Relationship:
CalOptima's Government/Legislative Affairs Department staff will be the primary CalOptima contacts and will direct the work of the CONTRACTOR. Any work determined to be beyond the scope of this Contract will be approved by the Government/Legislative Affairs Department in conjunction with the CalOptima Vendor Management Department. This additional work will not be provided or have fees incurred until an Amendment has signed by both CalOptima and CONTRACTOR.

C. Objective/Deliverables:
CONTRACTOR shall:

1. Maintain regular contact with the Administration, members of Congress, specifically the Orange County congressional delegation, legislative staff, and committee staff to identify impending changes in laws, new program opportunities, and funding priorities that relate to CalOptima. When directed by CalOptima, CONTRACTOR shall also communicate with federal departments, agencies, boards, committees, committees and staff regarding identified issues.

2. As directed by CalOptima, brief Orange County congressional delegation with CalOptima updates, publications and other informational items. These may include the annual Report to the Community, Fast Facts, and other materials.

3. Arrange meetings and briefings for CalOptima Board and staff with elected officials and legislative staff. CONTRACTOR shall be proactive in scheduling strategic, targeted meetings and briefings especially, but not limited to, times when CalOptima Board and staff are scheduled to be in Washington, D.C. Meetings and briefings may include formal briefings, as well as informal social meetings, as appropriate.

4. Provide monthly, written reports which shall include a federal budget and legislative update, as well as a description of the nature and extent of services or actions taken on behalf of CalOptima. The services and actions shall include a summary of the meetings CONTRACTOR had along with the issues discussed with members of Congress, specifically the Orange County congressional delegation, legislative staff, relevant committee staff as well as appropriate departments, agencies, boards, and commissions, committees, and staff. The reports shall be delivered on a schedule as directed by CalOptima staff, and may be included in the CalOptima board book and/or provided to board members. The frequency of written reports may be modified at any time.

5. Provide in-person or over-the-phone briefings, as directed by CalOptima staff, to the CalOptima board and executive staff.

6. Notify CalOptima of anticipated, introduced or amended federal legislation, and proposed regulations which could impact CalOptima. These activities include, but are not limited to:
   - Providing the bill number and brief summary of introduced or amended federal legislation;
   - Providing copies of legislation and committee analysis;
   - Providing information relative to legislative hearings; and

- Providing a brief summary of proposed or final federal regulations.

Additionally, CONTRACTOR shall advocate for CalOptima's programs and positions regarding proposed legislation, proposed regulations, and funding priorities as directed.

Provide copies of all written correspondence, testimony, and position papers given on behalf of CalOptima, as well as access to the federal budget and any related documents (Congressional Budget Office analysis, etc.) as they become available.

CalOptima staff may prepare a formal annual review of CONTRACTORs work product at the end of each calendar/fiscal year.

Exhibit B

PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

B. CONTRACTOR shall invoice CalOptima on a fixed monthly retainer basis. The rates, as defined below, are acknowledged to include CONTRACTOR's base labor rates, overhead and profit. Work completed shall be documented in a detailed monthly progress report prepared by CONTRACTOR, which report shall accompany each invoice submitted by CONTRACTOR. CONTRACTOR shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as CONTRACTOR has documented, to CalOptima's satisfaction, that CONTRACTOR has fully completed all work required under this Contract and CONTRACTOR's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of CONTRACTOR's work under this Contract.

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 21-10013; detailed description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that for the period of July 1 through June 30 annually, CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed Twelve Thousand Five Hundred Dollars ($12,500.00) per month equaling One Hundred Fifty Thousand Dollars ($150,000.00) annually, including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract. This rate is fixed for the duration of the Contract. CONTRACTOR agrees to extend this rate to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

E. Additionally, to clarify for the period of May 21, 2021 through May 31, 2021, the fee's will be prorated at 11 out of 31 days, equaling Four Thousand Four Hundred Thirty-Five Dollars ($4,435.00), and June 1, 2021 through June 30, 2021 will be at the full monthly rate of Twelve Thousand Five Hundred Dollars ($12,500.00). Beginning July 1,2021, the payments outlined in Section D above will begin.

F. Not included in the maximum cumulative payment obligation above in Section D, CONTRACTOR shall also invoice CalOptima on a monthly basis for travel-related expenses. All expenses charged to CalOptima under this Contract shall be consistent with Exhibit C, CalOptima's Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging, and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client. Travel related expenses shall not exceed Five Thousand Dollars ($5,000.00) in the aggregate. CalOptima shall not pay CONTRACTOR for time spent traveling.

Exhibit B-1

Not applicable for this Contract

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Exhibit C

CalOptima Travel Policy

CalOptima
A Public Agency
Better. Together.

Policy #:	GA.5004		
Title:	**Travel Policy**		
Department:	Finance		
Section:	Purchasing		
CEO Approval:		Michael Schrader	MS
Effective Date:	8/1/12	Revised: 9/6/12, 3/1/13	
Board Approval:	9/6/12		

I. PURPOSE

To establish a process for reasonable and equitable reimbursement of approved travel and other related expenses incurred by CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants while traveling on authorized CalOptima Business.

II. POLICY

A. For the purpose of this policy, Individual shall mean, unless otherwise specified, all persons authorized to submit an Expense Report, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima employees, and; individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses, in accordance with CalOptima rules and regulations.

B. CalOptima shall provide an expense reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel expenses and miscellaneous expenses incurred by authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal regulations.

C. CalOptima shall reimburse employees for reasonable expenses incurred while traveling on CalOptima business. All travel must be for the benefit of CalOptima, and must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible.

1. Travel Expenses shall include the following items:

   a. Transportation: including commercial carriers, rental vehicles, and mileage for use of personal vehicle;

   b. Lodging;

   c. Meals;

   d. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

   e. Insurance for rental vehicles;

   f. Parking fees and tolls fees (i.e., toll roads and necessary parking);

g. Miscellaneous expenses including:

i. Authorized local and long-distance telephone calls;

ii. Baggage fees;

iii. Internet or Wi-Fi charges;

iv. Facsimiles;

v. Expenses in connection with the preparation of authorized company reports or correspondence;

vi. Taxi or public transit fares, required to conduct business; and

vii. Other unforeseen or unusual expenses that are properly justified and substantiated.

D. Board Member/Standing Committee Member Travel

1. CalOptima shall allow Board members and Standing Committee members reasonable and necessary Travel Expenses and miscellaneous expenses incurred when participating in activities as a member of their respective Board or Committee. Eligible Travel Expenses shall be governed by this policy.

a. The CEO or the Chairperson of the CalOptima Board of Directors, or his or her designee, shall review and approve all Board member and Standing Committee member non-local travel.

b. CalOptima shall limit Board member and Standing Committee member travel to the following purposes:

i. CalOptima business-related activities;

ii. Requests to represent CalOptima as a speaker at an approved meeting, seminar or conference; and

iii. Other travel deemed necessary by the CalOptima Board of Directors.

E. Travel Approval

1. Budgeted Travel: All budgeted Travel and miscellaneous expenses for CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants shall be pre-approved by the appropriate level of CalOptima Management or Board Chair, prior to travel expenses being incurred, according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

2. Non-Budgeted Travel: Non-Budgeted Travel and miscellaneous expenses for authorized Individuals shall be pre-approved by the CEO, or his or her designee, prior to Travel Expenses being incurred.

F. Conferences and Seminars

1. Attendance at any given conference and/or seminar shall be:

   a. Limited to the number of Individuals deemed appropriate by the CEO for that particular conference or seminar, and

   b. Approved by Human Resources.

2. Payment of Fees

   a. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and seminar fees at the time the Travel and Training Authorization form is prepared, and submit necessary registration information to the Purchasing Department.

   b. In the event an Individual must personally pay for conference or seminar registration fees, the Individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

G. Meal Expenses

1. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

2. CalOptima shall reimburse authorized Individuals the actual cost of Travel Meals, excluding alcoholic beverages, in an amount not to exceed forty-five dollars ($45.00) per day, excluding taxes and gratuity.

   a. CalOptima shall reimburse employees and Board members for meals that exceed the forty-five dollars ($45.00) per day under the following conditions:

      i. The authorized Individual shall submit a valid receipt for such meals with a brief explanation of the expenditure. Individual meals shall be subject to the above limitations;

ii. The authorized Individual elects to pay for the meals of individuals with whom authorized CalOptima Business was conducted; or

iii. Extraordinary circumstances may cause it to be impractical or unfeasible for the authorized Individual to stay within the established meal rates, and the authorized Individual shall submit receipts for such meals with a brief explanation of the extraordinary expenditure.

iv. Expense reports containing extraordinary meal expenditures shall require approval of the CEO, or his or her designee.

b. CalOptima may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses, as stipulated in this policy. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board and Committee member meal reimbursement rate.

3. CalOptima shall reimburse for Business Meals at actual reasonable and necessary expenses for refreshments or meals, excluding alcoholic beverages, provided in conjunction with on-site or off-site meetings (e.g., in-house developed formal training sessions, conferences, seminars, workshops, staff meetings, and board and commission meetings) which extend over normal breaks or meal periods. An Expense Report for Business Meals must include receipt, names of those in attendance, and the business topic.

H. Lodging Expenses

1. CalOptima shall reimburse the cost of a single room at an Approved Lodging Facility for Non-Local Travel.

2. Adequate lodging expenses will be allowed. Price is an issue in selecting "adequate lodging". Prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged; booking through online travel Websites, as opposed to directly with the lodging facility, might provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

3. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. If such rates are not available, a hotel's discounted government rate shall be allowed. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) Website; www.gsa.gov.

4. CalOptima may reimburse additional lodging expenses for Non-Local Travel if:

a. It results in offsetting lower airfare; and

b. The cost of returning to home or office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

5. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima may approve Local Travel lodging expenses if:

a. It is not practical or feasible for the authorized Individual to return home due to extremely poor weather conditions; or

b. Less than eight (8) hours will elapse from the time business is concluded on one (1) day and the time business is scheduled to reconvene on the following calendar day; or

c. It is not practical or feasible for the authorized Individual to return home due to an extended commute.

6. Once approved, the Individual or his or her designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima travel services provider or another method approved by CalOptima's Purchasing Department.

7. The Individual shall be responsible for necessary cancellation of travel and lodging reservations, in accordance with the respective rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any cancellations.

I. Cash advances

1. Under normal circumstances, CalOptima shall not issue cash advances for Travel Expenses.

2. The Executive Management team shall approve cash advances for anticipated authorized travel.

3. CalOptima may authorize cash advances on a limited basis if the traveling Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized Travel Expenses, as defined in this policy.

4. When authorized, cash advances shall be based on an estimate of reasonable Travel Expenses, including travel, meals, lodging and miscellaneous expenses.

5. Individuals receiving cash advances shall complete an Expense Report within five (5) business days of the Individual's return to home or place of work, whichever occurs first. The Individual shall account for all expenses incurred while traveling on authorized CalOptima Business, and shall indicate any cash amounts due back to CalOptima, in the event the cash advance was greater than actual authorized expenses, or cash amounts due the Individual, in the event actual authorized expenses exceed the amount of the cash advance.

J. Transportation

1. The mode of transportation shall be based on the distance of the final destination from the Individual's home or primary workplace, business schedule, and the cost effectiveness of the various modes of transportation.

2. Cost of arrangements for personal travel in conjunction with a business travel itinerary will be at the authorized Individual's expense. The Individual shall document the incremental travel costs assessed to CalOptima, in accordance with this policy.

3. The Individual shall make transportation arrangements as far in advance as possible using the most economical carrier, and the most economical departure point, within the selected mode of transportation. A Saturday night stay may be required to obtain the lowest possible rate, and may be authorized if the savings will reasonably offset the additional cost of meals, automobile rental and lodging.

    a. Flight arrangements made through CalOptima's travel services provider shall be reviewed by CalOptima's Purchasing Department, and submitted directly to Accounts Payable for payment.

    b. Flight arrangements not made through the CalOptima travel services provider shall be submitted by the Individual on an Expense Report.

    c. Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance by the CEO. An Individual shall pay any increase in transportation fares based on indirect or interrupted direct travel routes. Any resulting excess travel time shall not be considered work time, but shall be charged to the appropriate type of leave.

    d. Additional expenses shall not be the responsibility of the Individual if, through no fault or control of the Individual, it is necessary to travel an indirect route, or an interrupted direct route. In such cases, additional time shall be considered work time, and shall not be charged to any type of leave.

    e. Whenever available, all Individuals shall travel via "Coach Class," or similar reduced fare accommodations. "Business Class" reservations shall not be used except in the event that "Coach Class" or similar reduced fare accommodations are unavailable, and departure time is critical to the nature of the reason for travel. Under no circumstances shall "First Class" travel be reserved.

    f. Individuals requesting travel reservations shall not insist on any certain commercial carrier if using the specified carrier will result in a fare which is higher than the lowest available fare.

    g. Any deviation from lowest available rate for commercial carriers shall be at the Individual's expense.

4. The Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective carrier rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established carrier rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any such cancellations.

5. Use of Privately-Owned Vehicles

    a. An authorized Individual may use a privately-owned vehicle for travel if such use is more economical than the lowest-priced direct commercial carrier fare plus rental car expenses. The Individual must be licensed, and shall carry liability insurance as required by the State of California, at the Individual's sole expense.

b. CalOptima shall reimburse the use of privately-owned vehicles solely based on actual mileage at the Internal Revenue Service (IRS) Standard Mileage Rate. Total mileage reimbursed should consider the Individual's daily commute.

c. CalOptima shall not reimburse costs for fuel, automobile repairs, or other automobile expense items.

d. If more than one authorized Individual is traveling for CalOptima Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

e. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

f. CalOptima shall compensate property damages to an Individual's automobile incurred without fault or cause on the part of the Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the Individual's insurance policy, whichever is the lesser amount, for each accident.

6. Rental Automobiles

a. An Individual may rent automobile when such rental is considered to be more advantageous to CalOptima than other means of transportation.

b. Advance reservations shall be made whenever possible. Reservations for employees, Board and Committee members shall be made in the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

c. The vehicle rental agreement for the authorized Individual shall reference the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

d. Rental automobile approved classes are as follows:

i. Economy Class: An Individual shall select an economy class vehicle whenever four (4) or fewer individuals, including the driver, will be passengers in the rental automobile at any one time.

ii. Mid-size Class: An Individual may select a mid-size class vehicle in the event more than four (4) individuals will be riding in the rental automobile at any one (1) time, or in the event an economy class vehicle is not available, and the nature of the travel requires immediate departure.

iii. Luxury Class: Under no circumstances shall an Individual select a luxury class vehicle.

7. Other Modes of Transportation

a. Taxi Fares: CalOptima shall reimburse taxi fares when public transportation is not practical or available. Examples include travel between hotel and place of business, and from one business to another.

III. PROCEDURE

A. Travel and Training Authorization Form

1. Shall be accessed and completed on-line by all Individuals or their designee using CalOptima's Intranet system (or similar system in place at the time request is made), and shall include all actual or estimated expense amounts related to the request; and

2. Shall be routed for approval systemically based on the Individual's level, cost center, and whether they are a CalOptima employee according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

3. Shall also be routed systemically to the Human Resources Department in order to track the Individual's training.

4. Shall also be routed systemically to the Finance Department for confirmation that requested expenses are budgeted, and that enough budget remains to cover requested expenses.

5. Requestors shall receive an automatic e-mail after submitting their request, notifying them of the approval status, and providing a link to the electronic form to track approval progress.

6. The Purchasing Department shall review, authorize for appropriate approvals, and notify the requestors that they may begin making travel commitments.

B. Travel and Training Arrangements

1. Authorizations that include event registration fees shall be pre-paid and processed by CalOptima's Purchasing Department, where possible. CalOptima's Purchasing Department shall verify with the requestor that the registration has not been processed before proceeding with registration of the Individual for the event.

2. The requestor, or his or her designee, shall make air travel arrangements through CalOptima's travel services provider, where possible. Arrangements should be made as far in advance as possible to minimize costs. Exceptions to using CalOptima's travel services provider are subject to approval by CalOptima's Purchasing Department.

3. All other arrangements shall be made with the Individual's personal credit card, either through CalOptima's travel services provider, another approved method, or directly with the establishment(s), subject to CalOptima's Purchasing Department approval.

C. Expense Reimbursement using Expense Report

1. Individuals or designees shall prepare and submit request claims for reimbursement of Travel Expenses on a CalOptima Expense Report. The report shall be completed by the Individual or designee, including all details, and shall be routed with a copy of the previously-approved Travel and Training Authorization Form for appropriate Expense Report approval signatures, if applicable, as follows:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee*
CEO	Board Chairperson or designee*
Board Member/Standing Committee Member	Board Chairperson, CEO or designee*

*Designee authorization is not valid when self approval would result.

2. Receipts

   a. For any expenses in excess of twenty-five dollars ($25.00), the Individual shall include an original credit card receipt, if available, or other computer-generated or hand-written receipt, in the event a credit card receipt is unavailable. CalOptima contractors authorized to receive reimbursement for expenses shall submit receipts for all expenses, regardless of the dollar amount of the expenditure.

   b. Small receipts, such as credit card, gas and airline receipts, shall be attached to an 8 ½ by 11 inch sheet of paper. Hotel receipts and other larger receipts may be submitted as is.

   c. In the absence of credit card receipts, or other proof of actual expenditure, CalOptima shall reimburse lodging expenses only if marked "paid" by the management of the lodging facility.

   d. In most instances, airfare for CalOptima employees and Board members shall be prepaid by CalOptima. CalOptima contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not prepaid for any reason, shall submit passenger receipts for reimbursement consideration.

   e. If receipts cannot be obtained or have been lost, a statement to that effect shall be made on the Expense Report, along with an appropriate explanation. In the absence of a satisfactory explanation, CalOptima shall not allow the amount.

3. Completed and approved Expense Reports and supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel.

4. No reimbursement shall be made for Expense Reports submitted beyond six (6) months after completion of travel.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

2. Code expenses to appropriate department and general ledger account numbers; and

3. Process payment for reimbursement.

E. The Purchasing Department shall:

1. Provide travel reports to the CEO, Executive Management, and Department Directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of individuals per event, and may be required to distinguish between budgeted and non-budgeted travel.

2. Review details of statements/invoices received from the CalOptima travel services provider for accuracy and reasonableness;

3. Attach appropriate copies of completed Travel and Training Authorization Forms related to travel service provider invoice line items, and submit to Accounts Payable for payment.

4. Review details of statements/invoices received from credit card account used by Purchasing to arrange attendance at conferences, training, and other events, and to make authorized purchases.

5. Attach appropriate copies of completed Travel and Training Authorization Forms related to credit card invoice travel and training line items, and submit to Accounts Payable for payment.

IV. ATTACHMENTS

A. Electronic Travel and Training Authorization Form
B. CalOptima Expense Report
C. Cash Advance Form

V. REFERENCES

A. Internal Revenue Service Publication 463
B. California Government Code Section 53232.2
C. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994

VI. APPROVALS OR BOARD ACTION

9/6/12: CalOptima Regular Board Meeting

VII. REVISION HISTORY

A. 9/6/12: GA.5004: Travel Policy
B. 8/1/12: GA.5004: Travel Policy

VIII. KEYWORDS

Approved Lodging
CalOptima Business
Executive Management

Expense Report
Individual
Local Travel
Lodging
Meals
Miscellaneous Expenses
Non-Local Travel
Non-Reimbursable Expenses
Parking, Fees and Tolls
Registration Fees
Reimbursable Expenses
Transportation
Travel
Travel and Training Authorization Form
Travel Expenses

Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

As a condition of obtaining access to information concerning procedures or other data records utilized/maintained by the Department of Health Care Services and CalOptima, Potomac Partners DC, LLC, including any and all individual employees and agents, agrees not to divulge any information obtained in the course of completion of this Contract to any unauthorized persons.

CONTRACTOR further agrees not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

CONTRACTOR further recognizes that unauthorized release of confidential information may be subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: Rick Alcalde Date: 04/09/2021

Print Name: Rick Alcalde

Title: President, Potomac Partners DC

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Exhibit E
Part 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that :

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

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Potomac Partners DC	Rick Alcalde
Name of Contractor	Printed Name of Person Signing for Contractor
21-10013	Rick Alcalde
Contract/Grant Number	Signature of Person Signing for Contractor
04/09/2021	President, Potomac Partners DC
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

Exhibit E

Part 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	☐a. bid/offer/application ☐b. initial award ☐c. post-award	☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known*:
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*): *(attach Continuation Sheet(s) SF-LLLA, if necessary)*	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):
11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned 12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value_____	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____
14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11: *(Attach Continuation Sheet(s) SF-LLL-A, If necessary)*	
15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No	
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

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Exhibit E

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.
2. Identify the status of the covered federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.
4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.
6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.
7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."
9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

Exhibit F

Not applicable for this Contract

Exhibit G

ADDENDUM 1
MEDICARE ADVANTAGE PROGRAM

The following additional terms and conditions apply to the provision of goods or services to be utilized, directly or indirectly, by or for the Medicare Advantage Program. These terms and conditions are additive to those contained in the main Contract, and apply to the extent applicable to the services provided by CONTRACTOR. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

A. In addition to compliance with the provisions of Section 8 in the Contract, CONTRACTOR expressly warrants that CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

B. For any medical records or other health and enrollment information CONTRACTOR maintains with respect to Medicare enrollees, CONTRACTOR shall establish procedures to:

1. Abide by all Federal and State laws regarding confidentiality and disclosure of medical records and other health and enrollment information. CONTRACTOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify: (a) the purpose or purposes the information will be used within CONTRACTOR's organization; and (b) to whom and for what purpose CONTRACTOR will disclose the information.

2. Ensure that the medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

3. Maintain the records and information in an accurate and timely manner.

4. Ensure timely access by enrollees to the records and information that pertain to them.

C. CONTRACTOR shall comply with the reporting requirements provided in Title 42 of the Code of Federal Regulations, Section 422.516 as well as the encounter data submission requirements of 42 CFR Section 422.257.

D. For all contracts in the amount of $100,000 or more, in addition to the Equal Opportunity provisions included in the Contract, CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with 41 CFR 60-300.5(a) and 41 CFR 60-741.5(a) as follows:

1. **THIS CONTRACTOR AND SUBCONTRACTOR SHALL ABIDE BY THE REQUIREMENTS OF 41 CFR 60-300.5(a). THIS REGULATION PROHIBITS DISCRIMINATION AGAINST QUALIFIED PROTECTED VETERANS, AND REQUIRES AFFIRMATIVE ACTION BY COVERED PRIME CONTRACTORS AND SUBCONTRACTORS TO EMPLOY AND ADVANCE IN EMPLOYMENT QUALIFIED PROTECTED VETERANS.** (41 CFR 60-300.5(d).)

2. **THIS CONTRACTOR AND SUBCONTRACTOR SHALL ABIDE BY THE REQUIREMENTS OF 41 CFR 60-741.5(a). THIS REGULATION PROHIBITS DISCRIMINATION AGAINST QUALIFIED INDIVIDUALS ON THE BASIS OF DISABILITY, AND REQUIRES AFFIRMATIVE ACTION BY COVERED PRIME CONTRACTORS AND SUBCONTRACTORS TO EMPLOY AND ADVANCE IN EMPLOYMENT QUALIFIED INDIVIDUALS WITH DISABILITIES.** (41 CFR 60-741.5(d).)

E. In addition to the termination provisions of Section 16 of this Contract, CONTRACTOR agrees and acknowledges that CalOptima may terminate the Contract if CMS or CalOptima determines that

CONTRACTOR has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay CONTRACTOR its allowable costs incurred to the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima for matters pertaining to this Contract.

F. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its contract with CMS, CONTRACTOR shall comply with all such requirements at the direction of CalOptima.

G. CalOptima shall review, approve, and audit on an ongoing basis, the credentialing of medical professionals, if any, associated with CONTRACTOR and CONTRACTOR's performance of this Contract.

H. Notwithstanding the delegation by CalOptima to CONTRACTOR for the selection of providers, contractors, or subcontractors, CalOptima expressly retains the right to approve, suspend, or terminate any such arrangement.

I. Notwithstanding the written delegation by CalOptima to CONTRACTOR of any other activities under this Contract, CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its contract with CMS, and expressly retains the right to approve, suspend, or terminate any such arrangement with CONTRACTOR. With all such delegated activities, CalOptima shall monitor CONTRACTOR's performance on an ongoing basis to ensure compliance with all applicable CalOptima and CMS requirements.

Exhibit H

Not applicable for this Contract

Exhibit I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: Potomac Partners DC

Business Entity Type: LLC
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: 700 Pennsylvania Ave SE, Suite 320

City: Washington State: DC Zip: 20003

Business Phone: 202-544-4848 Email: : RICK@PPDC.PRO

President: Rick Alcalde Contact Person: Rick Alcalde

Person(s) Signing Contract & Title: : Rick Alcalde, President

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
Rick Alcalde	President, 100% Ownership

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

Rick Alcalde
Authorized Signature

04/09/2021
Date

Rick Alcalde, President
Name and Title

Exhibit J

Not applicable for this Contract

Exhibit K

Not applicable for this Contract

Exhibit L

Not applicable for this Contract

CalOptima Health Board Action Agenda Referral

Action To Be Taken February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Approve Actions Related to the Procurement of a Member and Provider Engagement Platform Solution

Contacts

Deanne Thompson, Executive Director, Marketing and Communications, (714) 954-2141
Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154

Recommended Actions

1. Approve the scope of work for the Member and Provider Engagement Platform Solution.
2. Authorize the Chief Executive Officer to release the request for proposal (RFP), select a vendor, and negotiate and execute a contract with the selected vendor.

Background

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

Discussion

CalOptima Health's ITS and Communications staff are seeking approval for the attached scope of work (SOW) for a Member and Provider Engagement Platform solution (Engagement Platform) and request approval to release the RFP to select and contract with a vendor to provide the solution.

Business users from Population Health, Customer Service, Communications, Provider Relations, and Community Relations departments will use the Engagement Platform for multi-channel communication campaigns, including text, email, and phone calls, to engage with members, providers, and other stakeholders. The Engagement Platform enables business users to set up and deploy communication campaigns that can drive action from members for specific programs, such as new member on-boarding, redetermination, health assessments, or cancer screening appointments. The Engagement Platform can take an automated action tailored to the recipient's response or lack of response, such as a follow-up communication.

CalOptima Health business users will manage and execute communication campaigns and select the parameters for a target audience, such as specific member attributes. The system should support a workflow engine to define next processes and actions. Natural language and artificial intelligence

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technologies can be applied to member or provider responses or inquiries for automated processing to enhance response rates.

Implementing a modern Engagement Platform will lead to more effective, efficient, and timely communications about CalOptima Health programs and services for members and providers to access and utilize.

The ITS and Communications teams will work in conjunction with Vendor Management to review the proposals received to determine the vendor that best meets the needs of the organization. Once the vendor is selected, CalOptima Health will negotiate and execute a contract with the vendor for implementation. The initial contract term will be for three (3) years with two (2) one-year options to extend at CalOptima Health's sole discretion, at an estimated annual cost of no more than $2,865,000.

Fiscal Impact

The recommended action is a budgeted item. Funding for the recommended action of up to $2,865,000 is included as part of the capital project, "Artificial Intelligence/Machine Learning Tool to Turn Data into Information," under the "Applications Development" category in the Fiscal Year 2022-23 Digital Transformation Year One Capital Budget approved by the Board on June 2, 2022.

Rationale for Recommendation

CalOptima Health recognizes the importance of two-way communications with members and providers to drive better health outcomes for members. By implementing a modern Engagement Platform, CalOptima Health staff will be enabled to automate communications with members and providers about new programs and services available. The Engagement Platform allows business users to readily initiate and maintain communication campaigns to be proactive and responsive to member and provider needs.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Scope of Work for the Member and Provider Engagement Platform Solution.

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

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Member and Provider Engagement Platform

A. OBJECTIVE

The objective of the current initiative is for CalOptima to identify and select the most appropriate software vendor for its Member and Provider Engagement Platform ("Engagement Platform") requirements. The Engagement Platform should provide all the services outlined in the Scope of Work (SOW).

The following are a few examples of how the Engagement Platform will be used:

- New Member Communications
- New Services Announcements
- Redetermination of Members
- Proactive Status Notifications
- Follow-up Communications on Recommended Actions
- Coordination of Annual Wellness Visits and Health Risk Assessment
- Promote Cancer Screening
- Capture of Social Determinants of Health from Members
- Communication of Authorizations

B SCOPE OF WORK

CalOptima Health is seeking to implement an Engagement Platform system with the following capabilities:

1. The Engagement Platform will support:
    a. Omnichannel communications platform including text, email, phone call, and in-application notifications
    b. Members, providers, other stakeholders are able to continue their interaction with the campaign on any channel or device.
    c. Easy to use, mobile app-like interface that does not require recipients to download and install apps.
    d. Low-Code/No-Code platform for CalOptima business employees to rapidly build and deploy communication campaigns without any need for vendor professional services.
    e. Ability to segment a target audience using complex selection criteria.
    f. Ability to customize the communication with content specific to the recipient.
    g. No system limits on number of campaigns or number of outreaches per campaign.
    h. Ability to set limits on campaigns per member per month to not overcommunicate with member.
    i. Monitoring and reporting for campaigns per member per month.
    j. Ability to capture responses on all communication channels
    k. Ability to ingest responses and take appropriate actions, including kicking off workflows.
    l. Conditional branch logic for actions based on specific responses
    m. Ability to apply Artificial Intelligence and Machine Learning (AI/ML) to ingest, interpret, and process automated responses
    n. Communication campaigns must be able to support specific initiatives to help increase member engagement and communications between CalOptima and the member, such as:
        - Quality Improvement (i.e., preferable experience in assisting health plans

with improving HEDIS measures, preventive care, medication adherence, wellness, disease management, etc.)
        - Health Plan Navigation Support (i.e., providing information on health care benefits, how to access CalOptima's programs or services such as Nurse Advice Line, assisting new enrollees on how to choose a doctor, etc.)
    o. Ability to send surveys to measure member or provider satisfaction with CalOptima's services
2. Text Messaging-specific Requirements
    a. Text blasting/bulk messaging
    b. Two-way text messaging
    c. Tailored or personalized text messages
    d. Automated responses
    e. Conditional branch logic for keyword text responses
    f. Conditional branch logic for automated responses
    g. Message delivery scheduling/staggering
    h. Message queuing
    i. Text with links to web site pages
    j. Voting and polling
    k. Short codes
    l. Unicode support
3. Security, Privacy, Data Exchange, and System Interface Requirements
    a. Comply with all state and federal regulations, including but not limited to FDA, Affordable Care Act (ACA), Centers for Medicare and Medicaid Services (CMS), the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
    b. Provide a HIPAA compliant platform and secure encryption texting capability to ensure the safe management of PHI and other sensitive data.
    c. Management of user opt-out/opt-in and text preferences.
    d. Identification of mobile numbers and land line numbers to distinguish users who can receive text messages.
    e. Provide system interfaces for Member and Provider contact data
    f. Provide system interfaces for Member and Provider attributes data to support target audience segmentation
    g. System interfaces should be compatible with RESTful / JSON APIs and flat file data interfaces
    h. Support ingestion of responses as structured and unstructured information
    i. Ability to use Optical Character Recognition (OCR) to ingest data from documents and forms
    j. Ability to integrate and handoff to IVR platform.
    k. Support data record retention for ten (10) years at minimum.
    l. Vendor agrees, upon termination of the relationship (regardless of which party terminates), to provide all information required for successful data transition files at no additional cost.
4. Reporting
    a. Dashboard reporting with graphical, at-a-glance key indicators for campaign progress and results
        - Real-time updates of message delivery and campaign performance.
        - Summaries of responses received and resulting actions (as defined by the campaign)
        - Composite dashboard with all active campaign with summary performance (for a given department or campaign category)

b. Summary reports shall be provided at the conclusion of each communications campaign that measures performance and outcomes.
c. Ability to perform Analytics on Campaigns in progress.
d. Flexibility for summary or detailed reports.
e. Reports should be in a format that allows results and response data to be integrated into CalOptima systems.

5. Multiple Language Support
    a. CalOptima supports seven (7) "threshold" languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese, and Arabic.
    b. At a minimum, the Engagement Platform must support text messaging services in English and Spanish.
    c. Specify multi-lingual support for Natural Language Processing/AI functionality including two-way communication and text to language capabilities, and potentially for OCR
6. Branding
    a. Support "white label software" to brand the application as a CalOptima Health application.

C. SUPPLIER'S RESPONSIBILITIES

1. Configuration of software
2. Validation of detailed business requirements and system configuration to support requirements
3. Test integration with CalOptima systems for Member and Provider data
4. Test deployed software and equipment prior to system launch
5. Provide end-user training to business users and IT application support resources
6. Provide system configuration and technical training to IT resources
7. Provide live on-going support services
8. Provide end-user reference guides

Financial Summary

November 30, 2022

Board of Directors Meeting
February 2, 2023

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

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

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Financial Highlights: November 2022

November					July - November			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
943,598	909,583	34,015	3.7%	Member Months	4,667,280	4,570,004	97,276	2.1%
232,396,025	330,887,958	(98,491,934)	(29.8%)	Revenues	1,648,266,017	1,660,398,506	(12,132,489)	(0.7%)
207,508,087	307,656,467	100,148,380	32.6%	Medical Expenses	1,547,694,125	1,552,624,201	4,930,076	0.3%
15,963,594	17,909,997	1,946,403	10.9%	Administrative Expenses	73,690,991	87,015,800	13,324,809	15.3%
8,924,343	**5,321,494**	**3,602,849**	**67.7%**	**Operating Margin**	**26,880,901**	**20,758,505**	**6,122,396**	**29.5%**
				Non-Operating Income (Loss)				
11,856,362	500,000	11,356,362	2271.3%	Net Investment Income/Expense	17,116,307	2,500,000	14,616,307	584.7%
134,979	90,835	44,144	48.6%	Net Rental Income/Expense	563,871	454,175	109,696	24.2%
1,084	-	1,084	100.0%	Net MCO Tax	24,752	-	24,752	100.0%
(15,863,636)	(1,363,636)	(14,500,000)	(1063.3%)	Grant Expense	(19,318,182)	(5,454,544)	(13,863,638)	(254.2%)
-	-	-	0.0%	Net QAF/IGT Income/Expense	-	-	-	0.0%
15	-	15	100.0%	Other Income/Expense	25,893	-	25,893	100.0%
(3,871,195)	**(772,801)**	**(3,098,394)**	**(400.9%)**	**Total Non-Operating Income (Loss)**	**(1,587,360)**	**(2,500,369)**	**913,009**	**36.5%**
5,053,148	**4,548,693**	**504,455**	**11.1%**	**Change in Net Assets**	**25,293,540**	**18,258,136**	**7,035,404**	**38.5%**
89.3%	93.0%	(3.7%)		Medical Loss Ratio	93.9%	93.5%	0.4%	
6.9%	5.4%	(1.5%)		Administrative Loss Ratio	4.5%	5.2%	0.8%	
3.8%	1.6%	2.2%		Operating Margin Ratio	1.6%	1.3%	0.4%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
89.3%	93.0%	(3.7%)		*MLR (excluding Directed Payments)	93.5%	93.5%	0.0%	
6.9%	5.4%	(1.5%)		*ALR (excluding Directed Payments)	4.9%	5.2%	0.4%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima Health

Consolidated Performance: November 2022 (in millions)

November				July-November		
Actual	Budget	Variance	**Operating Income (Loss)**	Actual	Budget	Variance
8.3	6.3	2.0	Medi-Cal	29.8	26.3	3.5
0.5	(0.3)	0.8	OCC	(2.6)	(2.1)	(0.5)
0.2	(0.6)	0.8	OneCare	(0.0)	(2.9)	2.9
0.0	(0.0)	0.1	PACE	0.2	(0.3)	0.4
(0.1)	(0.0)	(0.1)	MSSP	(0.4)	(0.2)	(0.2)
8.9	**5.3**	**3.6**	**Total Operating Income (Loss)**	**26.9**	**20.8**	**6.1**
			Non-Operating Income (Loss)			
11.9	0.5	11.4	Net Investment Income/Expense	17.1	2.5	14.6
0.1	0.1	0.0	Net Rental Income/Expense	0.6	0.5	0.1
0.0	0.0	0.0	Net Operating Tax	0.0	0.0	0.0
(15.9)	(1.4)	(14.5)	Grant Expense	(19.3)	(5.5)	(13.9)
0.0	0.0	0.0	Net Other Income/Expense	0.0	0.0	0.0
(3.9)	**(0.8)**	**(3.1)**	**Total Non-Operating Income/(Loss)**	**(1.6)**	**(2.5)**	**0.9**
5.1	**4.5**	**0.5**	**TOTAL**	**25.3**	**18.3**	**7.0**

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CalOptima Health

FY 2022-23: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) November 2022: $5.1 million, favorable to budget $0.5 million or 11.1%
  - Year To Date (YTD) July – November 2022: $25.3 million, favorable to budget $7.0 million or 38.5%
- Enrollment
  - MTD: 943,598 members, favorable to budget 34,015 or 3.7%
  - YTD: 4,667,280 members, favorable to budget 97,276 or 2.1%
  - Favorable enrollment primarily driven by a pause in Medi-Cal redetermination due to the extension of the COVID-19 Public Health Emergency

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Revenue
  - MTD: $232.4 million, unfavorable to budget $98.5 million or 29.8% driven by Medi-Cal Line of Business (MC LOB):
    - $117.9 million due to COVID-19 and Enhanced Care Management (ECM) risk corridor reserves, and a logic update for prior years' Proposition 56 program reconciliation
    - Offset by $11.3 million of favorable volume related variance
  - YTD: $1,648.3 million, unfavorable to budget $12.1 million or 0.7% driven by MC LOB:
    - $203.0 million due to COVID-19 and ECM risk corridor reserves, and Proposition 56 logic update
    - Offset by $135.2 million of Fiscal Year (FY) 2021 hospital Directed Payments (DP) and $36.7 million due to favorable volume related variance and prior year retroactive eligibility changes

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - MTD: $207.5 million, favorable to budget $100.1 million or 32.6% driven by MC LOB:
    - Provider Capitation expense favorable variance of $91.8 million primarily due to updated logic for Proposition 56 estimates
    - Facilities Claims expense favorable variance of $7.5 million due to Incurred But Not Reported (IBNR) claims

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - YTD: $1,547.7 million, favorable to budget $4.9 million or 0.3% driven by MC LOB:
    - Provider Capitation expense favorable variance of $118.8 million due primarily to updated logic for Proposition 56
    - Net favorable variance of $13.7 million from Facilities and Professional related Claims, Medical Management, and Incentive Payments
    - Offset by $129.3 million from Other Medical Expenses due to FY 2021 hospital DP

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FY 2022-23:Management Summary (cont.)

- Administrative Expenses
  - MTD: $16.0 million, favorable to budget $1.9 million or 10.9%
    - Salaries & Benefits expense favorable variance of $1.2 million
    - Other Non-Salary expenses favorable variance of $0.8 million
  - YTD: $73.7 million, favorable to budget $13.3 million or 15.3%
    - Other Non-Salary expenses favorable variance of $8.2 million
    - Salaries & Benefits expense favorable variance of $5.1 million

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FY 2022-23:Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: ($3.9) million, unfavorable to budget $3.1 million or 400.9%
    - Non-operating loss is primarily driven by $15.9 million grant agreement with Mind OC, offset by $11.9 million in net investment income
  - YTD: ($1.6) million, favorable to budget $0.9 million or 36.5%

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CalOptima Health

FY 2022-23: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 89.3% (89.3% excluding DP), Budget 93.0%
  - YTD: Actual 93.9% (93.5% excluding DP), Budget 93.5%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 6.9% (6.9% excluding DP), Budget 5.4%
  - YTD: Actual 4.5% (4.9% excluding DP), Budget 5.2%
- Balance Sheet Ratios
  - *Current ratio: 1.5
  - Board-designated reserve level: 1.83
  - Net-position: $1.4 billion, including required Tangible Net Equity (TNE) of $100.9 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations

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CalOptima Health

Enrollment Summary: November 2022

November					July - November			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
125,831	123,080	2,751	2.2%	SPD	623,038	612,703	10,335	1.7%
304,414	305,616	(1,202)	(0.4%)	TANF Child	1,518,445	1,531,935	(13,490)	(0.9%)
134,842	133,568	1,274	1.0%	TANF Adult	669,955	676,056	(6,101)	(0.9%)
3,275	3,349	(74)	(2.2%)	LTC	16,225	16,653	(428)	(2.6%)
345,846	314,411	31,435	10.0%	MCE	1,692,003	1,585,076	106,927	6.7%
11,745	11,786	(41)	(0.3%)	WCM	59,149	58,757	392	0.7%
925,953	**891,810**	**34,143**	**3.8%**	**Medi-Cal Total**	**4,578,815**	**4,481,180**	**97,635**	**2.2%**
14,197	**14,632**	**(435)**	**(3.0%)**	**OneCare Connect**	**71,774**	**73,282**	**(1,508)**	**(2.1%)**
3,015	**2,673**	**342**	**12.8%**	**OneCare**	**14,522**	**13,248**	**1,274**	**9.6%**
433	**468**	**(35)**	**(7.5%)**	**PACE**	**2,169**	**2,294**	**(125)**	**(5.4%)**
476	**568**	**(92)**	**(16.2%)**	**MSSP**	**2,368**	**2,840**	**(472)**	**(16.6%)**
943,598	**909,583**	**34,015**	**3.7%**	**CalOptima Health Total**	**4,667,280**	**4,570,004**	**97,276**	**2.1%**

*CalOptima Health Total does not include MSSP

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CalOptima Health

Consolidated Revenue & Expenses: November 2022 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	568,362	345,846	11,745	925,953	14,197	3,015	433	476	943,598
REVENUES									
Capitation Revenue	91,426,959	$ 86,414,627	$ 19,735,038	$ 197,576,624	$ 27,284,162	$ 3,779,200	$ 3,618,536	$ 137,503	$ 232,396,025
Total Operating Revenue	91,426,959	86,414,627	19,735,038	197,576,624	27,284,162	3,779,200	3,618,536	137,503	232,396,025
MEDICAL EXPENSES									
Provider Capitation	(7,544,251)	13,226,635	8,450,457	14,132,841	10,695,942	1,029,878			25,858,661
Facilities	27,278,112	26,990,202	4,889,482	59,157,796	4,491,293	921,263	849,757		65,420,108
Professional Claims	22,432,504	13,800,835	1,409,304	37,642,643	1,444,024	157,499	909,816		40,153,982
Prescription Drugs	521,711	(10,727)	(500)	510,484	5,624,115	1,003,384	360,671		7,498,654
MLTSS	39,951,680	4,491,249	2,220,892	46,663,821	1,548,564		221,724	12,879	48,446,988
Incentive Payments	5,973,799	5,204,496	153,682	11,331,978	335,854	(14,143)	5,413		11,659,102
Medical Management	2,733,763	2,198,748	367,179	5,299,690	1,158,040	72,035	956,516	152,637	7,638,919
Other Medical Expenses	485,741	333,909	12,025	831,675					831,675
Total Medical Expenses	91,833,059	66,235,346	17,502,521	175,570,927	25,297,831	3,169,916	3,303,897	165,516	207,508,087
Medical Loss Ratio	100.4%	76.6%	88.7%	88.9%	92.7%	83.9%	91.3%	120.4%	89.3%
GROSS MARGIN	**(406,101)**	**20,179,280**	**2,232,517**	**22,005,696**	**1,986,331**	**609,284**	**314,639**	**(28,014)**	**24,887,937**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				9,077,161	750,091	156,005	145,922	78,602	10,207,782
Professional Fees				712,560	9,599	53,608		1,333	777,100
Purchased Services				1,474,528	30,112	34,737	(19,187)		1,520,190
Printing & Postage				331,224	101,590	57,549	96,969		587,332
Depreciation & Amortization				401,204			557		401,761
Other Expenses				1,960,394	2,419	9,870	40,181	5,877	2,018,742
Indirect Cost Allocation, Occupancy				(287,338)	640,809	79,498	12,467	5,252	450,688
Total Administrative Expenses				**13,669,734**	**1,534,620**	**391,267**	**276,908**	**91,065**	**15,963,594**
Admin Loss Ratio				6.9%	5.6%	10.4%	7.7%	66.2%	6.9%
INCOME (LOSS) FROM OPERATIONS				8,335,963	451,711	218,018	37,731	(119,079)	8,924,343
INVESTMENT INCOME									11,856,362
NET RENTAL INCOME									134,979
TOTAL MCO TAX				1,084					1,084
TOTAL GRANT EXPENSE				(15,863,636)					(15,863,636)
OTHER INCOME				15					15
CHANGE IN NET ASSETS				**$ (7,526,574)**	**$ 451,711**	**$ 218,018**	**$ 37,731**	**$ (119,079)**	**$ 5,053,148**
BUDGETED CHANGE IN NET ASSETS				4,943,849	(314,244)	(588,109)	(39,807)	(43,831)	4,548,693
VARIANCE TO BUDGET - FAV (UNFAV)				$ (12,470,423)	$ 765,955	$ 806,127	$ 77,538	$ (75,248)	$ 504,455

Note:* Total membership does not include MSSP

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CalOptima Health

Consolidated Revenue & Expenses: November 2022 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	2,827,663	1,692,003	59,149	4,578,815	71,774	14,522	2,169	2,368	4,667,280
REVENUES									
Capitation Revenue	748,379,681	$ 610,474,876	$ 115,105,727	$ 1,473,960,285	$ 137,692,835	$ 17,857,113	$ 17,790,555	$ 965,229	$ 1,648,266,017
Total Operating Revenue	748,379,681	610,474,876	115,105,727	1,473,960,285	137,692,835	17,857,113	17,790,555	965,229	1,648,266,017
MEDICAL EXPENSES									
Provider Capitation	158,024,705	208,084,288	47,526,887	413,635,879	55,476,341	4,982,747			474,094,967
Facilities	162,831,508	148,218,594	29,430,368	340,480,470	22,122,510	4,776,343	4,570,938		371,950,261
Professional Claims	110,267,964	71,867,382	7,469,687	189,605,034	7,206,707	738,708	4,622,435		202,172,883
Prescription Drugs	(1,040,011)	(205,891)	5,604	(1,240,298)	32,610,828	5,519,672	1,996,817		38,887,019
MLTSS	206,186,959	22,417,554	10,167,055	238,771,568	8,411,166		821,426	147,974	248,152,133
Incentive Payments	17,706,379	19,030,579	584,992	37,321,950	2,071,899	6,526	27,113		39,427,488
Medical Management	13,612,354	9,620,945	1,827,945	25,061,244	5,162,792	250,707	4,585,605	752,900	35,813,246
Other Medical Expenses	73,502,447	55,422,777	8,270,903	137,196,127					137,196,127
Total Medical Expenses	741,092,304	534,456,228	105,283,442	1,380,831,973	133,062,243	16,274,702	16,624,333	900,874	1,547,694,125
Medical Loss Ratio	99.0%	87.5%	91.5%	93.7%	96.6%	91.1%	93.4%	93.3%	93.9%
GROSS MARGIN	**7,287,377**	**76,018,648**	**9,822,285**	**93,128,311**	**4,630,593**	**1,582,411**	**1,166,222**	**64,356**	**100,571,892**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				45,531,168	3,422,530	659,734	680,881	380,792	50,675,104
Professional Fees				2,866,194	29,250	166,714	1,553	6,667	3,070,378
Purchased Services				5,079,111	421,397	118,746	38,438		5,657,692
Printing & Postage				1,448,184	194,291	267,531	156,549		2,066,555
Depreciation & Amortization				1,849,691			2,750		1,852,441
Other Expenses				8,068,336	6,827	9,870	62,976	29,198	8,177,208
Indirect Cost Allocation, Occupancy				(1,498,512)	3,204,043	397,489	62,332	26,261	2,191,614
Total Administrative Expenses				**63,344,172**	**7,278,338**	**1,620,084**	**1,005,479**	**442,918**	**73,690,991**
Admin Loss Ratio				4.3%	5.3%	9.1%	5.7%	45.9%	4.5%
INCOME (LOSS) FROM OPERATIONS				29,784,139	(2,647,745)	(37,674)	160,743	(378,562)	26,880,901
INVESTMENT INCOME									17,116,307
NET RENTAL INCOME									563,871
TOTAL MCO TAX				24,752					24,752
TOTAL GRANT EXPENSE				(19,318,182)					(19,318,182)
OTHER INCOME				25,893					25,893
CHANGE IN NET ASSETS				**$ 10,516,601**	**$ (2,647,745)**	**$ (37,674)**	**$ 160,743**	**$ (378,562)**	**$ 25,293,540**
BUDGETED CHANGE IN NET ASSETS				20,831,627	(2,117,324)	(2,921,844)	(271,701)	(216,797)	18,258,136
VARIANCE TO BUDGET - FAV (UNFAV)				$ (10,315,026)	$ (530,421)	$ 2,884,170	$ 432,444	$ (161,765)	$ 7,035,404

Note:* Total membership does not include MSSP

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CalOptima Health

Balance Sheet: As of November 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$763,390,896	Accounts Payable	$40,970,703
Short-term Investments	1,281,306,852	Medical Claims Liability	1,535,128,457
Capitation Receivable	396,979,370	Accrued Payroll Liabilities	19,088,706
Receivables - Other	92,739,977	Deferred Revenue	10,241,383
Prepaid Expenses	18,937,042	Deferred Lease Obligations	77,036
		Capitation and Withholds	94,123,554
Total Current Assets	**2,553,354,135**	**Total Current Liabilities**	**1,699,629,839**
Capital Assets			
Furniture & Equipment	49,240,969		
Building/Leasehold Improvements	5,059,408		
Construction in Progress	5,640,640		
505 City Parkway West	52,782,700		
500 City Parkway West	22,631,500		
	135,355,217		
Less: Accumulated Depreciation	(67,271,094)	**Other Liabilities**	
Capital Assets, Net	68,084,123	GASB 96 Subscription Liabilities	-
GASB 96 Capital Assets		**Other (than pensions) Post**	
GASB 96 Subscription Assets	-	Employment Benefits Liability	22,363,628
		Net Pension Liabilities	577,854
Less: GASB 96 Accumulated Depreciation	-	Bldg. 505 Development Rights	-
GASB 96 Capital Assets, Net	-		
Total Capital Assets	68,084,123		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,722,571,321**
Homeless Health Reserve	536,739		
Board-Designated Assets:			
Cash and Cash Equivalents	3,027,557		
Investments	564,194,986		
Total Board-Designated Assets	567,222,543	**Deferred Inflows**	
		Excess Earnings	686,563
		OPEB 75 Difference in Experience	4,822,000
		Change in Assumptions	1,909,305
		OPEB Changes in Assumptions	3,389,000
		Diff in Proj vs Act	20,982,636
Total Other Assets	568,059,282		
		Net Position	
		TNE	100,875,159
		Funds in Excess of TNE	1,343,887,149
TOTAL ASSETS	**3,189,497,540**	**TOTAL NET POSITION**	1,444,762,308
Deferred Outflows			
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	**3,199,123,133**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,199,123,133**

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CalOptima Health

Board Designated Reserve and TNE Analysis: As of November 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	231,025,758				
	Tier 1 - MetLife	229,388,360				
Board-designated Reserve		460,414,119	333,129,389	519,131,338	127,284,729	(58,717,220)
	Tier 2 - Payden & Rygel	53,587,997				
	Tier 2 - MetLife	53,220,427				
TNE Requirement		106,808,424	100,875,159	100,875,159	5,933,265	5,933,265
	Consolidated:	**567,222,543**	**434,004,548**	**620,006,497**	**133,217,994**	**(52,783,955)**
	Current reserve level	*1.83*	*1.40*	*2.00*		

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CalOptima Health

Net Assets Analysis: As of November 2022

Category	Item Description	Amount (millions)	Spend to Date	%
	Total Net Position @ 11/30/2022:	**$1,444.8**		**100.0%**
Resources Assigned	Board Designated Reserve*	**567.2**		**39.3%**
	Capital Assets, net of depreciation	**68.1**		**4.7%**
Resources Allocated	Homeless Health Initiative**	$100.0	$35.6	6.9%
	Intergovernmental Transfers (IGT)	111.7	48.0	7.7%
	Mind OC Grant	1.0	1.0	0.1%
	CalFresh Outreach Strategy	2.0	0.9	0.1%
	Digital Transformation and Workplace Modernization	100.0	3.3	6.9%
	Coalition of Orange County Community Health Centers Grant	50.0	10.0	3.5%
	Subtotal:	**$364.7**	**$98.7**	**25.2%**
Resources Available for New Initiatives:	Unallocated/Unassigned*	**$444.7**		**30.8%**

*Total of Board-designated reserve and unallocated reserve amount can support approximately 104 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 November 2022

Program Commitment	**$100,000,000**
Funds Allocation, approved initiatives	**$99,463,261**
***Program Commitment Balance, available for new initiatives**	**$536,739**

Funds Allocation, approved initiatives:	**Allocated Amount**	**Utilized Amount**	**Remaining Approved Amount**
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	8,250,000	6,194,190	2,055,810
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	6,000,000	1,651,203	4,348,797
Homeless Coordination at Hospitals	10,000,000	8,611,208	1,388,792
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,693,261	667,719	1,025,542
FQHC (Community Health Center) Expansion and HHI Support	570,000	21,902	548,098
HCAP Expansion for Telehealth and CFT On Call Days	1,700,000	2,612,800	(912,800)
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
Street Medicine	8,000,000	-	8,000,000
Outreach and Engagement	7,000,000	-	7,000,000
Office of Care Coordination - Housing and Homelessness Incentive Program (HHIP)	2,200,000	-	2,200,000
Pulse For Good (HHIP)	800,000	-	800,000
Consultant (HHIP)	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations (HHIP)	5,000,000	-	5,000,000
Infrastructure Projects (HHIP)	10,500,000	-	10,500,000
Capital Projects (HHIP)	21,000,000	-	21,000,000
Funds Total	**$99,463,261**	**$35,563,670**	**$63,899,591**

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UNAUDITED FINANCIAL STATEMENTS

November 30, 2022

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CalOptima Health - Consolidated
Financial Highlights
For the Five Months Ended November 30, 2022

November					July - November			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
943,598	909,583	34,015	3.7%	Member Months	4,667,280	4,570,004	97,276	2.1%
232,396,025	330,887,958	(98,491,934)	(29.8%)	Revenues	1,648,266,017	1,660,398,506	(12,132,489)	(0.7%)
207,508,087	307,656,467	100,148,380	32.6%	Medical Expenses	1,547,694,125	1,552,624,201	4,930,076	0.3%
15,963,594	17,909,997	1,946,403	10.9%	Administrative Expenses	73,690,991	87,015,800	13,324,809	15.3%
8,924,343	**5,321,494**	**3,602,849**	**67.7%**	**Operating Margin**	**26,880,901**	**20,758,505**	**6,122,396**	**29.5%**
				Non-Operating Income (Loss)				
11,856,362	500,000	11,356,362	2271.3%	Net Investment Income/Expense	17,116,307	2,500,000	14,616,307	584.7%
134,979	90,835	44,144	48.6%	Net Rental Income/Expense	563,871	454,175	109,696	24.2%
1,084	-	1,084	100.0%	Net MCO Tax	24,752	-	24,752	100.0%
(15,863,636)	(1,363,636)	(14,500,000)	(1063.3%)	Grant Expense	(19,318,182)	(5,454,544)	(13,863,638)	(254.2%)
-	-	-	0.0%	Net QAF/IGT Income/Expense	-	-	-	0.0%
15	-	15	100.0%	Other Income/Expense	25,893	-	25,893	100.0%
(3,871,195)	**(772,801)**	**(3,098,394)**	**(400.9%)**	**Total Non-Operating Income (Loss)**	**(1,587,360)**	**(2,500,369)**	**913,009**	**36.5%**
5,053,148	**4,548,693**	**504,455**	**11.1%**	**Change in Net Assets**	**25,293,540**	**18,258,136**	**7,035,404**	**38.5%**
89.3%	93.0%	(3.7%)		Medical Loss Ratio	93.9%	93.5%	0.4%	
6.9%	5.4%	(1.5%)		Administrative Loss Ratio	4.5%	5.2%	0.8%	
3.8%	1.6%	2.2%		Operating Margin Ratio	1.6%	1.3%	0.4%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
89.3%	93.0%	(3.7%)		*MLR (excluding Directed Payments)	93.5%	93.5%	0.0%	
6.9%	5.4%	(1.5%)		*ALR (excluding Directed Payments)	4.9%	5.2%	0.4%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima Health
Financial Dashboard
For the Five Months Ended November 30, 2022

NOVEMBER

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	925,953	891,810	34,143	3.8%
OneCare Connect	14,197	14,632	(435)	(3.0%)
OneCare	3,015	2,673	342	12.8%
PACE	433	468	(35)	(7.5%)
MSSP	476	568	(92)	(16.2%)
Total*	943,598	909,583	34,015	3.7%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (7,527)	$ 4,944	(12,471)	(252.2%)
OneCare Connect	452	(314)	766	243.9%
OneCare	218	(588)	806	137.1%
PACE	38	(40)	78	195.0%
MSSP	(119)	(44)	(75)	(170.5%)
Buildings	135	91	44	48.4%
Investment Income/Expense	11,856	500	11,356	2271.2%
Total	$ 5,053	$ 4,549	504	11.1%

MLR	Actual	Budget	% Point Var
Medi-Cal	88.9%	92.7%	(3.8)
OneCare Connect	92.7%	94.5%	(1.7)
OneCare	83.9%	107.7%	(23.9)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 13,670	$ 15,349	$ 1,680	10.9%
OneCare Connect	1,535	1,852	317	17.1%
OneCare	391	345	(46)	(13.5%)
PACE	277	266	(11)	(4.2%)
MSSP	91	98	7	7.0%
Total	$ 15,964	$ 17,910	$ 1,946	10.9%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,163	1,318	155
OneCare Connect	163	197	33
OneCare	21	27	6
PACE	98	115	17
MSSP	20	23	3
Total	1,465	1,679	214

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	796	677	(120)
OneCare Connect	87	74	(13)
OneCare	144	98	(46)
PACE	4	4	(0)
MSSP	24	25	1
Total	644	542	(102)

JULY - NOVEMBER

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	4,578,815	4,481,180	97,635	2.2%
OneCare Connect	71,774	73,282	(1,508)	(2.1%)
OneCare	14,522	13,248	1,274	9.6%
PACE	2,169	2,294	(125)	(5.4%)
MSSP	2,368	2,840	(472)	(16.6%)
Total*	4,667,280	4,570,004	97,276	2.1%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 10,517	$ 20,832	(10,315)	(49.5%)
OneCare Connect	(2,648)	(2,117)	(531)	(25.1%)
OneCare	(38)	(2,922)	2,884	98.7%
PACE	161	(272)	433	159.2%
MSSP	(379)	(217)	(162)	(74.7%)
Buildings	564	454	110	24.2%
Investment Income/Expense	17,116	2,500	14,616	584.6%
Total	$ 25,293	$ 18,258	7,035	38.5%

MLR	Actual	Budget	% Point Var
Medi-Cal	93.7%	93.2%	0.5
OneCare Connect	96.6%	94.9%	1.7
OneCare	91.1%	108.1%	(17.0)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 63,344	$ 74,302	$ 10,957	14.7%
OneCare Connect	7,278	9,244	1,966	21.3%
OneCare	1,620	1,660	40	2.4%
PACE	1,005	1,323	317	24.0%
MSSP	443	487	44	9.0%
Total	$ 73,691	$ 87,016	$ 13,325	15.3%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	5,728	6,533	805
OneCare Connect	811	984	173
OneCare	81	119	38
PACE	469	569	100
MSSP	101	115	14
Total	7,189	8,319	1,130

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	799	686	(113)
OneCare Connect	88	74	(14)
OneCare	179	112	(68)
PACE	5	4	(1)
MSSP	23	25	1
Total	649	549	(100)

Note:* Total membership does not include MSSP

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CalOptima Health - Consolidated
Statement of Revenues and Expenses
For the One Month Ended November 30, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	943,598		909,583		34,015	
REVENUE						
Medi-Cal	$ 197,576,624	$ 213.38	$ 295,884,364	$ 331.78	$ (98,307,740)	$ (118)
OneCare Connect	27,284,162	1,921.83	27,771,339	1,897.99	(487,177)	23.84
OneCare	3,779,200	1,253.47	3,143,275	1,175.94	635,925	77.53
PACE	3,618,536	8,356.90	3,835,463	8,195.43	(216,927)	161.47
MSSP	137,503	288.87	253,517	446.33	(116,014)	(157.46)
Total Operating Revenue	232,396,025	246.29	330,887,958	363.78	(98,491,934)	(117.49)
MEDICAL EXPENSES						
Medi-Cal	175,570,927	189.61	274,227,419	307.50	98,656,492	117.89
OneCare Connect	25,297,831	1,781.91	26,233,568	1,792.89	935,737	10.98
OneCare	3,169,916	1,051.38	3,386,560	1,266.95	216,644	215.57
PACE	3,303,897	7,630.25	3,609,440	7,712.48	305,543	82.23
MSSP	165,516	347.72	199,480	351.20	33,964	3.48
Total Medical Expenses	207,508,087	219.91	307,656,467	338.24	100,148,380	118.33
GROSS MARGIN	24,887,937	26.38	23,231,491	25.54	1,656,446	0.84
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	10,207,782	10.82	11,393,836	12.53	1,186,054	1.71
Professional Fees	777,100	0.82	971,317	1.07	194,217	0.25
Purchased Services	1,520,190	1.61	1,554,421	1.71	34,231	0.10
Printing & Postage	587,332	0.62	504,078	0.55	(83,254)	(0.07)
Depreciation & Amortization	401,761	0.43	525,900	0.58	124,139	0.15
Other Expenses	2,018,742	2.14	2,434,318	2.68	415,576	0.54
Indirect Cost Allocation, Occupancy	450,688	0.48	526,127	0.58	75,439	0.10
Total Administrative Expenses	15,963,594	16.92	17,909,997	19.69	1,946,403	2.77
INCOME (LOSS) FROM OPERATIONS	8,924,343	9.46	5,321,494	5.85	3,602,849	3.61
INVESTMENT INCOME						
Interest Income	7,137,442	7.56	500,000	0.55	6,637,442	7.01
Realized Gain/(Loss) on Investments	(983,316)	(1.04)	-	-	(983,316)	(1.04)
Unrealized Gain/(Loss) on Investments	5,702,236	6.04	-	-	5,702,236	6.04
Total Investment Income	11,856,362	12.57	500,000	0.55	11,356,362	12.02
NET RENTAL INCOME	134,979	0.14	90,835	0.10	44,144	0.04
TOTAL MCO TAX	1,084	-	-	-	1,084	-
TOTAL GRANT EXPENSE	(15,863,636)	(16.81)	(1,363,636)	(1.50)	(14,500,000)	(15.31)
OTHER INCOME	15	-	-	-	15	-
CHANGE IN NET ASSETS	**5,053,148**	**5.36**	**4,548,693**	**5.00**	**504,455**	**0.36**
MEDICAL LOSS RATIO	**89.3%**		**93.0%**		**(3.7%)**	
ADMINISTRATIVE LOSS RATIO	**6.9%**		**5.4%**		**(1.5%)**	

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CalOptima Health- Consolidated
Statement of Revenues and Expenses
For the Five Months Ended November 30, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	4,667,280		4,570,004		97,276	
REVENUE						
Medi-Cal	$ 1,473,960,285	$ 321.91	1,484,593,111	$ 331.30	$ (10,632,826)	$ (9.39)
OneCare Connect	137,692,835	1,918.42	140,013,314	1,910.61	(2,320,479)	7.81
OneCare	17,857,113	1,229.66	15,598,749	1,177.44	2,258,364	52.22
PACE	17,790,555	8,202.19	18,925,747	8,250.11	(1,135,192)	(47.92)
MSSP	965,229	407.61	1,267,585	446.33	(302,356)	(38.72)
Total Operating Revenue	1,648,266,017	353.15	1,660,398,506	363.33	(12,132,489)	(10.18)
MEDICAL EXPENSES						
Medi-Cal	1,380,831,973	301.57	1,384,005,277	308.85	3,173,304	7.28
OneCare Connect	133,062,243	1,853.91	132,886,300	1,813.36	(175,943)	(40.55)
OneCare	16,274,702	1,120.69	16,860,736	1,272.70	586,034	152.01
PACE	16,624,333	7,664.52	17,874,488	7,791.84	1,250,155	127.32
MSSP	900,874	380.44	997,400	351.20	96,526	(29.24)
Total Medical Expenses	1,547,694,125	331.61	1,552,624,201	339.74	4,930,076	8.13
GROSS MARGIN	100,571,892	21.54	107,774,305	23.59	(7,202,413)	(2.05)
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	50,675,104	10.86	55,822,608	12.22	5,147,504	1.36
Professional Fees	3,070,378	0.66	4,635,224	1.01	1,564,846	0.35
Purchased Services	5,657,692	1.21	6,567,938	1.44	910,246	0.23
Printing & Postage	2,066,555	0.44	2,557,525	0.56	490,970	0.12
Depreciation & Amortization	1,852,441	0.40	2,629,500	0.58	777,059	0.18
Other Expenses	8,177,208	1.75	12,171,945	2.66	3,994,737	0.91
Indirect Cost Allocation, Occupancy	2,191,614	0.47	2,631,060	0.58	439,446	0.11
Total Administrative Expenses	73,690,991	15.79	87,015,800	19.04	13,324,809	3.25
INCOME (LOSS) FROM OPERATIONS	26,880,901	5.76	20,758,505	4.54	6,122,396	1.22
INVESTMENT INCOME						
Interest Income	25,178,104	5.39	2,500,000	0.55	22,678,104	4.84
Realized Gain/(Loss) on Investments	(4,538,966)	(0.97)	-	0.00	(4,538,966)	(0.97)
Unrealized Gain/(Loss) on Investments	(3,522,831)	(0.75)	-	0.00	(3,522,831)	(0.75)
Total Investment Income	17,116,307	3.67	2,500,000	0.55	14,616,307	3.12
NET RENTAL INCOME	563,871	0.12	454,175	0.10	109,696	0.02
TOTAL MCO TAX	24,752	0.01	-	0.00	24,752	0.01
TOTAL GRANT EXPENSE	(19,318,182)	(4.14)	(5,454,544)	(1.19)	(13,863,638)	(2.95)
OTHER INCOME	25,893	0.01	-	0.00	25,893	0.01
CHANGE IN NET ASSETS	**25,293,540**	**5.42**	**18,258,136**	**4.00**	**7,035,404**	**1.42**
MEDICAL LOSS RATIO	**93.9%**		**93.5%**		**0.4%**	
ADMINISTRATIVE LOSS RATIO	**4.5%**		**5.2%**		**0.8%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended November 30, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	568,362	345,846	11,745	925,953	14,197	3,015	433	476	943,598
REVENUES									
Capitation Revenue	91,426,959	$ 86,414,627	$ 19,735,038	$ 197,576,624	$ 27,284,162	$ 3,779,200	$ 3,618,536	$ 137,503	$ 232,396,025
Total Operating Revenue	91,426,959	86,414,627	19,735,038	197,576,624	27,284,162	3,779,200	3,618,536	137,503	232,396,025
MEDICAL EXPENSES									
Provider Capitation	(7,544,251)	13,226,635	8,450,457	14,132,841	10,695,942	1,029,878			25,858,661
Facilities	27,278,112	26,990,202	4,889,482	59,157,796	4,491,293	921,263	849,757		65,420,108
Professional Claims	22,432,504	13,800,835	1,409,304	37,642,643	1,444,024	157,499	909,816		40,153,982
Prescription Drugs	521,711	(10,727)	(500)	510,484	5,624,115	1,003,384	360,671		7,498,654
MLTSS	39,951,680	4,491,249	2,220,892	46,663,821	1,548,564		221,724	12,879	48,446,988
Incentive Payments	5,973,799	5,204,496	153,682	11,331,978	335,854	(14,143)	5,413		11,659,102
Medical Management	2,733,763	2,198,748	367,179	5,299,690	1,158,040	72,035	956,516	152,637	7,638,919
Other Medical Expenses	485,741	333,909	12,025	831,675					831,675
Total Medical Expenses	91,833,059	66,235,346	17,502,521	175,570,927	25,297,831	3,169,916	3,303,897	165,516	207,508,087
Medical Loss Ratio	100.4%	76.6%	88.7%	88.9%	92.7%	83.9%	91.3%	120.4%	89.3%
GROSS MARGIN	**(406,101)**	**20,179,280**	**2,232,517**	**22,005,696**	**1,986,331**	**609,284**	**314,639**	**(28,014)**	**24,887,937**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				9,077,161	750,091	156,005	145,922	78,602	10,207,782
Professional Fees				712,560	9,599	53,608		1,333	777,100
Purchased Services				1,474,528	30,112	34,737	(19,187)		1,520,190
Printing & Postage				331,224	101,590	57,549	96,969		587,332
Depreciation & Amortization				401,204			557		401,761
Other Expenses				1,960,394	2,419	9,870	40,181	5,877	2,018,742
Indirect Cost Allocation, Occupancy				(287,338)	640,809	79,498	12,467	5,252	450,688
Total Administrative Expenses				**13,669,734**	**1,534,620**	**391,267**	**276,908**	**91,065**	**15,963,594**
Admin Loss Ratio				6.9%	5.6%	10.4%	7.7%	66.2%	6.9%
INCOME (LOSS) FROM OPERATIONS				8,335,963	451,711	218,018	37,731	(119,079)	8,924,343
INVESTMENT INCOME									11,856,362
NET RENTAL INCOME									134,979
TOTAL MCO TAX				1,084					1,084
TOTAL GRANT EXPENSE				(15,863,636)					(15,863,636)
OTHER INCOME				15					15
CHANGE IN NET ASSETS				**$ (7,526,574)**	**$ 451,711**	**$ 218,018**	**$ 37,731**	**$ (119,079)**	**$ 5,053,148**
BUDGETED CHANGE IN NET ASSETS				4,943,849	(314,244)	(588,109)	(39,807)	(43,831)	4,548,693
VARIANCE TO BUDGET - FAV (UNFAV)				$ (12,470,423)	$ 765,955	$ 806,127	$ 77,538	$ (75,248)	$ 504,455

Note:* Total membership does not include MSSP

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Five Months Ended November 30, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	2,827,663	1,692,003	59,149	4,578,815	71,774	14,522	2,169	2,368	4,667,280
REVENUES									
Capitation Revenue	748,379,681	$ 610,474,876	$ 115,105,727	$ 1,473,960,285	$ 137,692,835	$ 17,857,113	$ 17,790,555	$ 965,229	$ 1,648,266,017
Total Operating Revenue	748,379,681	610,474,876	115,105,727	1,473,960,285	137,692,835	17,857,113	17,790,555	965,229	1,648,266,017
MEDICAL EXPENSES									
Provider Capitation	158,024,705	208,084,288	47,526,887	413,635,879	55,476,341	4,982,747			474,094,967
Facilities	162,831,508	148,218,594	29,430,368	340,480,470	22,122,510	4,776,343	4,570,938		371,950,261
Professional Claims	110,267,964	71,867,382	7,469,687	189,605,034	7,206,707	738,708	4,622,435		202,172,883
Prescription Drugs	(1,040,011)	(205,891)	5,604	(1,240,298)	32,610,828	5,519,672	1,996,817		38,887,019
MLTSS	206,186,959	22,417,554	10,167,055	238,771,568	8,411,166		821,426	147,974	248,152,133
Incentive Payments	17,706,379	19,030,579	584,992	37,321,950	2,071,899	6,526	27,113		39,427,488
Medical Management	13,612,354	9,620,945	1,827,945	25,061,244	5,162,792	250,707	4,585,605	752,900	35,813,246
Other Medical Expenses	73,502,447	55,422,777	8,270,903	137,196,127					137,196,127
Total Medical Expenses	741,092,304	534,456,228	105,283,442	1,380,831,973	133,062,243	16,274,702	16,624,333	900,874	1,547,694,125
Medical Loss Ratio	99.0%	87.5%	91.5%	93.7%	96.6%	91.1%	93.4%	93.3%	93.9%
GROSS MARGIN	**7,287,377**	**76,018,648**	**9,822,285**	**93,128,311**	**4,630,593**	**1,582,411**	**1,166,222**	**64,356**	**100,571,892**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				45,531,168	3,422,530	659,734	680,881	380,792	50,675,104
Professional Fees				2,866,194	29,250	166,714	1,553	6,667	3,070,378
Purchased Services				5,079,111	421,397	118,746	38,438		5,657,692
Printing & Postage				1,448,184	194,291	267,531	156,549		2,066,555
Depreciation & Amortization				1,849,691			2,750		1,852,441
Other Expenses				8,068,336	6,827	9,870	62,976	29,198	8,177,208
Indirect Cost Allocation, Occupancy				(1,498,512)	3,204,043	397,489	62,332	26,261	2,191,614
Total Administrative Expenses				**63,344,172**	**7,278,338**	**1,620,084**	**1,005,479**	**442,918**	**73,690,991**
Admin Loss Ratio				4.3%	5.3%	9.1%	5.7%	45.9%	4.5%
INCOME (LOSS) FROM OPERATIONS				29,784,139	(2,647,745)	(37,674)	160,743	(378,562)	26,880,901
INVESTMENT INCOME									17,116,307
NET RENTAL INCOME									563,871
TOTAL MCO TAX				24,752					24,752
TOTAL GRANT EXPENSE				(19,318,182)					(19,318,182)
OTHER INCOME				25,893					25,893
CHANGE IN NET ASSETS				**$ 10,516,601**	**$ (2,647,745)**	**$ (37,674)**	**$ 160,743**	**$ (378,562)**	**$ 25,293,540**
BUDGETED CHANGE IN NET ASSETS				20,831,627	(2,117,324)	(2,921,844)	(271,701)	(216,797)	18,258,136
VARIANCE TO BUDGET - FAV (UNFAV)				$ (10,315,026)	$ (530,421)	$ 2,884,170	$ 432,444	$ (161,765)	$ 7,035,404

Note:* Total membership does not include MSSP

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CalOptima Health

November 30, 2022 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $5.1 million, $0.5 million favorable to budget
- Operating surplus is $8.9 million, with a deficit in non-operating income of $3.9 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $25.3 million, $7.0 million favorable to budget
- Operating surplus is $26.9 million, with a deficit in non-operating income of $1.6 million

Change in Net Assets by Line of Business (LOB) ($ millions):

November				July-November		
Actual	Budget	Variance	**Operating Income (Loss)**	Actual	Budget	Variance
8.3	6.3	2.0	Medi-Cal	29.8	26.3	3.5
0.5	(0.3)	0.8	OCC	(2.6)	(2.1)	(0.5)
0.2	(0.6)	0.8	OneCare	(0.0)	(2.9)	2.9
0.0	(0.0)	0.1	PACE	0.2	(0.3)	0.4
(0.1)	(0.0)	(0.1)	MSSP	(0.4)	(0.2)	(0.2)
8.9	**5.3**	**3.6**	**Total Operating Income (Loss)**	**26.9**	**20.8**	**6.1**
			Non-Operating Income (Loss)			
11.9	0.5	11.4	Net Investment Income/Expense	17.1	2.5	14.6
0.1	0.1	0.0	Net Rental Income/Expense	0.6	0.5	0.1
0.0	0.0	0.0	Net Operating Tax	0.0	0.0	0.0
(15.9)	(1.4)	(14.5)	Grant Expense	(19.3)	(5.5)	(13.9)
0.0	0.0	0.0	Net Other Income/Expense	0.0	0.0	0.0
(3.9)	**(0.8)**	**(3.1)**	**Total Non-Operating Income/(Loss)**	**(1.6)**	**(2.5)**	**0.9**
5.1	**4.5**	**0.5**	**TOTAL**	**25.3**	**18.3**	**7.0**

CalOptima Health - Consolidated
Enrollment Summary
For the Five Months Ended November 30, 2022

November					July - November			
		$	%				$	%
Actual	Budget	Variance	Variance	Enrollment (by Aid Category)	Actual	Budget	Variance	Variance
125,831	123,080	2,751	2.2%	SPD	623,038	612,703	10,335	1.7%
304,414	305,616	(1,202)	(0.4%)	TANF Child	1,518,445	1,531,935	(13,490)	(0.9%)
134,842	133,568	1,274	1.0%	TANF Adult	669,955	676,056	(6,101)	(0.9%)
3,275	3,349	(74)	(2.2%)	LTC	16,225	16,653	(428)	(2.6%)
345,846	314,411	31,435	10.0%	MCE	1,692,003	1,585,076	106,927	6.7%
11,745	11,786	(41)	(0.3%)	WCM	59,149	58,757	392	0.7%
925,953	**891,810**	**34,143**	**3.8%**	**Medi-Cal Total**	**4,578,815**	**4,481,180**	**97,635**	**2.2%**
14,197	**14,632**	**(435)**	**(3.0%)**	**OneCare Connect**	**71,774**	**73,282**	**(1,508)**	**(2.1%)**
3,015	**2,673**	**342**	**12.8%**	**OneCare**	**14,522**	**13,248**	**1,274**	**9.6%**
433	**468**	**(35)**	**(7.5%)**	**PACE**	**2,169**	**2,294**	**(125)**	**(5.4%)**
476	**568**	**(92)**	**(16.2%)**	**MSSP**	**2,368**	**2,840**	**(472)**	**(16.6%)**
943,598	**909,583**	**34,015**	**3.7%**	**CalOptima Health Total**	**4,667,280**	**4,570,004**	**97,276**	**2.1%**
				Enrollment (by Network)				
262,635	209,824	52,811	25.2%	HMO	1,108,656	1,055,993	52,663	5.0%
190,691	238,241	(47,550)	(20.0%)	PHC	1,140,914	1,195,957	(55,043)	(4.6%)
228,447	220,789	7,658	3.5%	Shared Risk Group	1,131,774	1,110,974	20,800	1.9%
244,180	222,956	21,224	9.5%	Fee for Service	1,197,471	1,118,256	79,215	7.1%
925,953	**891,810**	**34,143**	**3.8%**	**Medi-Cal Total**	**4,578,815**	**4,481,180**	**97,635**	**2.2%**
14,197	**14,632**	**(435)**	**(3.0%)**	**OneCare Connect**	**71,774**	**73,282**	**(1,508)**	**(2.1%)**
3,015	**2,673**	**342**	**12.8%**	**OneCare**	**14,522**	**13,248**	**1,274**	**9.6%**
433	**468**	**(35)**	**(7.5%)**	**PACE**	**2,169**	**2,294**	**(125)**	**(5.4%)**
476	**568**	**(92)**	**(16.2%)**	**MSSP**	**2,368**	**2,840**	**(472)**	**(16.6%)**
943,598	**909,583**	**34,015**	**3.7%**	**CalOptima Health Total**	**4,667,280**	**4,570,004**	**97,276**	**2.1%**

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CalOptima Health
Enrollment Trend by Network
Fiscal Year 2023

	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	YTD Actual	YTD Budget	Variance
HMOs															
SPD	11,237	11,250	11,290	11,288	14,002								59,067	54,803	4,264
BCCTP													-		0
Disabled													-		0
TANF Child	58,966	58,892	58,837	58,847	69,892								305,434	297,419	8,015
TANF Adult	38,926	38,983	39,331	39,640	48,530								205,410	209,591	(4,181)
LTC	1	2	2	1									6		6
MCE	99,022	99,788	100,301	101,292	127,939								528,342	483,606	44,736
WCM	2,034	2,020	2,021	2,050	2,272								10,397	10,574	(177)
Total	**210,186**	**210,935**	**211,782**	**213,118**	**262,635**								**1,108,656**	**1,055,993**	**52,663**
PHCs															
SPD	7,040	7,022	7,037	7,029	4,408								32,536	34,976	(2,440)
BCCTP													-		0
Disabled													-		0
TANF Child	158,385	158,345	158,767	159,067	148,298								782,862	799,131	(16,269)
TANF Adult	16,704	16,780	16,830	16,855	8,478								75,647	88,589	(12,942)
LTC		1	1	3									5		5
MCE	47,505	47,574	47,748	48,051	22,411								213,289	237,037	(23,748)
WCM	7,366	7,472	7,340	7,301	7,096								36,575	36,224	351
Total	**237,000**	**237,194**	**237,723**	**238,306**	**190,691**								**1,140,914**	**1,195,957**	**(55,043)**
Shared Risk Groups															
SPD	10,824	10,928	10,995	10,954	11,023								54,724	50,965	3,759
BCCTP													-		0
Disabled													-		0
TANF Child	57,419	57,075	56,762	56,460	56,201								283,917	298,311	(14,394)
TANF Adult	40,518	40,260	40,370	40,566	40,961								202,675	204,854	(2,179)
LTC	2	1	3	6	2								14		14
MCE	114,819	115,585	116,539	117,839	118,935								583,717	549,885	33,832
WCM	1,360	1,341	1,332	1,369	1,325								6,727	6,959	(232)
Total	**224,942**	**225,190**	**226,001**	**227,194**	**228,447**								**1,131,774**	**1,110,974**	**20,800**
Fee for Service (Dual)															
SPD	82,253	82,742	82,935	83,572	84,174								415,676	415,815	(139)
BCCTP													-		0
Disabled													-		0
TANF Child	1	1	1	1	1								5		5
TANF Adult	1,675	1,712	1,743	1,742	1,767								8,639	9,183	(544)
LTC	2,894	2,874	2,845	2,879	2,929								14,421	14,990	(569)
MCE	6,480	6,749	7,030	7,314	7,498								35,071	29,574	5,497
WCM	20	18	24	17	16								95	76	19
Total	**93,323**	**94,096**	**94,578**	**95,525**	**96,385**								**473,907**	**469,638**	**4,269**
Fee for Service (Non-Dual - Total)															
SPD	11,984	12,003	16,296	8,528	12,224								61,035	56,144	4,891
BCCTP													-		0
Disabled													-		0
TANF Child	28,613	28,702	29,350	29,540	30,022								146,227	137,074	9,153
TANF Adult	32,830	33,442	37,388	38,818	35,106								177,584	163,839	13,745
LTC	360	364	366	345	344								1,779	1,663	116
MCE	63,450	64,657	66,876	67,538	69,063								331,584	284,974	46,610
WCM	1,096	1,094	1,049	1,080	1,036								5,355	4,924	431
Total	**138,333**	**140,262**	**151,325**	**145,849**	**147,795**								**723,564**	**648,618**	**74,946**
Grand Totals															
SPD	123,338	123,945	128,553	121,371	125,831								623,038	612,703	10,335
BCCTP													-		0
Disabled													-		0
TANF Child	303,384	303,015	303,717	303,915	304,414								1,518,445	1,531,935	(13,490)
TANF Adult	130,653	131,177	135,662	137,621	134,842								669,955	676,056	(6,101)
LTC	3,257	3,242	3,217	3,234	3,275								16,225	16,653	(428)
MCE	331,276	334,353	338,494	342,034	345,846								1,692,003	1,585,076	106,927
WCM	11,876	11,945	11,766	11,817	11,745								59,149	58,757	392
Total MediCal MM	**903,784**	**907,677**	**921,409**	**919,992**	**925,953**								**4,578,815**	**4,481,180**	**97,635**
OneCare Connect	**14,203**	**14,771**	**14,405**	**14,198**	**14,197**								**71,774**	**73,282**	**(1,508)**
OneCare	**2,764**	**2,874**	**2,905**	**2,964**	**3,015**								**14,522**	**13,248**	**1,274**
PACE	**435**	**434**	**437**	**430**	**433**								**2,169**	**2,294**	**(125)**
MSSP	**466**	**470**	**478**	**478**	**476**								**2,368**	**2,840**	**(472)**
Grand Total	**921,186**	**925,756**	**939,156**	**937,584**	**943,598**								**4,667,280**	**4,570,004**	**97,276**

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ENROLLMENT:

Overall, November enrollment was 943,598

- Favorable to budget 34,015 or 3.7%
- Increased 6,014 or 0.6% from Prior Month (PM) (October 2022)
- Increased 99,345 or 11.8% from Prior Year (PY) (November 2021)

Medi-Cal enrollment was 925,953

- Favorable to budget 34,143 or 3.8% as the Department of Health Care Services (DHCS) pauses Medi-Cal redetermination due to the extension of the COVID-19 Public Health Emergency
  - Medi-Cal Expansion (MCE) favorable 31,435
  - Seniors and Persons with Disabilities (SPD) favorable 2,751
  - Temporary Assistance for Needy Families (TANF) favorable 72
  - Long-Term Care (LTC) unfavorable 74
  - Whole Child Model (WCM) unfavorable 41
- Increased 5,961 from PM

OneCare Connect enrollment was 14,197

- Unfavorable to budget 435 or 3.0%
- Decreased 1 from PM

OneCare enrollment was 3,015

- Favorable to budget 342 or 12.8%
- Increased 51 from PM

PACE enrollment was 433

- Unfavorable to budget 35 or 7.5%
- Increased 3 from PM

MSSP enrollment was 476

- Unfavorable to budget 92 or 16.2% due to MSSP currently being understaffed. There is a staff to member ratio that must be met
- Decreased 2 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
925,953	**891,810**	**34,143**	**3.8%**	**Member Months**	**4,578,815**	**4,481,180**	**97,635**	**2.2%**
				Revenues				
197,576,624	295,884,364	(98,307,740)	(33.2%)	Medi-Cal Capitation Revenue	1,473,960,285	1,484,593,111	(10,632,826)	(0.7%)
197,576,624	**295,884,364**	**(98,307,740)**	**(33.2%)**	**Total Operating Revenue**	**1,473,960,285**	**1,484,593,111**	**(10,632,826)**	**(0.7%)**
				Medical Expenses				
14,132,841	105,887,088	91,754,247	86.7%	Provider Capitation	413,635,879	532,439,697	118,803,818	22.3%
59,157,796	66,630,652	7,472,856	11.2%	Facilities Claims	340,480,470	339,201,461	(1,279,009)	(0.4%)
37,642,643	39,635,794	1,993,151	5.0%	Professional Claims	189,605,034	200,206,783	10,601,749	5.3%
46,663,821	49,034,717	2,370,896	4.8%	MLTSS	238,771,568	247,003,398	8,231,830	3.3%
510,484	-	(510,484)	(100.0%)	Prescription Drugs	(1,240,298)	-	1,240,298	100.0%
11,331,978	4,669,234	(6,662,744)	(142.7%)	Incentive Payments	37,321,950	23,433,355	(13,888,595)	(59.3%)
5,299,690	6,795,862	1,496,172	22.0%	Medical Management	25,061,244	33,850,223	8,788,979	26.0%
831,675	1,574,072	742,397	47.2%	Other Medical Expenses	137,196,127	7,870,360	(129,325,767)	(1643.2%)
175,570,927	**274,227,419**	**98,656,492**	**36.0%**	**Total Medical Expenses**	**1,380,831,973**	**1,384,005,277**	**3,173,304**	**0.2%**
22,005,696	**21,656,945**	**348,751**	**1.6%**	**Gross Margin**	**93,128,311**	**100,587,834**	**(7,459,523)**	**(7.4%)**
				Administrative Expenses				
9,077,161	10,055,958	978,797	9.7%	Salaries, Wages & Employee Benefits	45,531,168	49,222,181	3,691,013	7.5%
712,560	924,156	211,596	22.9%	Professional Fees	2,866,194	4,399,418	1,533,224	34.9%
1,474,528	1,377,067	(97,461)	(7.1%)	Purchased Services	5,079,111	5,718,669	639,558	11.2%
331,224	383,940	52,716	13.7%	Printing & Postage	1,448,184	1,919,334	471,150	24.5%
401,204	525,000	123,796	23.6%	Depreciation & Amortization	1,849,691	2,625,000	775,309	29.5%
1,960,394	2,408,999	448,605	18.6%	Other Operating Expenses	8,068,336	12,045,361	3,977,025	33.0%
(287,338)	(325,660)	(38,322)	(11.8%)	Indirect Cost Allocation, Occupancy	(1,498,512)	(1,628,300)	(129,788)	(8.0%)
13,669,734	**15,349,460**	**1,679,726**	**10.9%**	**Total Administrative Expenses**	**63,344,172**	**74,301,663**	**10,957,491**	**14.7%**
				Non-Operating Income (Loss)				
1,084	-	1,084	100.0%	Net Operating Tax	24,752	-	24,752	100.0%
(15,863,636)	(1,363,636)	(14,500,000)	(1063.3%)	Grant Expense	(19,318,182)	(5,454,544)	(13,863,638)	(254.2%)
15	-	15	100.0%	Other Income	25,893	-	25,893	100.0%
(15,862,537)	**(1,363,636)**	**(14,498,901)**	**(1063.3%)**	**Total Non-Operating Income (Loss)**	**(19,267,538)**	**(5,454,544)**	**(13,812,994)**	**(253.2%)**
(7,526,574)	**4,943,849**	**(12,470,423)**	**(252.2%)**	**Change in Net Assets**	**10,516,601**	**20,831,627**	**(10,315,026)**	**(49.5%)**
88.9%	***92.7%***	***(3.8%)***		***Medical Loss Ratio***	***93.7%***	***93.2%***	***0.5%***	
6.9%	***5.2%***	***(1.7%)***		***Admin Loss Ratio***	***4.3%***	***5.0%***	***0.7%***	

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MEDI-CAL INCOME STATEMENT– NOVEMBER MONTH:

REVENUES of $197.6 million are unfavorable to budget $98.3 million driven by:

- Favorable volume related variance of $11.3 million
- Unfavorable price related variance of $109.6 million
  - $92.4 million due to impact to Proposition 56 risk corridor from updated logic
  - $23.7 million due to COVID-19 risk corridor reserves

MEDICAL EXPENSES of $175.6 million are favorable to budget $98.7 million driven by:

- Unfavorable volume related variance of $10.5 million
- Favorable price related variance of $109.2 million
  - Provider Capitation expense favorable variance of $95.8 million primarily due to updated logic for Proposition 56 estimates
  - Facilities Claims expense favorable variance of $10.0 million due to Incurred But Not Reported (IBNR) claims
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $4.2 million due to low utilization
  - Professional Claims expense favorable variance of $3.5 million
  - Medical Management expense favorable variance of $1.8 million
  - Offset by:
    - Incentive Payments expense unfavorable variance of $6.5 million due to higher than estimated payout of Measurement Year 2021 Pay for Value Program

ADMINISTRATIVE EXPENSES of $13.7 million are favorable to budget $1.7 million driven by:

- Salaries & Benefit expense favorable to budget $1.0 million
- Other Non-Salary expense favorable to budget $0.7 million

CHANGE IN NET ASSETS is ($7.5) million, unfavorable to budget $12.5 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Five Months Ending November 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,197	**14,632**	**(435)**	**(3.0%)**	**Member Months**	**71,774**	**73,282**	**(1,508)**	**(2.1%)**
				Revenues				
2,655,651	2,809,110	(153,459)	(5.5%)	Medi-Cal Revenue	13,276,245	14,182,388	(906,143)	(6.4%)
17,880,361	19,454,695	(1,574,334)	(8.1%)	Medicare Part C Revenue	92,046,366	98,230,098	(6,183,732)	(6.3%)
6,748,149	5,507,534	1,240,615	22.5%	Medicare Part D Revenue	32,370,224	27,600,828	4,769,396	17.3%
27,284,162	**27,771,339**	**(487,177)**	**(1.8%)**	**Total Operating Revenue**	**137,692,835**	**140,013,314**	**(2,320,479)**	**(1.7%)**
				Medical Expenses				
10,695,942	11,493,783	797,841	6.9%	Provider Capitation	55,476,341	57,972,160	2,495,819	4.3%
4,491,293	4,030,749	(460,544)	(11.4%)	Facilities Claims	22,122,510	20,523,232	(1,599,278)	(7.8%)
1,444,024	1,178,981	(265,043)	(22.5%)	Ancillary	7,206,707	5,997,959	(1,208,748)	(20.2%)
1,548,564	1,457,046	(91,518)	(6.3%)	MLTSS	8,411,166	7,421,877	(989,289)	(13.3%)
5,624,115	6,238,023	613,908	9.8%	Prescription Drugs	32,610,828	31,717,467	(893,361)	(2.8%)
335,854	563,280	227,426	40.4%	Incentive Payments	2,071,899	2,784,813	712,914	25.6%
1,158,040	1,271,706	113,666	8.9%	Medical Management	5,162,792	6,468,792	1,306,000	20.2%
25,297,831	**26,233,568**	**935,737**	**3.6%**	**Total Medical Expenses**	**133,062,243**	**132,886,300**	**(175,943)**	**(0.1%)**
1,986,331	**1,537,771**	**448,560**	**29.2%**	**Gross Margin**	**4,630,593**	**7,127,014**	**(2,496,421)**	**(35.0%)**
				Administrative Expenses				
750,091	926,568	176,477	19.0%	Salaries, Wages & Employee Benefits	3,422,530	4,611,063	1,188,533	25.8%
9,599	20,833	11,234	53.9%	Professional Fees	29,250	104,165	74,915	71.9%
30,112	109,606	79,494	72.5%	Purchased Services	421,397	548,030	126,633	23.1%
101,590	67,512	(34,078)	(50.5%)	Printing & Postage	194,291	337,560	143,269	42.4%
2,419	6,096	3,677	60.3%	Other Operating Expenses	6,827	30,480	23,653	77.6%
640,809	721,400	80,591	11.2%	Indirect Cost Allocation, Occupancy	3,204,043	3,613,040	408,997	11.3%
1,534,620	**1,852,015**	**317,395**	**17.1%**	**Total Administrative Expenses**	**7,278,338**	**9,244,338**	**1,966,000**	**21.3%**
451,711	**(314,244)**	**765,955**	**243.7%**	**Change in Net Assets**	**(2,647,745)**	**(2,117,324)**	**(530,421)**	**(25.1%)**
92.7%	***94.5%***	***(1.7%)***		***Medical Loss Ratio***	***96.6%***	***94.9%***	***1.7%***	
5.6%	***6.7%***	***1.0%***		***Admin Loss Ratio***	***5.3%***	***6.6%***	***1.3%***	

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ONECARE CONNECT INCOME STATEMENT– NOVEMBER MONTH:

REVENUES of $27.3 million are unfavorable to budget $0.5 million driven by:

- Unfavorable volume related variance of $0.8 million
- Favorable price related variance of $0.3 million

MEDICAL EXPENSES of $25.3 million are favorable to budget $0.9 million driven by:

- Favorable volume related variance of $0.8 million
- Favorable price related variance of $0.2 million
  - Provider Capitation expense favorable variance of $0.5 million
  - Prescription Drugs expense favorable variance of $0.4 million
  - Incentive payments expense favorable variance of $0.2 million
  - Offset by:
    - Facilities Claims expense unfavorable variance of $0.6 million
    - Ancillary expense unfavorable variance of $0.3 million

ADMINISTRATIVE EXPENSES of $1.5 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 $0.1 million

CHANGE IN NET ASSETS is $0.5 million, favorable to budget $0.8 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
3,015	**2,673**	**342**	**12.8%**	**Member Months**	**14,522**	**13,248**	**1,274**	**9.6%**
				Revenues				
2,530,836	2,093,755	437,081	20.9%	Medicare Part C Revenue	12,386,323	10,382,042	2,004,281	19.3%
1,248,364	1,049,520	198,844	18.9%	Medicare Part D Revenue	5,470,790	5,216,707	254,083	4.9%
3,779,200	**3,143,275**	**635,925**	**20.2%**	**Total Operating Revenue**	**17,857,113**	**15,598,749**	**2,258,364**	**14.5%**
				Medical Expenses				
1,029,878	771,013	(258,865)	(33.6%)	Provider Capitation	4,982,747	3,823,102	(1,159,645)	(30.3%)
921,263	1,214,355	293,092	24.1%	Inpatient	4,776,343	6,116,334	1,339,991	21.9%
157,499	93,737	(63,762)	(68.0%)	Ancillary	738,708	473,138	(265,570)	(56.1%)
1,003,384	1,152,242	148,858	12.9%	Prescription Drugs	5,519,672	5,790,245	270,573	4.7%
(14,143)	25,471	39,614	155.5%	Incentive Payments	6,526	126,256	119,730	94.8%
72,035	129,742	57,707	44.5%	Medical Management	250,707	531,661	280,954	52.8%
3,169,916	**3,386,560**	**216,644**	**6.4%**	**Total Medical Expenses**	**16,274,702**	**16,860,736**	**586,034**	**3.5%**
609,284	**(243,285)**	**852,569**	**350.4%**	**Gross Margin**	**1,582,411**	**(1,261,987)**	**2,844,398**	**225.4%**
				Administrative Expenses				
156,005	152,731	(3,274)	(2.1%)	Salaries, Wages & Employee Benefits	659,734	704,192	44,458	6.3%
53,608	24,583	(29,025)	(118.1%)	Professional Fees	166,714	122,915	(43,799)	(35.6%)
34,737	24,068	(10,669)	(44.3%)	Purchased Services	118,746	82,840	(35,906)	(43.3%)
57,549	32,392	(25,157)	(77.7%)	Printing & Postage	267,531	199,460	(68,071)	(34.1%)
9,870	-	(9,870)	(100.0%)	Other Operating Expenses	9,870	-	(9,870)	(100.0%)
79,498	111,050	31,552	28.4%	Indirect Cost Allocation, Occupancy	397,489	550,450	152,961	27.8%
391,267	**344,824**	**(46,443)**	**(13.5%)**	**Total Administrative Expenses**	**1,620,084**	**1,659,857**	**39,773**	**2.4%**
218,018	**(588,109)**	**806,127**	**137.1%**	**Change in Net Assets**	**(37,674)**	**(2,921,844)**	**2,884,170**	**98.7%**
83.9%	***107.7%***	***(23.9%)***		***Medical Loss Ratio***	***91.1%***	***108.1%***	***(17.0%)***	
10.4%	***11.0%***	***0.6%***		***Admin Loss Ratio***	***9.1%***	***10.6%***	***1.6%***	

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CalOptima Health
PACE
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
433	**468**	(35)	(7.5%)	**Member Months**	**2,169**	**2,294**	**(125)**	**(5.4%)**
				Revenues				
2,788,260	2,969,420	(181,160)	(6.1%)	Medi-Cal Capitation Revenue	13,936,205	14,558,196	(621,991)	(4.3%)
626,863	666,731	(39,868)	(6.0%)	Medicare Part C Revenue	2,889,542	3,391,285	(501,743)	(14.8%)
203,413	199,312	4,101	2.1%	Medicare Part D Revenue	964,808	976,266	(11,458)	(1.2%)
3,618,536	**3,835,463**	**(216,927)**	**(5.7%)**	**Total Operating Revenue**	**17,790,555**	**18,925,747**	**(1,135,192)**	**(6.0%)**
				Medical Expenses				
956,516	1,132,716	176,200	15.6%	Medical Management	4,585,605	5,587,407	1,001,802	17.9%
849,757	911,084	61,327	6.7%	Facilities Claims	4,570,938	4,520,171	(50,767)	(1.1%)
656,137	916,101	259,965	28.4%	Professional Claims	3,811,718	4,543,519	731,801	16.1%
360,671	390,737	30,066	7.7%	Prescription Drugs	1,996,817	1,930,251	(66,566)	(3.4%)
221,724	65,766	(155,958)	(237.1%)	MLTSS	821,426	328,775	(492,651)	(149.8%)
253,680	187,270	(66,410)	(35.5%)	Patient Transportation	810,717	935,540	124,823	13.3%
5,413	5,766	354	6.1%	Incentive Payments	27,113	28,825	1,713	5.9%
3,303,897	**3,609,440**	**305,543**	**8.5%**	**Total Medical Expenses**	**16,624,333**	**17,874,488**	**1,250,155**	**7.0%**
314,639	**226,023**	**88,616**	**39.2%**	**Gross Margin**	**1,166,222**	**1,051,259**	**114,963**	**10.9%**
				Administrative Expenses				
145,922	177,744	31,822	17.9%	Salaries, Wages & Employee Benefits	680,881	883,347	202,466	22.9%
-	412	412	100.0%	Professional Fees	1,553	2,061	508	24.6%
(19,187)	43,680	62,867	143.9%	Purchased Services	38,438	218,399	179,961	82.4%
96,969	20,234	(76,735)	(379.2%)	Printing & Postage	156,549	101,171	(55,378)	(54.7%)
557	900	343	38.1%	Depreciation & Amortization	2,750	4,500	1,750	38.9%
40,181	10,073	(30,108)	(298.9%)	Other Operating Expenses	62,976	50,362	(12,614)	(25.0%)
12,467	12,787	320	2.5%	Indirect Cost Allocation, Occupancy	62,332	63,120	788	1.2%
276,908	**265,830**	**(11,078)**	**(4.2%)**	**Total Administrative Expenses**	**1,005,479**	**1,322,960**	**317,481**	**24.0%**
37,731	**(39,807)**	**77,538**	**194.8%**	**Change in Net Assets**	**160,743**	**(271,701)**	**432,444**	**159.2%**
91.3%	***94.1%***	***(2.8%)***		***Medical Loss Ratio***	***93.4%***	***94.4%***	***(1.0%)***	
7.7%	***6.9%***	***(0.7%)***		***Admin Loss Ratio***	***5.7%***	***7.0%***	***1.3%***	

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CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
476	**568**	**(92)**	**(16.2%)**	**Member Months**	**2,368**	**2,840**	**(472)**	**(16.6%)**
				Revenues				
137,503	253,517	(116,014)	(45.8%)	Revenue	965,229	1,267,585	(302,356)	(23.9%)
137,503	**253,517**	**(116,014)**	**(45.8%)**	**Total Operating Revenue**	**965,229**	**1,267,585**	**(302,356)**	**(23.9%)**
				Medical Expenses				
152,637	166,522	13,885	8.3%	Medical Management	752,900	832,610	79,710	9.6%
12,879	32,958	20,079	60.9%	Waiver Services	147,974	164,790	16,816	10.2%
152,637	166,522	13,885	8.3%	Total Medical Management	752,900	832,610	79,710	9.6%
12,879	32,958	20,079	60.9%	Total Waiver Services	147,974	164,790	16,816	10.2%
165,516	**199,480**	**33,964**	**17.0%**	**Total Program Expenses**	**900,874**	**997,400**	**96,526**	**9.7%**
(28,014)	**54,037**	**(82,051)**	**(151.8%)**	**Gross Margin**	**64,356**	**270,185**	**(205,829)**	**(76.2%)**
				Administrative Expenses				
78,602	80,835	2,233	2.8%	Salaries, Wages & Employee Benefits	380,792	401,825	21,033	5.2%
1,333	1,333	(0)	(0.0%)	Professional Fees	6,667	6,665	(2)	(0.0%)
5,877	9,150	3,273	35.8%	Other Operating Expenses	29,198	45,742	16,544	36.2%
5,252	6,550	1,298	19.8%	Indirect Cost Allocation, Occupancy	26,261	32,750	6,489	19.8%
91,065	**97,868**	**6,803**	**7.0%**	**Total Administrative Expenses**	**442,918**	**486,982**	**44,064**	**9.0%**
(119,079)	**(43,831)**	**(75,248)**	**(171.7%)**	**Change in Net Assets**	**(378,562)**	**(216,797)**	**(161,765)**	**(74.6%)**
120.4%	***78.7%***	***41.7%***		***Medical Loss Ratio***	***93.3%***	***78.7%***	***14.6%***	
66.2%	***38.6%***	***(27.6%)***		***Admin Loss Ratio***	***45.9%***	***38.4%***	***(7.5%)***	

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CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Five Months Ending November 30, 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				
41,077	55,650	14,573	26.2%	Purchased Services	202,239	278,250	76,011	27.3%
211,922	224,250	12,328	5.5%	Depreciation & Amortization	1,059,611	1,121,250	61,639	5.5%
20,875	22,500	1,625	7.2%	Insurance Expense	104,375	112,500	8,125	7.2%
131,901	138,755	6,854	4.9%	Repair & Maintenance	620,203	693,775	73,572	10.6%
62,441	48,405	(14,036)	(29.0%)	Other Operating Expenses	361,075	242,025	(119,050)	(49.2%)
(468,218)	(489,560)	(21,342)	(4.4%)	Indirect Cost Allocation, Occupancy	(2,347,503)	(2,447,800)	(100,297)	(4.1%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

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CalOptima Health
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
181,633	172,500	9,133	5.3%	Rental Income	919,418	862,500	56,918	6.6%
181,633	**172,500**	**9,133**	**5.3%**	**Total Operating Revenue**	**919,418**	**862,500**	**56,918**	**6.6%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
12,040	13,333	1,293	9.7%	Purchased Services	58,642	66,665	8,023	12.0%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
-	2,733	2,733	100.0%	Insurance Expense	-	13,665	13,665	100.0%
29,785	25,666	(4,119)	(16.0%)	Repair & Maintenance	160,598	128,330	(32,268)	(25.1%)
4,828	39,933	35,105	87.9%	Other Operating Expenses	136,306	199,665	63,359	31.7%
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
46,653	**81,665**	**35,012**	**42.9%**	**Total Administrative Expenses**	**355,547**	**408,325**	**52,778**	**12.9%**
134,979	**90,835**	**44,144**	**48.6%**	**Change in Net Assets**	**563,871**	**454,175**	**109,696**	**24.2%**

OTHER INCOME STATEMENTS – NOVEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.2 million, favorable to budget $0.8 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $37,731, favorable to budget $77,538

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($119,079), unfavorable to budget $75,248

BUILDING 500 INCOME STATEMENT

CHANGE IN NET ASSETS is $134,979, favorable to budget $44,144

- Net of $181,633 in rental income and $46,653 in expenses for the month of November

INVESTMENT INCOME

- Favorable variance of $11.4 million is due to November's interest income of $6.9 million and decrease in treasury rates, resulting in unrealized gain on investments

CalOptima Health
Balance Sheet
November 30, 2022

ASSETS		**LIABILITIES & NET POSITION**	
Current Assets		Current Liabilities	
Operating Cash	$763,390,896	Accounts Payable	$40,970,703
Short-term Investments	1,281,306,852	Medical Claims Liability	1,535,128,457
Capitation Receivable	396,979,370	Accrued Payroll Liabilities	19,088,706
Receivables - Other	92,739,977	Deferred Revenue	10,241,383
Prepaid Expenses	18,937,042	Deferred Lease Obligations	77,036
		Capitation and Withholds	94,123,554
Total Current Assets	**2,553,354,135**	**Total Current Liabilities**	**1,699,629,839**
Capital Assets			
Furniture & Equipment	49,240,969		
Building/Leasehold Improvements	5,059,408		
Construction in Progress	5,640,640		
505 City Parkway West	52,782,700		
500 City Parkway West	22,631,500		
	135,355,217		
Less: Accumulated Depreciation	(67,271,094)	Other Liabilities	
Capital Assets, Net	68,084,123	GASB 96 Subscription Liabilities	-
GASB 96 Capital Assets		Other (than pensions) Post	
GASB 96 Subscription Assets	-	Employment Benefits Liability	22,363,628
		Net Pension Liabilities	577,854
Less: GASB 96 Accumulated Depreciation	-	Bldg. 505 Development Rights	-
GASB 96 Capital Assets, Net	-		
Total Capital Assets	68,084,123		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,722,571,321**
Homeless Health Reserve	536,739		
Board-Designated Assets:			
Cash and Cash Equivalents	3,027,557		
Investments	564,194,986	Deferred Inflows	
Total Board-Designated Assets	567,222,543	Excess Earnings	686,563
		OPEB 75 Difference in Experience	4,822,000
		Change in Assumptions	1,909,305
Total Other Assets	568,059,282	OPEB Changes in Assumptions	3,389,000
		Diff in Proj vs Act	20,982,636
		Net Position	
TOTAL ASSETS	**3,189,497,540**	TNE	100,875,159
		Funds in Excess of TNE	1,343,887,149
Deferred Outflows		**TOTAL NET POSITION**	1,444,762,308
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	**3,199,123,133**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,199,123,133**

CalOptima Health
Board Designated Reserve and TNE Analysis
as of November 30, 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	231,025,758				
	Tier 1 - MetLife	229,388,360				
Board-designated Reserve		460,414,119	333,129,389	519,131,338	127,284,729	(58,717,220)
	Tier 2 - Payden & Rygel	53,587,997				
	Tier 2 - MetLife	53,220,427				
TNE Requirement		106,808,424	100,875,159	100,875,159	5,933,265	5,933,265
	Consolidated:	**567,222,543**	**434,004,548**	**620,006,497**	**133,217,994**	**(52,783,955)**
	Current reserve level	*1.83*	*1.40*	*2.00*		

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CalOptima Health
Statement of Cash Flows
November 30, 2022

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	5,053,148	25,293,540
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	613,684	2,912,053
Changes in assets and liabilities:		
Prepaid expenses and other	1,510,381	3,655,213
Catastrophic reserves		
Capitation receivable	(15,661,769)	(12,854,761)
Medical claims liability	130,214,682	257,113,108
Deferred revenue	3,847,987	2,137,338
Payable to health networks	(108,072,114)	(99,091,075)
Accounts payable	16,039,752	(11,346,185)
Accrued payroll	884,152	(293,205)
Other accrued liabilities	(3,042)	(15,136)
Net cash provided by/(used in) operating activities	34,426,862	167,510,891
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	(25,751,661)	(266,846,349)
Change in Property and Equipment	(768,789)	(4,132,140)
Change in Restricted Deposit & Other	-	51
Change in Board designated reserves	(4,498,015)	3,269,098
Change in Homeless Health Reserve	40,100,000	40,100,000
Net cash provided by/(used in) investing activities	9,081,535	(227,609,340)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	43,508,397	(60,098,449)
CASH AND CASH EQUIVALENTS, beginning of period	$719,882,499	823,489,344
CASH AND CASH EQUIVALENTS, end of period	**763,390,896**	**763,390,896**

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BALANCE SHEET – NOVEMBER MONTH:

ASSETS of $3.2 billion increased $48.0 million from October or 1.5%

- Operating Cash and Short-term Investments net increase of $69.3 million due to prepayment from the Centers for Medicare & Medicaid Services (CMS) and timing of premium tax payments
- Receivables – Other increased $10.6 million due to timing of cash receipt
- Board-designated Assets increased $4.5 million
- Offset by:
  - Homeless Health Reserve decrease of $40.1 million due to Housing and Homelessness Incentive Program (HHIP) initiatives

LIABILITIES of $1.7 billion increased $42.9 million from October or 2.6%

- Claims Liabilities increased $130.2 million due to Proposition 56 risk corridor estimates, COVID-19 risk corridor estimates, and timing of claim payments
- Accounts Payable increased $16.0 million due to the timing of capitation premium tax payments
- Offset by:
  - Capitation and Withhold decrease of $108.1 million due to updated Proposition 56 logic

NET ASSETS of $1.4 billion, increased $5.1 million from October or 0.4%

CalOptima Health - Consolidated
Net Assets Analysis
For the Five Months Ended November 30, 2022

Category	Item Description	Amount (millions)	Spend to Date	%
	Total Net Position @ 11/30/2022:	**$1,444.8**		**100.0%**
Resources Assigned	Board Designated Reserve*	**567.2**		**39.3%**
	Capital Assets, net of depreciation	**68.1**		**4.7%**
Resources Allocated	Homeless Health Initiative**	$100.0	$35.6	6.9%
	Intergovernmental Transfers (IGT)	111.7	48.0	7.7%
	Mind OC Grant	1.0	1.0	0.1%
	CalFresh Outreach Strategy	2.0	0.9	0.1%
	Digital Transformation and Workplace Modernization	100.0	3.3	6.9%
	Coalition of Orange County Community Health Centers Grant	50.0	10.0	3.5%
	Subtotal:	**$364.7**	**$98.7**	**25.2%**
Resources Available for New Initiatives:	Unallocated/Unassigned*	**$444.7**		**30.8%**

*Total of Board Designated reserve and unallocated reserve amount can support approximately 104 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 November 2022

	Item Name	Month-to-Date (November 2022)					FY 2023 Year-to-Date (November 2022)				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	*Member Months*	943,598	909,583	34,015	3.7%		4,667,280	4,570,004	97,276	2.1%	
	*Operating Revenue **	232,396,025	330,887,958	(98,491,934)	(29.8%)		1,648,266,017	1,660,398,506	(12,132,489)	(0.7%)	
	*Medical Expenses **	207,508,087	307,656,467	100,148,380	32.6%		1,547,694,125	1,552,624,201	4,930,076	0.3%	
	General and Administrative Expense	15,963,594	17,909,997	1,946,403	10.9%		73,690,991	87,015,800	13,324,809	15.3%	
	Non-Operating Income/(Loss)	(3,871,195)	(772,801)	(3,098,394)	(400.9%)		(1,587,360)	(2,500,369)	913,009	36.5%	
	Summary of Income & Expenses	5,053,148	4,548,693	504,455	11.1%		25,293,540	18,258,136	7,035,404	38.5%	
Ratios	**Medical Loss Ratio (MLR)**	**Actual**	**Budget**	**Variance**			**Actual**	**Budget**	**Variance**		
	Consolidated	89.3%	93.0%	(3.7%)			93.9%	93.5%	0.4%		
	Administrative Loss Ratio (ALR)	**Actual**	**Budget**	**Variance**			**Actual**	**Budget**	**Variance**		
	Consolidated	6.9%	5.4%	(1.5%)			4.5%	5.2%	0.8%		

Key:

> 0%	
> -20%, < 0%	
< -20%	

	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
Investment	*@11/30/2022*	1,837,514,383	1,801,280,677	36,233,705	2.0%

Unallocated/Unassigned Reserve Balance	Current Month @ November 2022	Fiscal Year Ending June 2022	Change	%
Consolidated	444,729,540	448,294,548	(3,565,008)	(0.8%)
*Days Cash On Hand***	104			

*$135M of Directed Payments (DP) are included in YTD revenue and $133M of DP are included in YTD expenses.
**Total of Board Designated reserve and unallocated reserve amount can support approximatley 104 days of CalOptima Health's current operations.

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Five Months Ending November 30, 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	**792,204**	**660,000**	**(132,204)**	**-20.0%**	**2,734,333**	**28,768,000**	**26,033,667**	**90.5%**
Operating Expenses:								
Salaries, Wages & Benefits	143,122	471,080	327,958	69.6%	362,056	1,680,652	1,318,596	78.5%
Professional Fees	-	186,041	186,041	100.0%	-	930,205	930,205	100.0%
Purchased Services	-	13,333	13,333	100.0%	-	66,665	66,665	100.0%
Depreciation Expenses	-	-	-	0.0%	-	-	-	0.0%
Other Expenses	66,576	274,365	207,789	75.7%	176,828	1,371,825	1,194,997	87.1%
Total Operating Expenses	**209,697**	**944,819**	**735,122**	**77.8%**	**538,884**	**4,049,347**	**3,510,463**	**86.7%**

Funding Balance Tracking:	**Actual Spend**	**Approved Budget**
Beginning Funding Balance	100,000,000	100,000,000
Less:		
FY2022-23	3,273,217	47,323,113
FY2023-24		
FY2024-25		
Ending Funding Balance	**96,726,783**	**52,676,887**

Summary of Homeless Health Initiatives (HHI) and Allocated Funds

As of November 2022

Program Commitment	**$100,000,000**
Funds Allocation, approved initiatives	**$99,463,261**
***Program Commitment Balance, available for new initiatives**	**$536,739**

Funds Allocation, approved initiatives:	**Allocated Amount**	**Utilized Amount**	**Remaining Approved Amount**
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	8,250,000	6,194,190	2,055,810
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	6,000,000	1,651,203	4,348,797
Homeless Coordination at Hospitals	10,000,000	8,611,208	1,388,792
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,693,261	667,719	1,025,542
FQHC (Community Health Center) Expansion and HHI Support	570,000	21,902	548,098
HCAP Expansion for Telehealth and CFT On Call Days	1,700,000	2,612,800	(912,800)
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
Street Medicine	8,000,000	-	8,000,000
Outreach and Engagement	7,000,000	-	7,000,000
Office of Care Coordination - Housing and Homelessness Incentive Program (HHIP)	2,200,000	-	2,200,000
Pulse For Good (HHIP)	800,000	-	800,000
Consultant (HHIP)	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations (HHIP)	5,000,000	-	5,000,000
Infrastructure Projects (HHIP)	10,500,000	-	10,500,000
Capital Projects (HHIP)	21,000,000	-	21,000,000
Funds Total	**$99,463,261**	**$35,563,670**	**$63,899,591**

Budget Allocation Changes
Reporting Changes for November 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 Purchased Services – Health Reward Incentive Fulfillment to Incentive Budget for PHM Health Rewards.	2022-23
September	No budget reallocations for September					2022-23
October	Medi-Cal	Quality Improvements - Professional Fees - Consultants for NCQA Accreditation	Quality Improvements - Subscriptions - CAQH Application Subscription - Credentialing Database	$75,000	To reallocate funds from Professional Fees – Consultants for NCQA Accreditation to Subscriptions – CAQH Application Subscription – Credentialing Database to provide additional funding for expanding scope of services.	2022-23
November	OneCare	Customer Service - Member Communication	Cultural & Linguistic Services - Purchased Services	$75,000	To reallocate funds from OC Customer Service – Member Communication to OC Cultural & Linguistic Services – Purchased Services to provide additional funding for translation of documents due to OCC/OC transition.	2022-23
November	Medi-Cal	Human Resources - Cert/Cont. Education	Human Resources - Training & Seminars	$10,000	To reallocate funds from HR Onsite Computer Classes to Training & Seminars, HR Staff Development (for the CPS Academy classes)	2022-23
November	Medi-Cal	Population Health Management - Professional Fees	Case management - Training & Seminars	$27,000	To reallocate funds from Population Health Management – Purchased Services to Case Management – Training & Seminars to provide funding for WPATH training.	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.

Financial Summary

December 31, 2022

Board of Directors Meeting
February 2, 2023

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

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

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Financial Highlights: December 2022

December					July - December			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
944,975	905,500	39,475	4.4%	Member Months	5,612,255	5,475,504	136,751	2.5%
329,355,510	352,179,156	(22,823,646)	(6.5%)	Revenues	1,977,621,527	2,012,577,662	(34,956,135)	(1.7%)
298,197,638	334,994,845	36,797,207	11.0%	Medical Expenses	1,845,891,763	1,887,619,046	41,727,283	2.2%
14,629,091	18,061,579	3,432,488	19.0%	Administrative Expenses	88,320,082	105,075,379	16,755,297	15.9%
16,528,781	**(877,268)**	**17,406,049**	**1984.1%**	**Operating Margin**	**43,409,682**	**19,883,237**	**23,526,445**	**118.3%**
				Non-Operating Income (Loss)				
9,695,109	500,000	9,195,109	1839.0%	Net Investment Income/Expense	26,811,416	3,000,000	23,811,416	793.7%
114,649	90,835	23,814	26.2%	Net Rental Income/Expense	678,519	545,010	133,509	24.5%
(1,619)	-	(1,619)	(100.0%)	Net MCO Tax	23,133	-	23,133	100.0%
(863,636)	(2,077,922)	1,214,286	58.4%	Grant Expense	(20,181,818)	(7,532,466)	(12,649,352)	(167.9%)
-	-	-	0.0%	Net QAF/IGT Income/Expense	-	-	-	0.0%
15	-	15	100.0%	Other Income/Expense	25,908	-	25,908	100.0%
8,944,518	**(1,487,087)**	**10,431,605**	**701.5%**	**Total Non-Operating Income (Loss)**	**7,357,157**	**(3,987,456)**	**11,344,613**	**284.5%**
25,473,299	**(2,364,355)**	**27,837,654**	**1177.4%**	**Change in Net Assets**	**50,766,839**	**15,895,781**	**34,871,058**	**219.4%**
90.5%	95.1%	(4.6%)		Medical Loss Ratio	93.3%	93.8%	(0.5%)	
4.4%	5.1%	0.7%		Administrative Loss Ratio	4.5%	5.2%	0.8%	
5.0%	(0.2%)	5.3%		Operating Margin Ratio	2.2%	1.0%	1.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
90.5%	95.1%	(4.6%)		*MLR (excluding Directed Payments)	93.0%	93.8%	(0.8%)	
4.4%	5.1%	0.7%		*ALR (excluding Directed Payments)	4.8%	5.2%	0.4%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima Health

Consolidated Performance: December 2022 (in millions)

December				July-December		
Actual	Budget	Variance	**Operating Income (Loss)**	Actual	Budget	Variance
15.5	0.9	14.7	Medi-Cal	45.3	27.1	18.2
1.4	(0.8)	2.2	OCC	(1.3)	(2.9)	1.7
(0.4)	(0.8)	0.3	OneCare	(0.5)	(3.7)	3.2
0.1	(0.1)	0.2	PACE	0.3	(0.4)	0.7
(0.1)	(0.0)	(0.0)	MSSP	(0.4)	(0.3)	(0.2)
16.5	**(0.9)**	**17.4**	**Total Operating Income (Loss)**	**43.4**	**19.9**	**23.5**
			Non-Operating Income (Loss)			
9.7	0.5	9.2	Net Investment Income/Expense	26.8	3.0	23.8
0.1	0.1	0.0	Net Rental Income/Expense	0.7	0.5	0.1
(0.0)	0.0	(0.0)	Net Operating Tax	0.0	0.0	0.0
(0.9)	(2.1)	1.2	Grant Expense	(20.2)	(7.5)	(12.6)
0.0	0.0	0.0	Net Other Income/Expense	0.0	0.0	0.0
8.9	**(1.5)**	**10.4**	**Total Non-Operating Income/(Loss)**	**7.4**	**(4.0)**	**11.3**
25.5	**(2.4)**	**27.8**	**TOTAL**	**50.8**	**15.9**	**34.9**

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CalOptima Health

FY 2022-23: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) December 2022: $25.5 million, favorable to budget $27.8 million or 1,177.4%
  - Year To Date (YTD) July – December 2022: $50.8 million, favorable to budget $34.9 million or 219.4%
- Enrollment
  - MTD: 944,975 members, favorable to budget 39,475 or 4.4%
  - YTD: 5,612,255 members, favorable to budget 136,751 or 2.5%
  - Favorable enrollment primarily driven by a pause in Medi-Cal redetermination due to the extension of the COVID-19 Public Health Emergency
  - Effective January 1, 2023, OneCare Connect members will transition to One Care

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Revenue
  - MTD: $329.4 million, unfavorable to budget $22.8 million or 6.5% driven by Medi-Cal Line of Business (MC LOB):
    - $53.1 million due to COVID-19, Proposition 56, and Enhanced Care Management (ECM) risk corridor reserves, and CalAIM Incentive Payment Program (IPP) forecasted funds
    - Offset by $14.1 million of favorable volume related variance
  - YTD: $1,977.6 million, unfavorable to budget $35.0 million or 1.7% driven by MC LOB:
    - $233.6 million due to COVID-19 and ECM risk corridor reserves, and Proposition 56 logic update
    - Offset by $135.2 million of Fiscal Year (FY) 2021 hospital Directed Payments (DP) and $50.8 million due to favorable volume related variance and prior year retroactive eligibility changes

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - MTD: $298.2 million, favorable to budget $36.8 million or 11.0% driven by MC LOB:
    - Other Medical expenses favorable variance of $21.8 million due to CalAIM IPP forecasted funds
    - Managed Long-Term Services and Supports (MLTSS) and Professional Claims expense favorable variance of $16.7 million due to low utilization, Incurred But Not Reported (IBNR) claims and CalAIM community support estimates
    - Net favorable variance of $7.0 million from Provider Capitation, Facilities Claims, Prescription Drugs, Medical Management and Incentive Payments expenses

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FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - YTD: $1,845.9 million, favorable to budget $41.7 million or 2.2% driven by MC LOB:
    - Provider Capitation favorable variance of $117.8 million primarily due to updated logic for Proposition 56
    - Net favorable variance of $51.3 million from Facilities, Professional, MLTSS, Prescription Drugs related claims and Medical Management expenses
    - Offset by $120.4 million from Incentive Payments and Other Medical Expenses due to FY 2021 hospital DP

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FY 2022-23:Management Summary (cont.)

- Administrative Expenses
  - MTD: $14.6 million, favorable to budget $3.4 million or 19.0%
    - Other Non-Salary expenses favorable variance of $1.9 million
    - Salaries & Benefits expense favorable variance of $1.5 million
  - YTD: $88.3 million, favorable to budget $16.8 million or 15.9%
    - Other Non-Salary expenses favorable variance of $10.1 million
    - Salaries & Benefits expense favorable variance of $6.7 million

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: $8.9 million, favorable to budget $10.4 million or 701.5%
    - Non-operating gain is primarily due to December's interest income of $7.3 million and $2.1 million of unrealized gains due to an increased investment in short-term securities with higher yields
  - YTD: $7.4 million, favorable to budget $11.3 million or 284.5%

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CalOptima Health

FY 2022-23: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 90.5% (90.5% excluding DP), Budget 95.1%
  - YTD: Actual 93.3% (93.0% excluding DP), Budget 93.8%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 4.4% (4.4% excluding DP), Budget 5.1%
  - YTD: Actual 4.5% (4.8% excluding DP), Budget 5.2%
- Balance Sheet Ratios
  - *Current ratio: 1.5
  - Board-designated reserve level: 1.85
  - Net-position: $1.5 billion, including required Tangible Net Equity (TNE) of $99.1 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: December 2022

December					July - December			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
125,776	123,352	2,424	2.0%	SPD	748,814	736,055	12,759	1.7%
302,954	305,024	(2,070)	(0.7%)	TANF Child	1,821,399	1,836,959	(15,560)	(0.8%)
135,705	132,242	3,463	2.6%	TANF Adult	805,660	808,298	(2,638)	(0.3%)
3,263	3,357	(94)	(2.8%)	LTC	19,488	20,010	(522)	(2.6%)
347,588	311,964	35,624	11.4%	MCE	2,039,591	1,897,040	142,551	7.5%
11,800	11,804	(4)	(0.0%)	WCM	70,949	70,561	388	0.5%
927,086	**887,743**	**39,343**	**4.4%**	**Medi-Cal Total**	**5,505,901**	**5,368,923**	**136,978**	**2.6%**
14,385	**14,605**	**(220)**	**(1.5%)**	**OneCare Connect**	**86,159**	**87,887**	**(1,728)**	**(2.0%)**
3,067	**2,679**	**388**	**14.5%**	**OneCare**	**17,589**	**15,927**	**1,662**	**10.4%**
437	**473**	**(36)**	**(7.6%)**	**PACE**	**2,606**	**2,767**	**(161)**	**(5.8%)**
471	**568**	**(97)**	**(17.1%)**	**MSSP**	**2,839**	**3,408**	**(569)**	**(16.7%)**
944,975	**905,500**	**39,475**	**4.4%**	**CalOptima Total**	**5,612,255**	**5,475,504**	**136,751**	**2.5%**

*CalOptima Health Total does not include MSSP

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CalOptima Health

Consolidated Revenue & Expenses: December 2022 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	567,698	347,588	11,800	927,086	14,385	3,067	437	471	944,975
REVENUES									
Capitation Revenue	142,795,616	$ 118,459,792	$ 20,920,810	$ 282,176,218	$ 38,742,037	$ 4,537,917	$ 3,689,851	$ 209,486	$ 329,355,510
Total Operating Revenue	142,795,616	118,459,792	20,920,810	282,176,218	38,742,037	4,537,917	3,689,851	209,486	329,355,510
MEDICAL EXPENSES									
Provider Capitation	46,989,059	52,102,776	7,262,855	106,354,690	16,460,116	1,322,525			124,137,330
Facilities	31,302,735	27,808,096	5,488,723	64,599,553	5,334,814	1,133,528	712,530		71,780,426
Professional Claims	19,758,559	11,511,013	1,320,032	32,589,604	1,432,479	136,873	865,004		35,023,960
Prescription Drugs	(778,113)	(1,700,867)		(2,478,980)	8,401,421	1,589,000	456,809		7,968,251
MLTSS	35,608,054	4,121,770	2,327,932	42,057,755	1,543,986		218,479	30,435	43,850,655
Incentive Payments	1,443,031	2,158,107	36,861	3,637,999	458,457	156,198	5,463		4,258,117
Medical Management	3,216,861	2,243,675	879,912	6,340,447	1,160,002	75,071	1,131,251	154,395	8,861,166
Other Medical Expenses	1,400,885	880,490	36,358	2,317,732					2,317,732
Total Medical Expenses	138,941,070	99,125,058	17,352,672	255,418,801	34,791,276	4,413,195	3,389,536	184,830	298,197,638
Medical Loss Ratio	97.3%	83.7%	82.9%	90.5%	89.8%	97.3%	91.9%	88.2%	90.5%
GROSS MARGIN	**3,854,546**	**19,334,734**	**3,568,138**	**26,757,418**	**3,950,762**	**124,722**	**300,315**	**24,656**	**31,157,872**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				8,985,758	699,087	127,991	128,678	70,116	10,011,630
Professional Fees				394,019	(4,741)		175	1,333	390,786
Purchased Services				1,234,768	78,392	79,369	32,930		1,425,459
Printing & Postage				243,246	61,409	117,783	18,202		440,640
Depreciation & Amortization				375,719			764		376,483
Other Expenses				1,655,728	1,953	(4,500)	3,680	5,842	1,662,703
Indirect Cost Allocation, Occupancy				(1,660,733)	1,725,789	228,258	21,513	6,562	321,389
Total Administrative Expenses				**11,228,505**	**2,561,887**	**548,902**	**205,943**	**83,853**	**14,629,091**
Admin Loss Ratio				4.0%	6.6%	12.1%	5.6%	40.0%	4.4%
INCOME (LOSS) FROM OPERATIONS				15,528,912	1,388,875	(424,180)	94,372	(59,197)	16,528,781
INVESTMENT INCOME									9,695,109
NET RENTAL INCOME									114,649
TOTAL MCO TAX				(1,619)					(1,619)
TOTAL GRANT EXPENSE				(863,636)					(863,636)
OTHER INCOME				15					15
CHANGE IN NET ASSETS				**$ 14,663,672**	**$ 1,388,875**	**$ (424,180)**	**$ 94,372**	**$ (59,197)**	**$ 25,473,299**
BUDGETED CHANGE IN NET ASSETS				(1,218,395)	(811,039)	(751,975)	(130,176)	(43,605)	(2,364,355)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 15,882,067	$ 2,199,914	$ 327,795	$ 224,548	$ (15,592)	$ 27,837,654

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CalOptima Health

Consolidated Revenue & Expenses: December 2022 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	3,395,361	2,039,591	70,949	5,505,901	86,159	17,589	2,606	2,839	5,612,255
REVENUES									
Capitation Revenue	891,175,297	$ 728,934,668	$ 136,026,537	$ 1,756,136,503	$ 176,434,873	$ 22,395,030	$ 21,480,406	$ 1,174,715	$ 1,977,621,527
Total Operating Revenue	891,175,297	728,934,668	136,026,537	1,756,136,503	176,434,873	22,395,030	21,480,406	1,174,715	1,977,621,527
MEDICAL EXPENSES									
Provider Capitation	205,013,763	260,187,064	54,789,742	519,990,569	71,936,457	6,305,271			598,232,297
Facilities	194,134,242	176,026,690	34,919,091	405,080,023	27,457,324	5,909,871	5,283,468		443,730,687
Professional Claims	130,026,523	83,378,396	8,789,719	222,194,638	8,639,186	875,581	5,487,439		237,196,844
Prescription Drugs	(1,818,124)	(1,906,758)	5,604	(3,719,278)	41,012,249	7,108,672	2,453,627		46,855,270
MLTSS	241,795,013	26,539,323	12,494,987	280,829,323	9,955,152		1,039,905	178,409	292,002,788
Incentive Payments	19,149,411	21,188,685	621,853	40,959,949	2,530,356	162,725	32,575		43,685,605
Medical Management	16,829,214	11,864,620	2,707,857	31,401,691	6,322,794	325,778	5,716,855	907,295	44,674,413
Other Medical Expenses	74,903,332	56,303,267	8,307,261	139,513,859					139,513,859
Total Medical Expenses	880,033,374	633,581,286	122,636,114	1,636,250,774	167,853,518	20,687,898	20,013,869	1,085,703	1,845,891,763
Medical Loss Ratio	98.7%	86.9%	90.2%	93.2%	95.1%	92.4%	93.2%	92.4%	93.3%
GROSS MARGIN	**11,141,923**	**95,353,382**	**13,390,424**	**119,885,729**	**8,581,354**	**1,707,133**	**1,466,536**	**89,012**	**131,729,764**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				54,516,926	4,121,616	787,725	809,559	450,907	60,686,734
Professional Fees				3,260,213	24,509	166,714	1,728	8,000	3,461,164
Purchased Services				6,313,879	499,789	198,116	71,368		7,083,151
Printing & Postage				1,691,430	255,699	385,314	174,752		2,507,195
Depreciation & Amortization				2,225,410			3,515		2,228,924
Other Expenses				9,724,065	8,779	5,370	66,656	35,041	9,839,911
Indirect Cost Allocation, Occupancy				(3,159,245)	4,929,832	625,748	83,844	32,823	2,513,003
Total Administrative Expenses				**74,572,678**	**9,840,225**	**2,168,987**	**1,211,422**	**526,771**	**88,320,082**
Admin Loss Ratio				4.2%	5.6%	9.7%	5.6%	44.8%	4.5%
INCOME (LOSS) FROM OPERATIONS				45,313,051	(1,258,870)	(461,854)	255,114	(437,759)	43,409,682
INVESTMENT INCOME									26,811,416
NET RENTAL INCOME									678,519
TOTAL MCO TAX				23,133					23,133
TOTAL GRANT EXPENSE				(20,181,818)					(20,181,818)
OTHER INCOME				25,908					25,908
CHANGE IN NET ASSETS				**$ 25,180,273**	**$ (1,258,870)**	**$ (461,854)**	**$ 255,114**	**$ (437,759)**	**$ 50,766,839**
BUDGETED CHANGE IN NET ASSETS				19,615,232	(2,928,363)	(3,673,819)	(401,877)	(260,402)	15,895,781
VARIANCE TO BUDGET - FAV (UNFAV)				$ 5,565,041	$ 1,669,493	$ 3,211,965	$ 656,991	$ (177,357)	$ 34,871,058

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Balance Sheet: As of December 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$788,691,172	Accounts Payable	$55,593,351
Short-term Investments	1,321,795,687	Medical Claims Liability	1,573,242,628
Capitation Receivable	406,195,152	Accrued Payroll Liabilities	13,689,505
Receivables - Other	88,777,921	Deferred Revenue	10,257,983
Prepaid Expenses	19,800,203	Deferred Lease Obligations	73,994
		Capitation and Withholds	93,917,479
Total Current Assets	**2,625,260,134**	**Total Current Liabilities**	**1,746,774,940**
Capital Assets			
Furniture & Equipment	50,187,075		
Building/Leasehold Improvements	5,059,408		
Construction in Progress	4,547,213		
505 City Parkway West	52,951,401		
500 City Parkway West	22,631,500		
	135,376,597		
Less: Accumulated Depreciation	(67,864,515)	**Other Liabilities**	
Capital Assets, Net	67,512,081	GASB 96 Subscription Liabilities	-
GASB 96 Capital Assets		**Other (than pensions) Post**	
GASB 96 Subscription Assets	-	Employment Benefits Liability	22,425,370
		Net Pension Liabilities	577,854
Less: GASB 96 Accumulated Depreciation	-	Bldg. 505 Development Rights	-
GASB 96 Capital Assets, Net	-		
Total Capital Assets	67,512,081		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,769,778,164**
Homeless Health Reserve	536,739		
Board-Designated Assets:			
Cash and Cash Equivalents	1,554,383		
Investments	567,014,344	**Deferred Inflows**	
Total Board-Designated Assets	568,568,727	Excess Earnings	686,563
		OPEB 75 Difference in Experience	4,822,000
		Change in Assumptions	1,909,305
Total Other Assets	569,405,466	OPEB Changes in Assumptions	3,389,000
		Diff in Proj vs Act	20,982,636
		Net Position	
TOTAL ASSETS	**3,262,177,682**	TNE	99,063,353
		Funds in Excess of TNE	1,371,172,253
Deferred Outflows		**TOTAL NET POSITION**	1,470,235,607
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	**3,271,803,275**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,271,803,275**

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CalOptima Health

Board Designated Reserve and TNE Analysis: As of December 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	231,827,848				
	Tier 1 - MetLife	229,782,741				
Board-designated Reserve		461,610,588	332,306,104	517,178,728	129,304,485	(55,568,140)
	Tier 2 - Payden & Rygel	53,688,188				
	Tier 2 - MetLife	53,269,951				
TNE Requirement		106,958,138	99,063,353	99,063,353	7,894,785	7,894,785
	Consolidated:	**568,568,727**	**431,369,457**	**616,242,081**	**137,199,270**	**(47,673,355)**
	Current reserve level	*1.85*	*1.40*	*2.00*		

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CalOptima Health

Net Assets Analysis: As of December 2022

Category	Item Description	Amount (millions)	Approved Initiative	Spend to Date	%
	Total Net Position @ 12/31/2022	**$1,470.2**			**100.0%**
Resources Assigned	Board Designated Reserve*	**568.6**			**38.7%**
	Capital Assets, net of depreciation	**67.5**			**4.6%**
Resources Allocated	Homeless Health Initiative**	$64.1	$100.0	$35.9	4.4%
	Intergovernmental Transfers (IGT)	63.7	111.7	48.0	4.3%
	OneCare Member Health Rewards and Incentives	1.0	1.0	0.0	0.1%
	Five-Year Hospital Quality Program Beginning Measurement Year (MY) 2023	153.5	153.5	0.0	10.4%
	Medi-Cal Annual Wellness Initiative	15.0	15.0	0.0	1.0%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.7%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	5.0	5.0	0.0	0.3%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	CalFresh Outreach Strategy	1.3	2.0	0.7	0.1%
	Digital Transformation and Workplace Modernization	96.2	100.0	3.8	6.5%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	Coalition of Orange County Community Health Centers Grant	40.0	50.0	10.0	2.7%
	Subtotal:	**$451.8**	**$566.2**	**$114.4**	**30.7%**
Resources Available for New Initiatives	Unallocated/Unassigned*	**$382.4**			**26.0%**

*Total of Board-designated reserve and unallocated reserve amount can support approximately 97 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 December 2022

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	8,250,000	6,194,190	2,055,810
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	6,000,000	1,681,734	4,318,266
Homeless Coordination at Hospitals	10,000,000	8,611,208	1,388,792
Homeless Clinical Access Program (HCAP) and CalOptima Days	2,700,000	2,891,200	(191,200)
FQHC (Community Health Center) Expansion	300,000	21,902	278,098
Cal Optima Days, HCAP and FQHC Administrative Support	963,261	678,278	284,983
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
Street Medicine	8,000,000	-	8,000,000
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP): 40.1 million			
Office of Care Coordination	2,200,000	-	2,200,000
Pulse For Good	800,000	-	800,000
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	5,000,000	-	5,000,000
Infrastructure Projects	10,500,000	-	10,500,000
Capital Projects	21,000,000	-	21,000,000
Subtotal of Approved Initiatives	**$99,463,261**	**$35,883,160**	**$63,580,101**
Program Commitment Balance, available for new Initiatives	536,739		536,739
Program Total	**$100,000,000**	**$35,883,160**	**$64,116,840**

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UNAUDITED FINANCIAL STATEMENTS

December 31, 2022

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CalOptima Health - Consolidated
Financial Highlights
For the Six Months Ended December 31, 2022

December					July - December			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
944,975	905,500	39,475	4.4%	Member Months	5,612,255	5,475,504	136,751	2.5%
329,355,510	352,179,156	(22,823,646)	(6.5%)	Revenues	1,977,621,527	2,012,577,662	(34,956,135)	(1.7%)
298,197,638	334,994,845	36,797,207	11.0%	Medical Expenses	1,845,891,763	1,887,619,046	41,727,283	2.2%
14,629,091	18,061,579	3,432,488	19.0%	Administrative Expenses	88,320,082	105,075,379	16,755,297	15.9%
16,528,781	**(877,268)**	**17,406,049**	**1984.1%**	**Operating Margin**	**43,409,682**	**19,883,237**	**23,526,445**	**118.3%**
				Non-Operating Income (Loss)				
9,695,109	500,000	9,195,109	1839.0%	Net Investment Income/Expense	26,811,416	3,000,000	23,811,416	793.7%
114,649	90,835	23,814	26.2%	Net Rental Income/Expense	678,519	545,010	133,509	24.5%
(1,619)	-	(1,619)	(100.0%)	Net MCO Tax	23,133	-	23,133	100.0%
(863,636)	(2,077,922)	1,214,286	58.4%	Grant Expense	(20,181,818)	(7,532,466)	(12,649,352)	(167.9%)
-	-	-	0.0%	Net QAF/IGT Income/Expense	-	-	-	0.0%
15	-	15	100.0%	Other Income/Expense	25,908	-	25,908	100.0%
8,944,518	**(1,487,087)**	**10,431,605**	**701.5%**	**Total Non-Operating Income (Loss)**	**7,357,157**	**(3,987,456)**	**11,344,613**	**284.5%**
25,473,299	**(2,364,355)**	**27,837,654**	**1177.4%**	**Change in Net Assets**	**50,766,839**	**15,895,781**	**34,871,058**	**219.4%**
90.5%	95.1%	(4.6%)		Medical Loss Ratio	93.3%	93.8%	(0.5%)	
4.4%	5.1%	0.7%		Administrative Loss Ratio	4.5%	5.2%	0.8%	
5.0%	(0.2%)	5.3%		Operating Margin Ratio	2.2%	1.0%	1.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
90.5%	95.1%	(4.6%)		*MLR (excluding Directed Payments)	93.0%	93.8%	(0.8%)	
4.4%	5.1%	0.7%		*ALR (excluding Directed Payments)	4.8%	5.2%	0.4%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

CalOptima Health
Financial Dashboard
For the Six Months Ended December 31, 2022

December

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	927,086	887,743	39,343	4.4%
OneCare Connect	14,385	14,605	(220)	(1.5%)
OneCare	3,067	2,679	388	14.5%
PACE	437	473	(36)	(7.6%)
MSSP	471	568	(97)	(17.1%)
Total*	944,975	905,500	39,475	4.4%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 14,664	$ (1,218)	15,882	1303.9%
OneCare Connect	1,389	(811)	2,200	271.3%
OneCare	(424)	(752)	328	43.6%
PACE	94	(130)	224	172.3%
MSSP	(59)	(44)	(15)	(34.1%)
Buildings	115	91	24	26.4%
Investment Income/Expense	9,695	500	9,195	1839.0%
Total	$ 25,474	$ (2,364)	27,838	1177.6%

MLR	Actual	Budget	% Point Var
Medi-Cal	90.5%	94.8%	(4.3)
OneCare Connect	89.8%	96.2%	(6.4)
OneCare	97.3%	112.9%	(15.7)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 11,229	$ 15,503	$ 4,275	27.6%
OneCare Connect	2,562	1,850	(712)	(38.5%)
OneCare	549	345	(204)	(59.0%)
PACE	206	266	60	22.5%
MSSP	84	98	14	14.1%
Total	$ 14,629	$ 18,062	$ 3,432	19.0%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,171	1,322	151
OneCare Connect	165	197	31
OneCare	21	27	6
PACE	97	115	17
MSSP	20	23	3
Total	1,475	1,683	208

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	792	672	(120)
OneCare Connect	87	74	(13)
OneCare	145	98	(47)
PACE	5	4	(0)
MSSP	23	25	2
Total	641	538	(103)

July - December

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	5,505,901	5,368,923	136,978	2.6%
OneCare Connect	86,159	87,887	(1,728)	(2.0%)
OneCare	17,589	15,927	1,662	10.4%
PACE	2,606	2,767	(161)	(5.8%)
MSSP	2,839	3,408	(569)	(16.7%)
Total*	5,612,255	5,475,504	136,751	2.5%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 25,180	$ 19,615	5,565	28.4%
OneCare Connect	(1,259)	(2,928)	1,669	57.0%
OneCare	(462)	(3,674)	3,212	87.4%
PACE	255	(402)	657	163.4%
MSSP	(438)	(260)	(178)	(68.5%)
Buildings	679	545	134	24.6%
Investment Income/Expense	26,811	3,000	23,811	793.7%
Total	$ 50,766	$ 15,896	34,870	219.4%

MLR	Actual	Budget	% Point Var
Medi-Cal	93.2%	93.5%	(0.3)
OneCare Connect	95.1%	95.1%	0.0
OneCare	92.4%	108.9%	(16.5)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 74,573	$ 89,803	$ 15,230	17.0%
OneCare Connect	9,840	11,094	1,254	11.3%
OneCare	2,169	2,005	(164)	(8.2%)
PACE	1,211	1,589	377	23.7%
MSSP	527	585	58	9.9%
Total	$ 88,320	$ 105,075	$ 16,755	15.9%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	6,899	7,855	956
OneCare Connect	976	1,181	204
OneCare	102	146	44
PACE	566	683	117
MSSP	121	138	17
Total	8,664	10,002	1,338

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	798	684	(115)
OneCare Connect	88	74	(14)
OneCare	172	109	(63)
PACE	5	4	(1)
MSSP	23	25	1
Total	648	547	(100)

Note:* Total membership does not include MSSP

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CalOptima Health - Consolidated
Statement of Revenues and Expenses
For the One Month Ended December 31, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	944,975		905,500		39,475	
REVENUE						
Medi-Cal	$ 282,176,218	$ 304.37	$ 317,297,456	$ 357.42	$ (35,121,238)	$ (53)
OneCare Connect	38,742,037	2,693.22	27,614,743	1,890.77	11,127,294	802.45
OneCare	4,537,917	1,479.59	3,149,433	1,175.60	1,388,484	303.99
PACE	3,689,851	8,443.59	3,864,007	8,169.15	(174,156)	274.44
MSSP	209,486	444.77	253,517	446.33	(44,031)	(1.56)
Total Operating Revenue	329,355,510	348.53	352,179,156	388.93	(22,823,646)	(40.40)
MEDICAL EXPENSES						
Medi-Cal	255,418,801	275.51	300,934,657	338.99	45,515,856	63.48
OneCare Connect	34,791,276	2,418.58	26,575,922	1,819.65	(8,215,354)	(598.93)
OneCare	4,413,195	1,438.93	3,556,173	1,327.43	(857,022)	(111.50)
PACE	3,389,536	7,756.38	3,728,613	7,882.90	339,077	126.52
MSSP	184,830	392.42	199,480	351.20	14,650	(41.22)
Total Medical Expenses	298,197,638	315.56	334,994,845	369.96	36,797,207	54.40
GROSS MARGIN	31,157,872	32.97	17,184,311	18.97	13,973,561	14.00
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	10,011,630	10.59	11,546,394	12.75	1,534,764	2.16
Professional Fees	390,786	0.41	970,318	1.07	579,532	0.66
Purchased Services	1,425,459	1.51	1,553,991	1.72	128,532	0.21
Printing & Postage	440,640	0.47	504,097	0.56	63,457	0.09
Depreciation & Amortization	376,483	0.40	525,900	0.58	149,417	0.18
Other Expenses	1,662,703	1.76	2,435,733	2.69	773,030	0.93
Indirect Cost Allocation, Occupancy	321,389	0.34	525,146	0.58	203,757	0.24
Total Administrative Expenses	14,629,091	15.48	18,061,579	19.95	3,432,488	4.47
INCOME (LOSS) FROM OPERATIONS	16,528,781	17.49	(877,268)	(0.97)	17,406,049	18.46
INVESTMENT INCOME						
Interest Income	7,828,979	8.28	500,000	0.55	7,328,979	7.73
Realized Gain/(Loss) on Investments	(254,220)	(0.27)	-	-	(254,220)	(0.27)
Unrealized Gain/(Loss) on Investments	2,120,349	2.24	-	-	2,120,349	2.24
Total Investment Income	9,695,109	10.26	500,000	0.55	9,195,109	9.71
NET RENTAL INCOME	114,649	0.12	90,835	0.10	23,814	0.02
TOTAL MCO TAX	(1,619)	-	-	-	(1,619)	-
TOTAL GRANT EXPENSE	(863,636)	(0.91)	(2,077,922)	(2.29)	1,214,286	1.38
OTHER INCOME	15	-	-	-	15	-
CHANGE IN NET ASSETS	**25,473,299**	**26.96**	**(2,364,355)**	**(2.61)**	**27,837,654**	**29.57**
MEDICAL LOSS RATIO	**90.5%**		**95.1%**		**(4.6%)**	
ADMINISTRATIVE LOSS RATIO	**4.4%**		**5.1%**		**0.7%**	

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CalOptima Health- Consolidated
Statement of Revenues and Expenses
For the Six Months Ended December 31, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	5,612,255		5,475,504		136,751	
REVENUE						
Medi-Cal	$ 1,756,136,503	$ 318.96	1,801,890,567	$ 335.61	$ (45,754,064)	$ (16.65)
OneCare Connect	176,434,873	2,047.78	167,628,057	1,907.31	8,806,816	140.47
OneCare	22,395,030	1,273.24	18,748,182	1,177.13	3,646,848	96.11
PACE	21,480,406	8,242.67	22,789,754	8,236.27	(1,309,348)	6.40
MSSP	1,174,715	413.78	1,521,102	446.33	(346,387)	(32.55)
Total Operating Revenue	1,977,621,527	352.38	2,012,577,662	367.56	(34,956,135)	(15.18)
MEDICAL EXPENSES						
Medi-Cal	1,636,250,774	297.18	1,684,939,934	313.83	48,689,160	16.65
OneCare Connect	167,853,518	1,948.18	159,462,222	1,814.40	(8,391,296)	(133.78)
OneCare	20,687,898	1,176.18	20,416,909	1,281.91	(270,989)	105.73
PACE	20,013,869	7,679.92	21,603,101	7,807.41	1,589,232	127.49
MSSP	1,085,703	382.42	1,196,880	351.20	111,177	(31.22)
Total Medical Expenses	1,845,891,763	328.90	1,887,619,046	344.74	41,727,283	15.84
GROSS MARGIN	131,729,764	23.48	124,958,616	22.82	6,771,148	0.66
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	60,686,734	10.81	67,369,002	12.30	6,682,268	1.49
Professional Fees	3,461,164	0.62	5,604,542	1.02	2,143,378	0.40
Purchased Services	7,083,151	1.26	8,120,929	1.48	1,037,778	0.22
Printing & Postage	2,507,195	0.45	3,061,622	0.56	554,427	0.11
Depreciation & Amortization	2,228,924	0.40	3,155,400	0.58	926,476	0.18
Other Expenses	9,839,911	1.75	14,607,678	2.67	4,767,767	0.92
Indirect Cost Allocation, Occupancy	2,513,003	0.45	3,156,206	0.58	643,203	0.13
Total Administrative Expenses	88,320,082	15.74	105,075,379	19.19	16,755,297	3.45
INCOME (LOSS) FROM OPERATIONS	43,409,682	7.73	19,883,237	3.63	23,526,445	4.10
INVESTMENT INCOME						
Interest Income	33,007,083	5.88	3,000,000	0.55	30,007,083	5.33
Realized Gain/(Loss) on Investments	(4,793,185)	(0.85)	-	0.00	(4,793,185)	(0.85)
Unrealized Gain/(Loss) on Investments	(1,402,482)	(0.25)	-	0.00	(1,402,482)	(0.25)
Total Investment Income	26,811,416	4.78	3,000,000	0.55	23,811,416	4.23
NET RENTAL INCOME	678,519	0.12	545,010	0.10	133,509	0.02
TOTAL MCO TAX	23,133	0.00	-	0.00	23,133	0.00
TOTAL GRANT EXPENSE	(20,181,818)	(3.60)	(7,532,466)	(1.38)	(12,649,352)	(2.22)
OTHER INCOME	25,908	0.00	-	0.00	25,908	0.00
CHANGE IN NET ASSETS	**50,766,839**	**9.05**	**15,895,781**	**2.90**	**34,871,058**	**6.15**
MEDICAL LOSS RATIO	**93.3%**		**93.8%**		**(0.5%)**	
ADMINISTRATIVE LOSS RATIO	**4.5%**		**5.2%**		**0.8%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended December 31, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	567,698	347,588	11,800	927,086	14,385	3,067	437	471	944,975
REVENUES									
Capitation Revenue	142,795,616	$ 118,459,792	$ 20,920,810	$ 282,176,218	$ 38,742,037	$ 4,537,917	$ 3,689,851	$ 209,486	$ 329,355,510
Total Operating Revenue	142,795,616	118,459,792	20,920,810	282,176,218	38,742,037	4,537,917	3,689,851	209,486	329,355,510
MEDICAL EXPENSES									
Provider Capitation	46,989,059	52,102,776	7,262,855	106,354,690	16,460,116	1,322,525			124,137,330
Facilities	31,302,735	27,808,096	5,488,723	64,599,553	5,334,814	1,133,528	712,530		71,780,426
Professional Claims	19,758,559	11,511,013	1,320,032	32,589,604	1,432,479	136,873	865,004		35,023,960
Prescription Drugs	(778,113)	(1,700,867)		(2,478,980)	8,401,421	1,589,000	456,809		7,968,251
MLTSS	35,608,054	4,121,770	2,327,932	42,057,755	1,543,986		218,479	30,435	43,850,655
Incentive Payments	1,443,031	2,158,107	36,861	3,637,999	458,457	156,198	5,463		4,258,117
Medical Management	3,216,861	2,243,675	879,912	6,340,447	1,160,002	75,071	1,131,251	154,395	8,861,166
Other Medical Expenses	1,400,885	880,490	36,358	2,317,732					2,317,732
Total Medical Expenses	138,941,070	99,125,058	17,352,672	255,418,801	34,791,276	4,413,195	3,389,536	184,830	298,197,638
Medical Loss Ratio	97.3%	83.7%	82.9%	90.5%	89.8%	97.3%	91.9%	88.2%	90.5%
GROSS MARGIN	**3,854,546**	**19,334,734**	**3,568,138**	**26,757,418**	**3,950,762**	**124,722**	**300,315**	**24,656**	**31,157,872**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				8,985,758	699,087	127,991	128,678	70,116	10,011,630
Professional Fees				394,019	(4,741)		175	1,333	390,786
Purchased Services				1,234,768	78,392	79,369	32,930		1,425,459
Printing & Postage				243,246	61,409	117,783	18,202		440,640
Depreciation & Amortization				375,719			764		376,483
Other Expenses				1,655,728	1,953	(4,500)	3,680	5,842	1,662,703
Indirect Cost Allocation, Occupancy				(1,660,733)	1,725,789	228,258	21,513	6,562	321,389
Total Administrative Expenses				**11,228,505**	**2,561,887**	**548,902**	**205,943**	**83,853**	**14,629,091**
Admin Loss Ratio				4.0%	6.6%	12.1%	5.6%	40.0%	4.4%
INCOME (LOSS) FROM OPERATIONS				15,528,912	1,388,875	(424,180)	94,372	(59,197)	16,528,781
INVESTMENT INCOME									9,695,109
NET RENTAL INCOME									114,649
TOTAL MCO TAX				(1,619)					(1,619)
TOTAL GRANT EXPENSE				(863,636)					(863,636)
OTHER INCOME				15					15
CHANGE IN NET ASSETS				**$ 14,663,672**	**$ 1,388,875**	**$ (424,180)**	**$ 94,372**	**$ (59,197)**	**$ 25,473,299**
BUDGETED CHANGE IN NET ASSETS				(1,218,395)	(811,039)	(751,975)	(130,176)	(43,605)	(2,364,355)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 15,882,067	$ 2,199,914	$ 327,795	$ 224,548	$ (15,592)	$ 27,837,654

Note:* Total membership does not include MSSP

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Six Months Ended December 31, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	3,395,361	2,039,591	70,949	5,505,901	86,159	17,589	2,606	2,839	5,612,255
REVENUES									
Capitation Revenue	891,175,297	$ 728,934,668	$ 136,026,537	$ 1,756,136,503	$ 176,434,873	$ 22,395,030	$ 21,480,406	$ 1,174,715	$ 1,977,621,527
Total Operating Revenue	891,175,297	728,934,668	136,026,537	1,756,136,503	176,434,873	22,395,030	21,480,406	1,174,715	1,977,621,527
MEDICAL EXPENSES									
Provider Capitation	205,013,763	260,187,064	54,789,742	519,990,569	71,936,457	6,305,271			598,232,297
Facilities	194,134,242	176,026,690	34,919,091	405,080,023	27,457,324	5,909,871	5,283,468		443,730,687
Professional Claims	130,026,523	83,378,396	8,789,719	222,194,638	8,639,186	875,581	5,487,439		237,196,844
Prescription Drugs	(1,818,124)	(1,906,758)	5,604	(3,719,278)	41,012,249	7,108,672	2,453,627		46,855,270
MLTSS	241,795,013	26,539,323	12,494,987	280,829,323	9,955,152		1,039,905	178,409	292,002,788
Incentive Payments	19,149,411	21,188,685	621,853	40,959,949	2,530,356	162,725	32,575		43,685,605
Medical Management	16,829,214	11,864,620	2,707,857	31,401,691	6,322,794	325,778	5,716,855	907,295	44,674,413
Other Medical Expenses	74,903,332	56,303,267	8,307,261	139,513,859					139,513,859
Total Medical Expenses	880,033,374	633,581,286	122,636,114	1,636,250,774	167,853,518	20,687,898	20,013,869	1,085,703	1,845,891,763
Medical Loss Ratio	98.7%	86.9%	90.2%	93.2%	95.1%	92.4%	93.2%	92.4%	93.3%
GROSS MARGIN	**11,141,923**	**95,353,382**	**13,390,424**	**119,885,729**	**8,581,354**	**1,707,133**	**1,466,536**	**89,012**	**131,729,764**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				54,516,926	4,121,616	787,725	809,559	450,907	60,686,734
Professional Fees				3,260,213	24,509	166,714	1,728	8,000	3,461,164
Purchased Services				6,313,879	499,789	198,116	71,368		7,083,151
Printing & Postage				1,691,430	255,699	385,314	174,752		2,507,195
Depreciation & Amortization				2,225,410			3,515		2,228,924
Other Expenses				9,724,065	8,779	5,370	66,656	35,041	9,839,911
Indirect Cost Allocation, Occupancy				(3,159,245)	4,929,832	625,748	83,844	32,823	2,513,003
Total Administrative Expenses				**74,572,678**	**9,840,225**	**2,168,987**	**1,211,422**	**526,771**	**88,320,082**
Admin Loss Ratio				4.2%	5.6%	9.7%	5.6%	44.8%	4.5%
INCOME (LOSS) FROM OPERATIONS				45,313,051	(1,258,870)	(461,854)	255,114	(437,759)	43,409,682
INVESTMENT INCOME									26,811,416
NET RENTAL INCOME									678,519
TOTAL MCO TAX				23,133					23,133
TOTAL GRANT EXPENSE				(20,181,818)					(20,181,818)
OTHER INCOME				25,908					25,908
CHANGE IN NET ASSETS				**$ 25,180,273**	**$ (1,258,870)**	**$ (461,854)**	**$ 255,114**	**$ (437,759)**	**$ 50,766,839**
BUDGETED CHANGE IN NET ASSETS				19,615,232	(2,928,363)	(3,673,819)	(401,877)	(260,402)	15,895,781
VARIANCE TO BUDGET - FAV (UNFAV)				$ 5,565,041	$ 1,669,493	$ 3,211,965	$ 656,991	$ (177,357)	$ 34,871,058

Note:* Total membership does not include MSSP

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CalOptima Health
December 31, 2022 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $25.5 million, $27.8 million favorable to budget
- Operating surplus is $16.5 million, with a surplus in non-operating income of $8.9 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $50.8 million, $34.9 million favorable to budget
- Operating surplus is $43.4 million, with a surplus in non-operating income of $7.4 million

Change in Net Assets by Line of Business (LOB) ($ millions):

December				July-December		
Actual	Budget	Variance	**Operating Income (Loss)**	Actual	Budget	Variance
15.5	0.9	14.7	Medi-Cal	45.3	27.1	18.2
1.4	(0.8)	2.2	OCC	(1.3)	(2.9)	1.7
(0.4)	(0.8)	0.3	OneCare	(0.5)	(3.7)	3.2
0.1	(0.1)	0.2	PACE	0.3	(0.4)	0.7
(0.1)	(0.0)	(0.0)	MSSP	(0.4)	(0.3)	(0.2)
16.5	**(0.9)**	**17.4**	**Total Operating Income (Loss)**	**43.4**	**19.9**	**23.5**
			Non-Operating Income (Loss)			
9.7	0.5	9.2	Net Investment Income/Expense	26.8	3.0	23.8
0.1	0.1	0.0	Net Rental Income/Expense	0.7	0.5	0.1
(0.0)	0.0	(0.0)	Net Operating Tax	0.0	0.0	0.0
(0.9)	(2.1)	1.2	Grant Expense	(20.2)	(7.5)	(12.6)
0.0	0.0	0.0	Net Other Income/Expense	0.0	0.0	0.0
8.9	**(1.5)**	**10.4**	**Total Non-Operating Income/(Loss)**	**7.4**	**(4.0)**	**11.3**
25.5	**(2.4)**	**27.8**	**TOTAL**	**50.8**	**15.9**	**34.9**

CalOptima Health - Consolidated
Enrollment Summary
For the Six Months Ended December 31, 2022

December					July - December			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
125,776	123,352	2,424	2.0%	SPD	748,814	736,055	12,759	1.7%
302,954	305,024	(2,070)	(0.7%)	TANF Child	1,821,399	1,836,959	(15,560)	(0.8%)
135,705	132,242	3,463	2.6%	TANF Adult	805,660	808,298	(2,638)	(0.3%)
3,263	3,357	(94)	(2.8%)	LTC	19,488	20,010	(522)	(2.6%)
347,588	311,964	35,624	11.4%	MCE	2,039,591	1,897,040	142,551	7.5%
11,800	11,804	(4)	(0.0%)	WCM	70,949	70,561	388	0.5%
927,086	**887,743**	**39,343**	**4.4%**	**Medi-Cal Total**	**5,505,901**	**5,368,923**	**136,978**	**2.6%**
14,385	**14,605**	**(220)**	**(1.5%)**	**OneCare Connect**	**86,159**	**87,887**	**(1,728)**	**(2.0%)**
3,067	**2,679**	**388**	**14.5%**	**OneCare**	**17,589**	**15,927**	**1,662**	**10.4%**
437	**473**	**(36)**	**(7.6%)**	**PACE**	**2,606**	**2,767**	**(161)**	**(5.8%)**
471	**568**	**(97)**	**(17.1%)**	**MSSP**	**2,839**	**3,408**	**(569)**	**(16.7%)**
944,975	**905,500**	**39,475**	**4.4%**	**CalOptima Total**	**5,612,255**	**5,475,504**	**136,751**	**2.5%**
				Enrollment (by Network)				
263,330	208,635	54,695	26.2%	HMO	1,371,986	1,264,628	107,358	8.5%
190,994	237,453	(46,459)	(19.6%)	PHC	1,331,908	1,433,410	(101,502)	(7.1%)
229,203	219,701	9,502	4.3%	Shared Risk Group	1,360,977	1,330,675	30,302	2.3%
243,559	221,954	21,605	9.7%	Fee for Service	1,441,030	1,340,210	100,820	7.5%
927,086	**887,743**	**39,343**	**4.4%**	**Medi-Cal Total**	**5,505,901**	**5,368,923**	**136,978**	**2.6%**
14,385	**14,605**	**(220)**	**(1.5%)**	**OneCare Connect**	**86,159**	**87,887**	**(1,728)**	**(2.0%)**
3,067	**2,679**	**388**	**14.5%**	**OneCare**	**17,589**	**15,927**	**1,662**	**10.4%**
437	**473**	**(36)**	**(7.6%)**	**PACE**	**2,606**	**2,767**	**(161)**	**(5.8%)**
471	**568**	**(97)**	**(17.1%)**	**MSSP**	**2,839**	**3,408**	**(569)**	**(16.7%)**
944,975	**905,500**	**39,475**	**4.4%**	**CalOptima Total**	**5,612,255**	**5,475,504**	**136,751**	**2.5%**

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2023

	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	YTD Actual	YTD Budget	Variance
HMOs															
SPD	11,237	11,250	11,290	11,288	14,002	14,044							73,111	65,801	7,310
TANF Child	58,966	58,892	58,837	58,847	69,892	69,736							375,170	356,426	18,744
TANF Adult	38,926	38,983	39,331	39,640	48,530	48,844							254,254	250,656	3,598
LTC	1	2	2	1									6		6
MCE	99,022	99,788	100,301	101,292	127,939	128,438							656,780	579,047	77,733
WCM	2,034	2,020	2,021	2,050	2,272	2,268							12,665	12,698	(33)
Total	**210,186**	**210,935**	**211,782**	**213,118**	**262,635**	**263,330**							**1,371,986**	**1,264,628**	**107,358**
PHCs															
SPD	7,040	7,022	7,037	7,029	4,408	4,387							36,923	41,972	(5,049)
TANF Child	158,385	158,345	158,767	159,067	148,298	148,419							931,281	958,202	(26,921)
TANF Adult	16,704	16,780	16,830	16,855	8,478	8,499							84,146	105,824	(21,678)
LTC		1	1	3		2							7		7
MCE	47,505	47,574	47,748	48,051	22,411	22,545							235,834	283,914	(48,080)
WCM	7,366	7,472	7,340	7,301	7,096	7,142							43,717	43,498	219
Total	**237,000**	**237,194**	**237,723**	**238,306**	**190,691**	**190,994**							**1,331,908**	**1,433,410**	**(101,502)**
Shared Risk Groups															
SPD	10,824	10,928	10,995	10,954	11,023	11,046							65,770	61,158	4,612
TANF Child	57,419	57,075	56,762	56,460	56,201	55,828							339,745	358,168	(18,423)
TANF Adult	40,518	40,260	40,370	40,566	40,961	41,218							243,893	244,895	(1,002)
LTC	2	1	3	6	2								14		14
MCE	114,819	115,585	116,539	117,839	118,935	119,808							703,525	658,101	45,424
WCM	1,360	1,341	1,332	1,369	1,325	1,303							8,030	8,353	(323)
Total	**224,942**	**225,190**	**226,001**	**227,194**	**228,447**	**229,203**							**1,360,977**	**1,330,675**	**30,302**
Fee for Service (Dual)															
SPD	82,253	82,742	82,935	83,572	84,174	83,819							499,495	499,584	(89)
TANF Child	1	1	1	1	1	1							6		6
TANF Adult	1,675	1,712	1,743	1,742	1,767	1,776							10,415	10,985	(570)
LTC	2,894	2,874	2,845	2,879	2,929	2,915							17,336	18,012	(676)
MCE	6,480	6,749	7,030	7,314	7,498	7,795							42,866	35,010	7,856
WCM	20	18	24	17	16	18							113	92	21
Total	**93,323**	**94,096**	**94,578**	**95,525**	**96,385**	**96,324**							**570,231**	**563,683**	**6,548**
Fee for Service (Non-Dual - Total)															
SPD	11,984	12,003	16,296	8,528	12,224	12,480							73,515	67,540	5,975
TANF Child	28,613	28,702	29,350	29,540	30,022	28,970							175,197	164,163	11,034
TANF Adult	32,830	33,442	37,388	38,818	35,106	35,368							212,952	195,938	17,014
LTC	360	364	366	345	344	346							2,125	1,998	127
MCE	63,450	64,657	66,876	67,538	69,063	69,002							400,586	340,968	59,618
WCM	1,096	1,094	1,049	1,080	1,036	1,069							6,424	5,920	504
Total	**138,333**	**140,262**	**151,325**	**145,849**	**147,795**	**147,235**							**870,799**	**776,527**	**94,272**
Grand Totals															
SPD	123,338	123,945	128,553	121,371	125,831	125,776							748,814	736,055	12,759
TANF Child	303,384	303,015	303,717	303,915	304,414	302,954							1,821,399	1,836,959	(15,560)
TANF Adult	130,653	131,177	135,662	137,621	134,842	135,705							805,660	808,298	(2,638)
LTC	3,257	3,242	3,217	3,234	3,275	3,263							19,488	20,010	(522)
MCE	331,276	334,353	338,494	342,034	345,846	347,588							2,039,591	1,897,040	142,551
WCM	11,876	11,945	11,766	11,817	11,745	11,800							70,949	70,561	388
Total MediCal MM	**903,784**	**907,677**	**921,409**	**919,992**	**925,953**	**927,086**							**5,505,901**	**5,368,923**	**136,978**
OneCare Connect	**14,203**	**14,771**	**14,405**	**14,198**	**14,197**	**14,385**							**86,159**	**87,887**	**(1,728)**
OneCare	**2,764**	**2,874**	**2,905**	**2,964**	**3,015**	**3,067**							**17,589**	**15,927**	**1,662**
PACE	**435**	**434**	**437**	**430**	**433**	**437**							**2,606**	**2,767**	**(161)**
MSSP	**466**	**470**	**478**	**478**	**476**	**471**							**2,839**	**3,408**	**(569)**
Grand Total	**921,186**	**925,756**	**939,156**	**937,584**	**943,598**	**944,975**							**5,612,255**	**5,475,504**	**136,751**

Note:* Total membership does not include MSSP

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ENROLLMENT:

Overall, December enrollment was 944,975

- Favorable to budget 39,475 or 4.4%
- Increased 1,377 or 0.1% from Prior Month (PM) (November 2022)
- Increased 74,486 or 8.6% from Prior Year (PY) (December 2021)

Medi-Cal enrollment was 927,086

- Favorable to budget 39,343 or 4.4% as the Department of Health Care Services (DHCS) pauses Medi-Cal redetermination due to the extension of the Public Health Emergency
  - Medi-Cal Expansion (MCE) favorable 35,624
  - Seniors and Persons with Disabilities (SPD) favorable 2,424
  - Temporary Assistance for Needy Families (TANF) favorable 1,393
  - Long-Term Care (LTC) unfavorable 94
  - Whole Child Model (WCM) unfavorable 4
- Increased 1,133 from PM

OneCare Connect enrollment was 14,385 (effective January 1, 2023, OneCare Connect members will transition to OneCare)

- Unfavorable to budget 220 or 1.5%
- Increased 188 from PM

OneCare enrollment was 3,067

- Favorable to budget 388 or 14.5%
- Increased 52 from PM

PACE enrollment was 437

- Unfavorable to budget 36 or 7.6%
- Increased 4 from PM

MSSP enrollment was 471

- Unfavorable to budget 97 or 17.1% due to MSSP currently being understaffed. There is a staff to member ratio that must be met
- Decreased 5 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
927,086	**887,743**	**39,343**	**4.4%**	**Member Months**	**5,505,901**	**5,368,923**	**136,978**	**2.6%**
				Revenues				
282,176,218	317,297,456	(35,121,238)	(11.1%)	Medi-Cal Capitation Revenue	1,756,136,503	1,801,890,567	(45,754,064)	(2.5%)
282,176,218	**317,297,456**	**(35,121,238)**	**(11.1%)**	**Total Operating Revenue**	**1,756,136,503**	**1,801,890,567**	**(45,754,064)**	**(2.5%)**
				Medical Expenses				
106,354,690	105,373,795	(980,895)	(0.9%)	Provider Capitation	519,990,569	637,813,492	117,822,923	18.5%
64,599,553	68,676,538	4,076,985	5.9%	Facilities Claims	405,080,023	407,877,999	2,797,976	0.7%
32,589,604	40,601,504	8,011,900	19.7%	Professional Claims	222,194,638	240,808,287	18,613,649	7.7%
42,057,755	50,769,512	8,711,757	17.2%	MLTSS	280,829,323	297,772,910	16,943,587	5.7%
(2,478,980)	-	2,478,980	100.0%	Prescription Drugs	(3,719,278)	-	3,719,278	100.0%
3,637,999	4,654,594	1,016,595	21.8%	Incentive Payments	40,959,949	28,087,949	(12,872,000)	(45.8%)
6,340,447	6,784,643	444,196	6.5%	Medical Management	31,401,691	40,634,866	9,233,176	22.7%
2,317,732	24,074,071	21,756,339	90.4%	Other Medical Expenses	139,513,859	31,944,431	(107,569,428)	(336.7%)
255,418,801	**300,934,657**	**45,515,856**	**15.1%**	**Total Medical Expenses**	**1,636,250,774**	**1,684,939,934**	**48,689,160**	**2.9%**
26,757,418	**16,362,799**	**10,394,619**	**63.5%**	**Gross Margin**	**119,885,729**	**116,950,633**	**2,935,096**	**2.5%**
				Administrative Expenses				
8,985,758	10,209,770	1,224,012	12.0%	Salaries, Wages & Employee Benefits	54,516,926	59,431,951	4,915,025	8.3%
394,019	923,156	529,137	57.3%	Professional Fees	3,260,213	5,321,574	2,061,361	38.7%
1,234,768	1,376,639	141,871	10.3%	Purchased Services	6,313,879	7,094,308	780,429	11.0%
243,246	383,940	140,694	36.6%	Printing & Postage	1,691,430	2,303,274	611,844	26.6%
375,719	525,000	149,281	28.4%	Depreciation & Amortization	2,225,410	3,150,000	924,590	29.4%
1,655,728	2,410,427	754,699	31.3%	Other Operating Expenses	9,724,065	14,455,788	4,731,723	32.7%
(1,660,733)	(325,660)	1,335,073	410.0%	Indirect Cost Allocation, Occupancy	(3,159,245)	(1,953,960)	1,205,285	61.7%
11,228,505	**15,503,272**	**4,274,767**	**27.6%**	**Total Administrative Expenses**	**74,572,678**	**89,802,935**	**15,230,257**	**17.0%**
				Non-Operating Income (Loss)				
(1,619)	-	(1,619)	(100.0%)	Net Operating Tax	23,133	-	23,133	100.0%
(863,636)	(2,077,922)	1,214,286	58.4%	Grant Expense	(20,181,818)	(7,532,466)	(12,649,352)	(167.9%)
-	-	-	0.0%	Net QAF & IGT Income/Expense	-	-	-	0.0%
15	-	15	100.0%	Other Income	25,908	-	25,908	100.0%
(865,240)	**(2,077,922)**	**1,212,682**	**58.4%**	**Total Non-Operating Income (Loss)**	**(20,132,778)**	**(7,532,466)**	**(12,600,312)**	**(167.3%)**
14,663,672	**(1,218,395)**	**15,882,067**	**1303.5%**	**Change in Net Assets**	**25,180,273**	**19,615,232**	**5,565,041**	**28.4%**
90.5%	***94.8%***	***(4.3%)***		***Medical Loss Ratio***	***93.2%***	***93.5%***	***(0.3%)***	
4.0%	***4.9%***	***0.9%***		***Admin Loss Ratio***	***4.2%***	***5.0%***	***0.7%***	

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MEDI-CAL INCOME STATEMENT– DECEMBER MONTH:

REVENUES of $282.2 million are unfavorable to budget $35.1 million driven by:

- Favorable volume related variance of $14.1 million
- Unfavorable price related variance of $49.2 million
  - $22.5 million due to forecasted funds from Program year 1 of the CalAIM Incentive Payment Program (IPP), which has not been finalized by the Department of Health Care Services (DHCS)
  - $27.0 million due to COVID-19 risk corridor reserves

MEDICAL EXPENSES of $255.4 million are favorable to budget $45.5 million driven by:

- Unfavorable volume related variance of $13.3 million
- Favorable price related variance of $58.9 million
  - Other Medical expense favorable variance of $22.8 million primarily due to CalAIM IPP
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $11.0 million due to low utilization and Incurred But Not Reported (IBNR) claims
  - Professional Claims expense favorable variance of $9.8 million primarily driven by CalAIM community support estimates
  - Facilities Claims expense favorable variance of $7.1 million due to IBNR claims
  - Provider Capitation expense favorable variance of $3.7 million
  - All other expenses favorable variance of $4.4 million

ADMINISTRATIVE EXPENSES of $11.2 million are favorable to budget $4.3 million driven by:

- Other Non-Salary expense favorable to budget $3.1 million
- Salaries & Benefit expense favorable to budget $1.2 million

CHANGE IN NET ASSETS is $14.7 million, favorable to budget $15.9 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Six Months Ending December 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,385	**14,605**	**(220)**	**(1.5%)**	**Member Months**	**86,159**	**87,887**	**(1,728)**	**(2.0%)**
				Revenues				
2,824,225	2,788,721	35,504	1.3%	Medi-Cal Revenue	16,100,470	16,971,109	(870,639)	(5.1%)
29,390,084	19,330,482	10,059,602	52.0%	Medicare Part C Revenue	121,436,450	117,560,580	3,875,870	3.3%
6,527,728	5,495,540	1,032,188	18.8%	Medicare Part D Revenue	38,897,952	33,096,368	5,801,584	17.5%
38,742,037	**27,614,743**	**11,127,294**	**40.3%**	**Total Operating Revenue**	**176,434,873**	**167,628,057**	**8,806,816**	**5.3%**
				Medical Expenses				
16,460,116	11,429,253	(5,030,863)	(44.0%)	Provider Capitation	71,936,457	69,401,413	(2,535,044)	(3.7%)
5,334,814	4,161,174	(1,173,640)	(28.2%)	Facilities Claims	27,457,324	24,684,406	(2,772,918)	(11.2%)
1,432,479	1,216,746	(215,733)	(17.7%)	Ancillary	8,639,186	7,214,705	(1,424,481)	(19.7%)
1,543,986	1,502,437	(41,549)	(2.8%)	MLTSS	9,955,152	8,924,314	(1,030,838)	(11.6%)
8,401,421	6,477,027	(1,924,394)	(29.7%)	Prescription Drugs	41,012,249	38,194,494	(2,817,755)	(7.4%)
458,457	519,741	61,284	11.8%	Incentive Payments	2,530,356	3,304,554	774,198	23.4%
1,160,002	1,269,544	109,542	8.6%	Medical Management	6,322,794	7,738,336	1,415,542	18.3%
34,791,276	**26,575,922**	**(8,215,354)**	**(30.9%)**	**Total Medical Expenses**	**167,853,518**	**159,462,222**	**(8,391,296)**	**(5.3%)**
3,950,762	**1,038,821**	**2,911,941**	**280.3%**	**Gross Margin**	**8,581,354**	**8,165,835**	**415,519**	**5.1%**
				Administrative Expenses				
699,087	925,750	226,663	24.5%	Salaries, Wages & Employee Benefits	4,121,616	5,536,813	1,415,197	25.6%
(4,741)	20,833	25,574	122.8%	Professional Fees	24,509	124,998	100,489	80.4%
78,392	109,605	31,213	28.5%	Purchased Services	499,789	657,635	157,846	24.0%
61,409	67,531	6,122	9.1%	Printing & Postage	255,699	405,091	149,392	36.9%
1,953	6,081	4,128	67.9%	Other Operating Expenses	8,779	36,561	27,782	76.0%
1,725,789	720,060	(1,005,729)	(139.7%)	Indirect Cost Allocation, Occupancy	4,929,832	4,333,100	(596,732)	(13.8%)
2,561,887	**1,849,860**	**(712,027)**	**(38.5%)**	**Total Administrative Expenses**	**9,840,225**	**11,094,198**	**1,253,973**	**11.3%**
1,388,875	**(811,039)**	**2,199,914**	**271.2%**	**Change in Net Assets**	**(1,258,870)**	**(2,928,363)**	**1,669,493**	**57.0%**
89.8%	***96.2%***	***(6.4%)***		***Medical Loss Ratio***	***95.1%***	***95.1%***	***0.0%***	
6.6%	***6.7%***	***0.1%***		***Admin Loss Ratio***	***5.6%***	***6.6%***	***1.0%***	

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ONECARE CONNECT INCOME STATEMENT– DECEMBER MONTH:

REVENUES of $38.7 million are favorable to budget $11.1 million driven by:

- Unfavorable volume related variance of $0.4 million
- Favorable price related variance of $11.5 million due primarily to estimated revenue relating to Calendar Year (CY) 2022 Hierarchical Condition Category (HCC) calculation

MEDICAL EXPENSES of $34.8 million are unfavorable to budget $8.2 million driven by:

- Favorable volume related variance of $0.4 million
- Unfavorable price related variance of $8.6 million
  - Provider Capitation expense unfavorable variance of $5.2 million due to estimated HCC calculation
  - Prescription Drugs expense unfavorable variance of $2.0 million
  - Facilities Claims expense unfavorable variance of $1.2 million
  - All other expenses net unfavorable variance of $0.2 million

ADMINISTRATIVE EXPENSES of $2.6 million are unfavorable to budget $0.7 million driven by:

- Other Non-Salary expense unfavorable to budget $0.9 million
- Salaries & Benefit expense favorable to budget $0.2 million

CHANGE IN NET ASSETS is $1.4 million, favorable to budget $2.2 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
3,067	**2,679**	**388**	**14.5%**	**Member Months**	**17,589**	**15,927**	**1,662**	**10.4%**
				Revenues				
3,291,166	2,098,790	1,192,376	56.8%	Medicare Part C Revenue	15,677,489	12,480,832	3,196,657	25.6%
1,246,752	1,050,643	196,109	18.7%	Medicare Part D Revenue	6,717,541	6,267,350	450,191	7.2%
4,537,917	**3,149,433**	**1,388,484**	**44.1%**	**Total Operating Revenue**	**22,395,030**	**18,748,182**	**3,646,848**	**19.5%**
				Medical Expenses				
1,322,525	772,867	(549,658)	(71.1%)	Provider Capitation	6,305,271	4,595,969	(1,709,302)	(37.2%)
1,133,528	1,260,212	126,684	10.1%	Inpatient	5,909,871	7,376,546	1,466,675	19.9%
136,873	97,047	(39,826)	(41.0%)	Ancillary	875,581	570,185	(305,396)	(53.6%)
1,589,000	1,199,552	(389,448)	(32.5%)	Prescription Drugs	7,108,672	6,989,797	(118,875)	(1.7%)
156,198	25,534	(130,664)	(511.7%)	Incentive Payments	162,725	151,790	(10,935)	(7.2%)
75,071	200,961	125,890	62.6%	Medical Management	325,778	732,622	406,844	55.5%
4,413,195	**3,556,173**	**(857,022)**	**(24.1%)**	**Total Medical Expenses**	**20,687,898**	**20,416,909**	**(270,989)**	**(1.3%)**
124,722	**(406,740)**	**531,462**	**130.7%**	**Gross Margin**	**1,707,133**	**(1,668,727)**	**3,375,860**	**202.3%**
				Administrative Expenses				
127,991	152,872	24,881	16.3%	Salaries, Wages & Employee Benefits	787,725	857,064	69,339	8.1%
-	24,583	24,583	100.0%	Professional Fees	166,714	147,498	(19,216)	(13.0%)
79,369	24,068	(55,301)	(229.8%)	Purchased Services	198,116	106,908	(91,208)	(85.3%)
117,783	32,392	(85,391)	(263.6%)	Printing & Postage	385,314	231,852	(153,462)	(66.2%)
(4,500)	-	4,500	100.0%	Other Operating Expenses	5,370	-	(5,370)	(100.0%)
228,258	111,320	(116,938)	(105.0%)	Indirect Cost Allocation, Occupancy	625,748	661,770	36,022	5.4%
548,902	**345,235**	**(203,667)**	**(59.0%)**	**Total Administrative Expenses**	**2,168,987**	**2,005,092**	**(163,895)**	**(8.2%)**
(424,180)	**(751,975)**	**327,795**	**43.6%**	**Change in Net Assets**	**(461,854)**	**(3,673,819)**	**3,211,965**	**87.4%**
97.3%	***112.9%***	***(15.7%)***		***Medical Loss Ratio***	***92.4%***	***108.9%***	***(16.5%)***	
12.1%	***11.0%***	***(1.1%)***		***Admin Loss Ratio***	***9.7%***	***10.7%***	***1.0%***	

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CalOptima Health
PACE
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
437	**473**	(36)	(7.6%)	**Member Months**	**2,606**	**2,767**	**(161)**	**(5.8%)**
				Revenues				
2,813,304	3,002,706	(189,402)	(6.3%)	Medi-Cal Capitation Revenue	16,749,509	17,560,902	(811,393)	(4.6%)
667,032	660,230	6,802	1.0%	Medicare Part C Revenue	3,556,575	4,051,515	(494,940)	(12.2%)
209,514	201,071	8,443	4.2%	Medicare Part D Revenue	1,174,322	1,177,337	(3,015)	(0.3%)
3,689,851	**3,864,007**	**(174,156)**	**(4.5%)**	**Total Operating Revenue**	**21,480,406**	**22,789,754**	**(1,309,348)**	**(5.7%)**
				Medical Expenses				
1,131,251	1,132,214	963	0.1%	Medical Management	5,716,855	6,719,621	1,002,766	14.9%
712,530	955,125	242,595	25.4%	Facilities Claims	5,283,468	5,475,296	191,828	3.5%
693,324	960,479	267,155	27.8%	Professional Claims	4,505,041	5,503,998	998,957	18.1%
456,809	410,441	(46,368)	(11.3%)	Prescription Drugs	2,453,627	2,340,692	(112,935)	(4.8%)
218,479	68,684	(149,795)	(218.1%)	MLTSS	1,039,905	397,459	(642,446)	(161.6%)
171,681	195,648	23,967	12.3%	Patient Transportation	982,398	1,131,188	148,790	13.2%
5,463	6,022	560	9.3%	Incentive Payments	32,575	34,847	2,272	6.5%
3,389,536	**3,728,613**	**339,077**	**9.1%**	**Total Medical Expenses**	**20,013,869**	**21,603,101**	**1,589,232**	**7.4%**
300,315	**135,394**	**164,921**	**121.8%**	**Gross Margin**	**1,466,536**	**1,186,653**	**279,883**	**23.6%**
				Administrative Expenses				
128,678	177,393	48,715	27.5%	Salaries, Wages & Employee Benefits	809,559	1,060,740	251,181	23.7%
175	413	238	57.6%	Professional Fees	1,728	2,474	746	30.1%
32,930	43,679	10,749	24.6%	Purchased Services	71,368	262,078	190,710	72.8%
18,202	20,234	2,032	10.0%	Printing & Postage	174,752	121,405	(53,347)	(43.9%)
764	900	136	15.1%	Depreciation & Amortization	3,515	5,400	1,885	34.9%
3,680	10,075	6,395	63.5%	Other Operating Expenses	66,656	60,437	(6,219)	(10.3%)
21,513	12,876	(8,637)	(67.1%)	Indirect Cost Allocation, Occupancy	83,844	75,996	(7,848)	(10.3%)
205,943	**265,570**	**59,627**	**22.5%**	**Total Administrative Expenses**	**1,211,422**	**1,588,530**	**377,108**	**23.7%**
94,372	**(130,176)**	**224,548**	**172.5%**	**Change in Net Assets**	**255,114**	**(401,877)**	**656,991**	**163.5%**
91.9%	***96.5%***	***(4.6%)***		***Medical Loss Ratio***	***93.2%***	***94.8%***	***(1.6%)***	
5.6%	***6.9%***	***1.3%***		***Admin Loss Ratio***	***5.6%***	***7.0%***	***1.3%***	

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CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
471	**568**	**(97)**	**(17.1%)**	**Member Months**	**2,839**	**3,408**	**(569)**	**(16.7%)**
				Revenues				
209,486	253,517	(44,031)	(17.4%)	Revenue	1,174,715	1,521,102	(346,387)	(22.8%)
209,486	**253,517**	**(44,031)**	**(17.4%)**	**Total Operating Revenue**	**1,174,715**	**1,521,102**	**(346,387)**	**(22.8%)**
				Medical Expenses				
154,395	166,522	12,127	7.3%	Medical Management	907,295	999,132	91,837	9.2%
30,435	32,958	2,523	7.7%	Waiver Services	178,409	197,748	19,339	9.8%
154,395	166,522	12,127	7.3%	Total Medical Management	907,295	999,132	91,837	9.2%
30,435	32,958	2,523	7.7%	Total Waiver Services	178,409	197,748	19,339	9.8%
184,830	**199,480**	**14,650**	**7.3%**	**Total Program Expenses**	**1,085,703**	**1,196,880**	**111,177**	**9.3%**
24,656	**54,037**	**(29,381)**	**(54.4%)**	**Gross Margin**	**89,012**	**324,222**	**(235,210)**	**(72.5%)**
				Administrative Expenses				
70,116	80,609	10,493	13.0%	Salaries, Wages & Employee Benefits	450,907	482,434	31,527	6.5%
1,333	1,333	(0)	(0.0%)	Professional Fees	8,000	7,998	(2)	(0.0%)
5,842	9,150	3,308	36.1%	Other Operating Expenses	35,041	54,892	19,851	36.2%
6,562	6,550	(12)	(0.2%)	Indirect Cost Allocation, Occupancy	32,823	39,300	6,477	16.5%
83,853	**97,642**	**13,789**	**14.1%**	**Total Administrative Expenses**	**526,771**	**584,624**	**57,853**	**9.9%**
(59,197)	**(43,605)**	**(15,592)**	**(35.8%)**	**Change in Net Assets**	**(437,759)**	**(260,402)**	**(177,357)**	**(68.1%)**
88.2%	***78.7%***	***9.5%***		***Medical Loss Ratio***	***92.4%***	***78.7%***	***13.7%***	
40.0%	***38.5%***	***(1.5%)***		***Admin Loss Ratio***	***44.8%***	***38.4%***	***(6.4%)***	

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CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Six Months Ending December 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				
43,498	55,650	12,152	21.8%	Purchased Services	245,737	333,900	88,163	26.4%
208,966	224,250	15,284	6.8%	Depreciation & Amortization	1,268,577	1,345,500	76,923	5.7%
20,875	22,500	1,625	7.2%	Insurance Expense	125,250	135,000	9,750	7.2%
173,225	138,755	(34,470)	(24.8%)	Repair & Maintenance	793,428	832,530	39,102	4.7%
33,344	48,405	15,061	31.1%	Other Operating Expenses	394,419	290,430	(103,989)	(35.8%)
(479,908)	(489,560)	(9,652)	(2.0%)	Indirect Cost Allocation, Occupancy	(2,827,412)	(2,937,360)	(109,948)	(3.7%)
-	**-**	**-**	**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 Six Months Ending December 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
181,333	172,500	8,833	5.1%	Rental Income	1,100,751	1,035,000	65,751	6.4%
181,333	**172,500**	**8,833**	**5.1%**	**Total Operating Revenue**	**1,100,751**	**1,035,000**	**65,751**	**6.4%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
17,976	13,333	(4,643)	(34.8%)	Purchased Services	76,618	79,998	3,380	4.2%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
-	2,733	2,733	100.0%	Insurance Expense	-	16,398	16,398	100.0%
37,794	25,666	(12,128)	(47.3%)	Repair & Maintenance	198,392	153,996	(44,396)	(28.8%)
10,914	39,933	29,019	72.7%	Other Operating Expenses	147,221	239,598	92,377	38.6%
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
66,684	**81,665**	**14,981**	**18.3%**	**Total Administrative Expenses**	**422,231**	**489,990**	**67,759**	**13.8%**
114,649	**90,835**	**23,814**	**26.2%**	**Change in Net Assets**	**678,519**	**545,010**	**133,509**	**24.5%**

OTHER INCOME STATEMENTS – DECEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($0.4) million, favorable to budget $0.3 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.1 million favorable to budget $0.2 million

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($59,197), unfavorable to budget $15,592

BUILDING 500 INCOME STATEMENT

CHANGE IN NET ASSETS is $114,649, favorable to budget $23,814

- Net of $181,333 in rental income and $66,684 in expenses for the month of December

INVESTMENT INCOME

- Favorable variance of $9.2 million is due to December's interest income of $7.3 million and $2.1 million of unrealized gains due to an increased investment in short-term securities with higher yields

CalOptima Health
Balance Sheet
December 31, 2022

ASSETS		**LIABILITIES & NET POSITION**	
Current Assets		Current Liabilities	
Operating Cash	$788,691,172	Accounts Payable	$55,593,351
Short-term Investments	1,321,795,687	Medical Claims Liability	1,573,242,628
Capitation Receivable	406,195,152	Accrued Payroll Liabilities	13,689,505
Receivables - Other	88,777,921	Deferred Revenue	10,257,983
Prepaid Expenses	19,800,203	Deferred Lease Obligations	73,994
		Capitation and Withholds	93,917,479
Total Current Assets	**2,625,260,134**	**Total Current Liabilities**	**1,746,774,940**
Capital Assets			
Furniture & Equipment	50,187,075		
Building/Leasehold Improvements	5,059,408		
Construction in Progress	4,547,213		
505 City Parkway West	52,951,401		
500 City Parkway West	22,631,500		
	135,376,597		
Less: Accumulated Depreciation	(67,864,515)	Other Liabilities	
Capital Assets, Net	67,512,081	GASB 96 Subscription Liabilities	-
GASB 96 Capital Assets		Other (than pensions) Post	
GASB 96 Subscription Assets	-	Employment Benefits Liability	22,425,370
		Net Pension Liabilities	577,854
Less: GASB 96 Accumulated Depreciation	-	Bldg. 505 Development Rights	-
GASB 96 Capital Assets, Net	-		
Total Capital Assets	67,512,081		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,769,778,164**
Homeless Health Reserve	536,739		
Board-Designated Assets:			
Cash and Cash Equivalents	1,554,383		
Investments	567,014,344	Deferred Inflows	
Total Board-Designated Assets	568,568,727	Excess Earnings	686,563
		OPEB 75 Difference in Experience	4,822,000
		Change in Assumptions	1,909,305
Total Other Assets	569,405,466	OPEB Changes in Assumptions	3,389,000
		Diff in Proj vs Act	20,982,636
		Net Position	
TOTAL ASSETS	**3,262,177,682**	TNE	99,063,353
		Funds in Excess of TNE	1,371,172,253
Deferred Outflows		**TOTAL NET POSITION**	1,470,235,607
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	**3,271,803,275**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,271,803,275**

CalOptima Health
Board Designated Reserve and TNE Analysis
as of December 31, 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	231,827,848				
	Tier 1 - MetLife	229,782,741				
Board-designated Reserve		461,610,588	332,306,104	517,178,728	129,304,485	(55,568,140)
	Tier 2 - Payden & Rygel	53,688,188				
	Tier 2 - MetLife	53,269,951				
TNE Requirement		106,958,138	99,063,353	99,063,353	7,894,785	7,894,785
	Consolidated:	**568,568,727**	**431,369,457**	**616,242,081**	**137,199,270**	**(47,673,355)**
	Current reserve level	*1.85*	*1.40*	*2.00*		

CalOptima Health
Statement of Cash Flows
December 31, 2022

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	25,473,299	50,766,839
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	585,449	3,574,120
Changes in assets and liabilities:		
Prepaid expenses and other	(863,161)	2,792,051
Catastrophic reserves		
Capitation receivable	(5,253,726)	(18,108,487)
Medical claims liability	38,114,170	295,227,279
Deferred revenue	16,600	2,153,939
Payable to health networks	(206,075)	(99,297,150)
Accounts payable	14,622,648	3,276,463
Accrued payroll	(5,337,459)	(5,630,664)
Other accrued liabilities	(3,042)	(18,177)
Net cash provided by/(used in) operating activities	67,148,704	234,736,213
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	(40,488,836)	(307,335,185)
Change in Property and Equipment	(13,408)	(4,222,166)
Change in Restricted Deposit & Other	-	51
Change in Board designated reserves	(1,346,184)	1,922,914
Change in Homeless Health Reserve	-	40,100,000
Net cash provided by/(used in) investing activities	(41,848,428)	(269,534,386)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	25,300,276	(34,798,173)
CASH AND CASH EQUIVALENTS, beginning of period	$763,390,896	823,489,344
CASH AND CASH EQUIVALENTS, end of period	**788,691,172**	**788,691,172**

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BALANCE SHEET – DECEMBER MONTH:

ASSETS of $3.3 billion increased $72.7 million from November or 2.3%

- Operating Cash and Short-term Investments net increase of $65.8 million due to higher State capitation receipts, along with month-end clearing for payment activity
- Capitation Receivables increased $9.2 million due to timing of cash receipt

LIABILITIES of $1.8 billion increased $47.2 million from November or 2.7%

- Claims Liabilities increased $38.1 million due to Proposition 56 risk corridor estimates, COVID-19 risk corridor estimates and timing of claim payments
- Accounts Payable increased $14.6 million due to the timing of capitation premium tax payments
- Offset by:
  - Accrued Payroll Liabilities decrease of $5.4 million

NET ASSETS of $1.5 billion, increased $25.5 million from November or 1.8%

CalOptima Health - Consolidated
Net Assets Analysis
For the Six Months Ended December 31, 2022

Category	Item Description	Amount (millions)	Approved Initiative	Spend to Date	%
	Total Net Position @ 12/31/2022	**$1,470.2**			**100.0%**
Resources Assigned	Board Designated Reserve*	**568.6**			**38.7%**
	Capital Assets, net of depreciation	**67.5**			**4.6%**
Resources Allocated	Homeless Health Initiative**	$64.1	$100.0	$35.9	4.4%
	Intergovernmental Transfers (IGT)	63.7	111.7	48.0	4.3%
	OneCare Member Health Rewards and Incentives	1.0	1.0	0.0	0.1%
	Five-Year Hospital Quality Program Beginning Measurement Year (MY) 2023	153.5	153.5	0.0	10.4%
	Medi-Cal Annual Wellness Initiative	15.0	15.0	0.0	1.0%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.7%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	5.0	5.0	0.0	0.3%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	CalFresh Outreach Strategy	1.3	2.0	0.7	0.1%
	Digital Transformation and Workplace Modernization	96.2	100.0	3.8	6.5%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	Coalition of Orange County Community Health Centers Grant	40.0	50.0	10.0	2.7%
	Subtotal:	**$451.8**	**$566.2**	**$114.4**	**30.7%**
Resources Available for New Initiatives	Unallocated/Unassigned*	**$382.4**			**26.0%**

*Total of Board Designated reserve and unallocated reserve amount can support approximately 97 days of CalOptima Health's current operations
**See Summary of Homeless Health Initiative and Allocated Funds for list of Board approved initiatives

CalOptima Health
Key Financial Indicators
As of December 2022

	Item Name	Month-to-Date (December 2022)					FY 2023 Year-to-Date (July - December 2022)				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	*Member Months*	944,975	905,500	39,475	4.4%		5,612,255	5,475,504	136,751	2.5%	
	*Operating Revenue **	329,355,510	352,179,156	(22,823,646)	(6.5%)		1,977,621,527	2,012,577,662	(34,956,135)	(1.7%)	
	*Medical Expenses **	298,197,638	334,994,845	36,797,207	11.0%		1,845,891,763	1,887,619,046	41,727,283	2.2%	
	General and Administrative Expense	14,629,091	18,061,579	3,432,488	19.0%		88,320,082	105,075,379	16,755,297	15.9%	
	Non-Operating Income/(Loss)	8,944,518	(1,487,087)	10,431,605	701.5%		7,357,157	(3,987,456)	11,344,613	284.5%	
	Summary of Income & Expenses	25,473,299	(2,364,355)	27,837,654	1,177.4%		50,766,839	15,895,781	34,871,058	219.4%	
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	90.5%	95.1%	(4.6%)			93.3%	93.8%	(0.5%)		
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	4.4%	5.1%	0.7%			4.5%	5.2%	0.8%		

Key:
> 0%
> -20%, < 0%
< -20%

	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
Investment	*@12/31/2022*	1,878,834,534	1,837,514,383	41,320,152	2.2%

Unallocated/Unassigned Reserve Balance	Current Month @ December 2022	Fiscal Year Ending June 2022	Change	%
Consolidated	382,354,799	448,294,548	(65,939,750)	(14.7%)
*Days Cash On Hand***	97			

*$135M of Directed Payments (DP) are included in YTD revenue and $133M of DP are included in YTD expenses.
**Total of Board Designated reserve and unallocated reserve amount can support approximatley 97 days of CalOptima Health's current operations.

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Six Months Ending December 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	**181,020**	**3,015,000**	**2,833,980**	**94.0%**	**2,915,353**	**31,783,000**	**28,867,647**	**90.8%**
Operating Expenses:								
Salaries, Wages & Benefits	234,732	505,712	270,980	53.6%	596,788	2,186,364	1,589,576	72.7%
Professional Fees	-	186,041	186,041	100.0%	-	1,116,246	1,116,246	100.0%
Purchased Services	-	13,333	13,333	100.0%	-	79,998	79,998	100.0%
Depreciation Expenses	-	-	-	0.0%	-	-	-	0.0%
Other Expenses	127,909	274,365	146,456	53.4%	304,737	1,646,190	1,341,453	81.5%
Total Operating Expenses	**362,641**	**979,451**	**616,810**	**63.0%**	**901,525**	**5,028,798**	**4,127,273**	**82.1%**

Funding Balance Tracking:	**Actual Spend**	**Approved Budget**
Beginning Funding Balance	100,000,000	100,000,000
Less:		
FY2022-23	3,816,878	47,323,113
FY2023-24		
FY2024-25		
Ending Funding Balance	**96,183,122**	**52,676,887**

CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of December 2022

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	8,250,000	6,194,190	2,055,810
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	6,000,000	1,681,734	4,318,266
Homeless Coordination at Hospitals	10,000,000	8,611,208	1,388,792
Homeless Clinical Access Program (HCAP) and CalOptima Days	2,700,000	2,891,200	(191,200)
FQHC (Community Health Center) Expansion	300,000	21,902	278,098
Cal Optima Days, HCAP and FQHC Administrative Support	963,261	678,278	284,983
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
Street Medicine	8,000,000	-	8,000,000
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP): 40.1 million			
Office of Care Coordination	2,200,000	-	2,200,000
Pulse For Good	800,000	-	800,000
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	5,000,000	-	5,000,000
Infrastructure Projects	10,500,000	-	10,500,000
Capital Projects	21,000,000	-	21,000,000
Subtotal of Approved Initiatives	**$99,463,261**	**$35,883,160**	**$63,580,101**
Program Commitment Balance, available for new Initiatives	536,739		536,739
Program Total	**$100,000,000**	**$35,883,160**	**$64,116,840**

CalOptima Health
Budget Allocation Changes
Reporting Changes for December 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 Purchased Services – Health Reward Incentive Fulfillment to Incentive Budget for PHM Health Rewards	2022-23
September	No budget reallocations for September					2022-23
October	Medi-Cal	Quality Improvements - Professional Fees - Consultants for NCQA Accreditation	Quality Improvements - Subscriptions - CAQH Application Subscription - Credentialing Database	$75,000	To reallocate funds from Professional Fees – Consultants for NCQA Accreditation to Subscriptions – CAQH Application Subscription – Credentialing Database to provide additional funding for expanding scope of services	2022-23
November	OneCare	Customer Service - Member Communication	Cultural & Linguistic Services - Purchased Services	$75,000	To reallocate funds from OC Customer Service – Member Communication to OC Cultural & Linguistic Services – Purchased Services to provide additional funding for translation of documents due to OCC/OC transition	2022-23
November	Medi-Cal	Human Resources - Cert/Cont. Education	Human Resources - Training & Seminars	$10,000	To reallocate funds from HR Onsite Computer Classes to Training & Seminars, HR Staff Development (for the CPS Academy classes)	2022-23
November	Medi-Cal	Population Health Management - Professional Fees	Case management - Training & Seminars	$27,000	To reallocate funds from Population Health Management – Purchased Services to Case Management – Training & Seminars to provide funding for WPATH training	2022-23
December	Medi-Cal	Quality Improvements - Subscriptions	Quality Improvements - Purchased Services	$75,000	To reallocate funds from Subscriptions – CAQH Application Subscription – Credentialing Database to Purchased Services to provide funding for additional credentialing services with a new vendor	2022-23
December	Medi-Cal	Communications - Purchased Services	Communications - Public Activities	$10,000	To reallocate funds from Purchased Services to Public Activities to provide funding for additional Medi-Cal Campaigns Support	2022-23
December	Medi-Cal	Population Health Management - Purchased Services	Quality Improvements - Purchased Services	$24,950	To reallocate funds from Population Health Management – Purchased Services to Quality Improvement – Purchased Services to provide additional funding for CVO credentialing services	2022-23
December	PACE	Capital: Interior Light Improvement	Capital: Additional Furniture, Fixtures and Equipment	$35,000	To reallocate funds from Interior Light Improvement to Additional Furniture Fixtures	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
February 2, 2023

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima Health's Board of Directors including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima Health's 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)*:

  - CMS provided feedback on the IVA report on September 12, 2022.
    - Inquiries/feedback were not substantial
  - Responses were submitted to CMS on September 30, 2022.
  - CalOptima Health had a call scheduled with CMS on January 10, 2023 to address the IVA report. CMS requested a corrective action plan (CAP) response for Formulary Administration (FA) 2.06 and Special Needs Plan Model of Care (SNP MOC) 5.41, due to CMS by January 18, 2023.
  - Once both CAP responses are reviewed and approved by CMS, both conditions will undergo another focused validation audit.

- 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.
  - The virtual audit was conducted by BluePeak October 11-17, 2022.
  - BluePeak provided the draft audit report on October 26, 2022 for review.
  - Blue Peak issued the final audit report on December 23, 2022. Audit results summary is provided below:

This chart summarizes the results of our review of Sponsor's compliance with CMS Medicare Advantage and Prescription Drug Program requirements.

Program Area	# of Invalid Data Submission (IDS)	# of Observations	# of Observations Requiring Corrective Action (ORCA)	# of Corrective Action Required (CAR)	Points (IDS) + (CARs)	# of Audit Elements Tested	Score[1] (Points / Elements Tested)
Total - Compliance Program Effectiveness (CPE)	0	1	1	1	1	3	0.33

[1]Note that a lower audit score denotes a better performing Sponsor.

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- The findings were minimal, and CalOptima Health Medicare Regulatory Affairs and Compliance (RAC) is implementing process improvements accordingly.

- 2022 Timeliness Monitoring Project (TMP) (*applicable to OneCare*):

  - CMS conducts an annual industry-wide appeals timeliness monitoring project. The 2022 TMP included a retrospective collection and review of CY 2022 Q1 data for standard and pre-service reconsiderations and payment reconsiderations.
  - CalOptima Health participated in two TMP audit webinars with a CMS contractor on September 26 and 29, 2022.
  - The CMS contractor validated the two reconsideration universes and has submitted the results to CMS.
  - CalOptima Health is awaiting timeliness results from CMS.

- 2023 Medicare Part C and Data Part D Data Validation Audit (MDVA)

  - CMS requires Sponsors to participate in a yearly independent review to validate data reported to CMS per the Medicare Part C and Part D Reporting Requirements.
  - On December 12, 2022, Regulatory Affairs and Compliance (RAC) began collecting universes. The reporting measures will be submitted no later than the regulatory deadlines of February 6 and February 27, 2023.

- 2023 CMS Readiness Checklist (applicable to OneCare):

  - A routine readiness checklist is released annually by CMS in anticipation of the upcoming calendar year.
  - On October 17, 2022, CMS released the 2023 Readiness Checklist.
  - CalOptima Health is expected to fulfill ongoing key operational Part C and D requirements summarized in the readiness checklist for the 2023 benefit year.
  - Regulatory Affairs and Compliance (RAC) is leading the 2023 Readiness Checklist activities with all departments to ensure compliance for requirements impacting their respective operational area(s).
  - The validation audit activities are expected to conclude by early January 2023.

2. Medi-Cal

- 2024 Managed Care Plan (MCP) Operational Readiness Contract:

  Update:

  As of December 22, 2022, CalOptima Health has **submitted a total of** 99 **deliverables** for 2024 MCP operational readiness. To date, CalOptima Health has received **approval for** 61 items. The remaining deliverables are awaiting response from the Department of Health Care Services (DHCS) or under review by CalOptima Health as part of an additional information request made by DHCS.

- Phase 1: Deliverable due dates vary from August 12, 2022 – December 15, 2022
  - 12/15/22 deliverables – submitted timely
  - 10/3/22 deliverables – submitted early on September 29, 2022
  - 9/12/22 deliverables – submitted timely
  - 8/12/22 deliverables – submitted timely
- Phase 2: Deliverables due December 15, 2022 – March 31, 2023
  - 12/19/22 deliverables – submitted timely
  - 1/9/23 deliverables – submitted timely
  - 3/1/23 deliverables – on-track
  - 3/30/23 deliverables – on-track
- Phase 3: Deliverables due April 20, 2023 – July 31, 2023

On-track for all remaining deliverables. Each phase must be completed and approved by DHCS prior to the initiation of the next phase.

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 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.

- 2023 DHCS Medical Audit:

On December 14, 2022, CalOptima Health was formally engaged by DHCS for its annual medical audit. This year is considered a **full-scope audit**, as such, many areas not audited in recent years are included (i.e., Cultural &Linguistics, Health Ed, Privacy, Complex Case Management, etc.).

This annual audit will consist of an evaluation of CalOptima Health's compliance with its contract and regulations in the areas of:

- utilization management
- case management and coordination of care
- availability and accessibility
- member rights
- quality management
- administrative and organizational capacity

In addition to its annual audit scope, DHCS simultaneously engaged CalOptima Health in a focused audit for services related to:

- Transportation
- Behavioral Health

This focused review is anticipated and aligned with DHCS' previous communication, distributed on November 3, 2022, which informed MCPs, including CalOptima Health, that DHCS would be conducting a focused audit to assess performance in identified high – risk areas starting in January 2023. These areas include behavioral health and transportation.

- **Key points/dates:**

  - Lookback-period: 2/1/22 - 1/31/23
  - Line of Business: Medi-Cal (including SPD and Non-SPD population), OneCare Connect
  - Delegate Impact: Yes, Monarch was selected to participate
  - Audit Interviews: 2/27/23 - 3/10/23, will occur virtually
  - Entrance Conference: 2/27/23 at 9:00am, will occur virtually
  - Provider Office Impact: Yes. The audit will also involve facility site visits and medical record review; this means impact to Provider offices.
  - Deliverables are due to DHCS by 1/12/23 and 1/20/23

  Regulatory Affairs and Compliance (RAC) staff have met with all areas responsible for universe data. Meetings and outreach will continue to ensure all impacted stakeholders are prepared leading up to the universe submissions. RAC will ensure all audit documents are reviewed prior to DHCS submission.

- 2021 DHCS Medical Audit:

  Update: On December 22, 2022, CalOptima Health submitted its formal corrective action plan to DHCS.

  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.
  - Audit close-out: 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: No updates.

  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.

- On 10/27/22, CalOptima Health met virtually with CMS & DHCS to discuss the internal PI efforts in place to ensure adequate oversight, as well as to deter and address fraud, waste, and abuse.
  - As requested by the auditors, CalOptima Health submitted a number of supporting documents and narrative responses by 11/10/22.

B. Regulatory Notices of Non-Compliance

- DHCS Quality Sanction

  - On December 13, 2022, the DHCS issued a **notice of imposition of monetary sanctions** to CalOptima Health in the amount of $25,000 for failure to meet Medi-Cal Managed Care Accountability Set (MCAS) measures for measurement year 2021.
  - In response to this quality sanctions notice, CalOptima Health must take the following actions:
    - Submit a revised comprehensive quality strategy to DHCS no later than **COB, Tuesday, January 31, 2023**.
    - Notify DHCS **within two business days (Thursday, November 15, 2022)** of this notice should CalOptima Health want to meet with DHCS to share additional information that may impact the sanction amount.
  - CalOptima Health has responded to DHCS to acknowledge receipt of the notice and to request a meeting to confer.
  - The "meeting to confer" scheduled date is January 13, 2023.
  - Appeal – If CalOptima Health decides to file an appeal, it has until January 23, 2023 to request a hearing.

- CMS Warning Letter

  - On December 21, 2022, CMS issued a Warning Letter (without Business Plan) to CalOptima Health's OneCare (H5433) Plan. CalOptima Health failed to submit 4Rx data after receiving the transaction reply reports (TRR) for CMS-generated enrollments as of December 20, 2022. Table 1 below provides the information on the number of beneficiaries whose January 1, 2023 enrollments have been generated by CMS but are still missing 4Rx data.

H5433 ORANGE COUNTY HEALTH AUTHORITY

Total TRC Sent	Number Missing 4Rx Data	Percent Missing 4Rx Data
14,292	13,932	97%

  - In response to the Warning Letter, on December 22, 2022, CalOptima Health has successfully submitted to CMS the 4RX file for the OneCare members who are effective January 1, 2023.
  - On December 23, 2022, RAC (Medicare) issued a corrective action plan (CAP) to the Customer Service Department. The CAP is due on January 10, 2023.

C. Updates on Internal and Health Network Monitoring and Audits

- 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:
    - Optum Care Arta– July 1, 2021 – June 30, 2022 (audit review period)
    - Optum Care Monarch– July 1, 2021-June 30, 2022 (audit review period)
  - 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
Optum Care Arta	100%	100%	100%	100%	100%	98%	100%	100%
Optum Care Monarch	100%	100%	100%	100%	100%	100%	100%	N/A

Non-Clinical File Review

Delegated Entity	Claims, Approved	Claims, Denied	PDRs	Customer Service	Initial Provider Training		Annual Provider Training		Initial Staff Training		Annual Staff Training	
					TAT	CT	TAT	CT	TAT	CT	TAT	CT
Optum Care Arta	98%	91%	94%	24%	100%	100%	100%	100%	78%	78%	86%	86%
Optum Care Monarch	99%	96%	98%	72%	0%	10%	0%	0%	100%	100%	100%	100%

- The compliance percentages shown are aggregate scores that include universe reviews, timeliness standards and processing accuracy of the sample selected.

TAT* Turnaround Time
CT* Completed Training

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Clinical Policy Review

Delegated Entity	Case Management	Case Management, Whole Child Model	Medi-Cal Addendum	Utilization Management
Optum Care Arta	100%	100%	100%	100%
Optum Care Monarch	100%	100%	100%	100%

Clinical File Review

Delegated Entity	Blood Lead Screening (MC)	Case Management	Community Support(s) (MC)	Whole Child Model (MC)	Expedited (MC)	NEMT (MC)	PSA (MC)	Retrospective Denials (MC	Standard (MC)	(NOMNC) (OC)	Pre-Service ODAG	MMP SARAG
Optum Care Arta	63%	91%	100%	None Reported	91%	100%	100%	None Reported	91%	100%	100%	99%
Optum Care Monarch	73%	98%	83%	None Reported	91%	87%	51%	87%	91%	54%	90%	88%

- The compliance percentages shown are aggregate scores that include universe reviews, timeliness standards and processing accuracy of the sample selected.

Credentialing and Recredentialing Policy

Delegated Entity	Policy Review
Optum Care Arta	100%
Optum Care Monarch	100%

Delegated Entity	Initial Credentialing File Review	Recredentialing File Review
Optum Care Arta	100%	100%
Optum Care Monarch	100%	73%

- Internal Audits

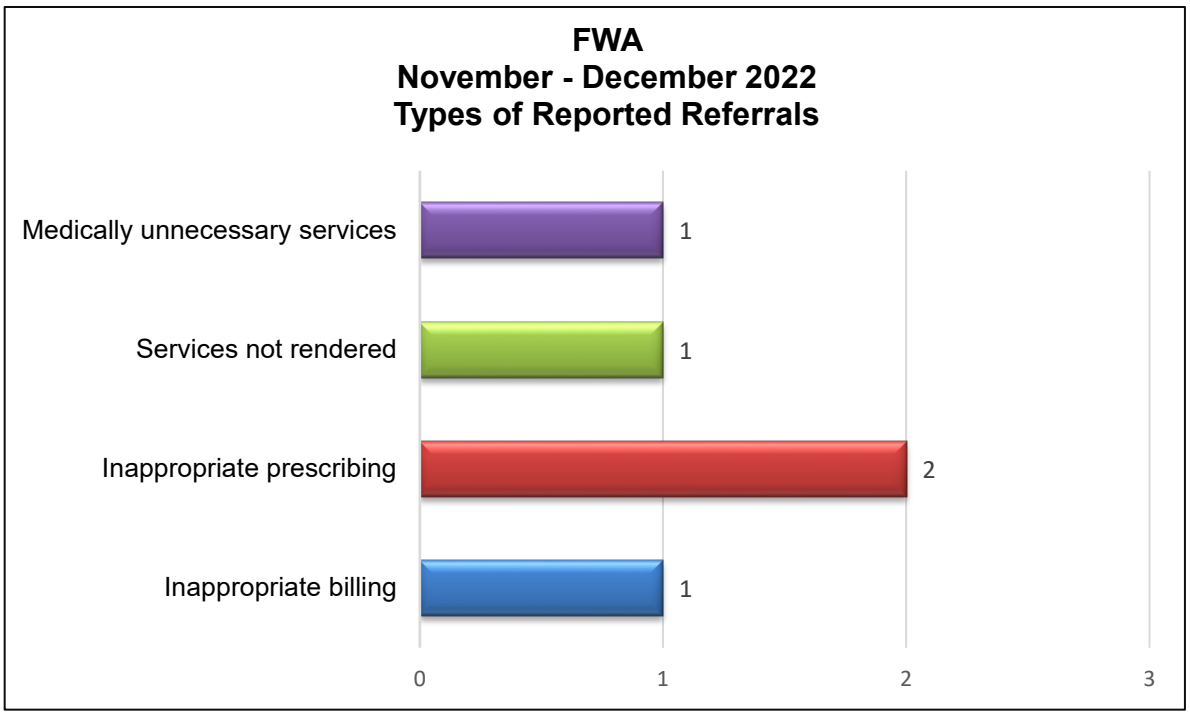
  - Internal Audit of Behavioral Health Services and Authorization Requests
    - During the fourth quarter of 2022, CalOptima's Audit & Oversight (A&O) department conducted an internal audit of Behavioral Health Services to ensure compliance with universe, timeliness, clinical decision-making, and processing requirements, as applicable for the review period of March 1, 2022 – September 30, 2022.
    - For areas that scored below the 95% threshold, A&O issued a corrective action plan (CAP) request and is actively working with the department to remediate findings.

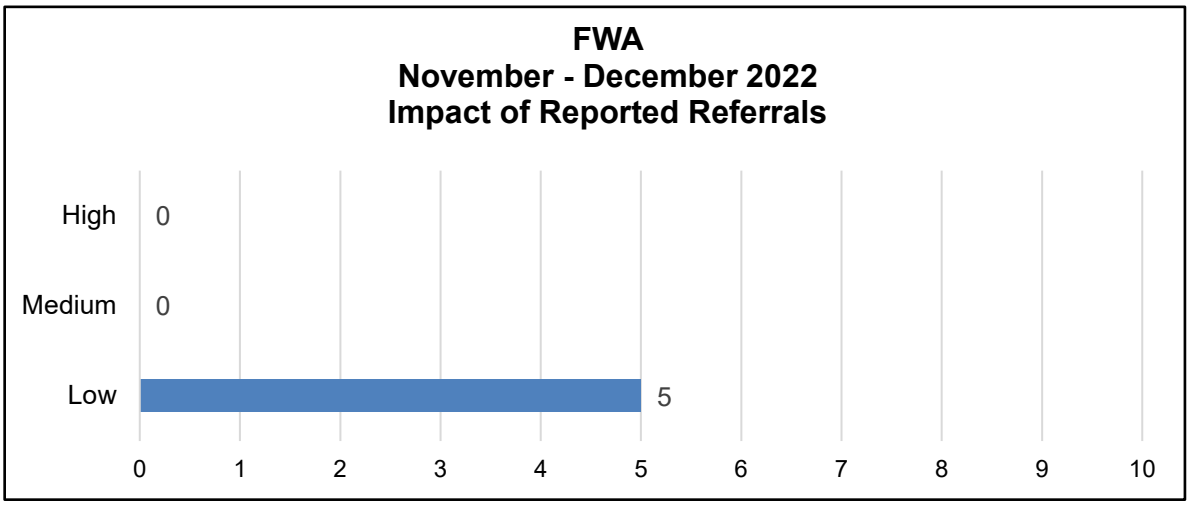
Audit Area	Files Reviewed	Files Passed	Final Audit Score
Behavioral Health Services			
Universe Integrity	30	0	0%
Referral Timeliness, within 15 business days	30	25	83%
Members under 21	30	30	100%
BH Treatment Plan Criteria Accuracy	30	30	100%
Behavior Health Treatment - Utilization Management			
Urgent Requests	N/A	N/A	None Reported
Universe Integrity (Standard)	30	30	100%
File Classification (Standard)	30	30	100%
Resolution Timeliness (Standard)	30	30	100%
Provider and Member Notification Timeliness (Standard)	30	30	100%
Clinical Decision-Making Review (Standard)	30	30	100%
Processing Accuracy (Standard)	30	30	100%
Written Response in Members Preferred Language (Standard)	4	0	0%
Accuracy of Member Notice Content (Standard)	4	1	25%

- Internal Audit of Customer Service OneCare
  - During the end of the third quarter of 2022, CalOptima's Audit & Oversight (A&O) department conducted an internal audit of Customer Service handling of Oral Grievances for OneCare and Call Log Classification to ensure compliance with universe, timeliness, clinical decision-making, and processing requirements, as applicable for the review period of March 1, 2022 – August 31, 2022.
  - For areas that scored below the 95% threshold, A&O issued a corrective action plan (CAP) request and is actively working with the department to remediate findings.

Audit Area	Files Reviewed	Files Passed	Final Audit Score
Customer Service ODAG 5			
Misclassified	10	10	100%
File Review	10	9	90%
Universe	10	10	100%
Customer Service ODAG 14			
Misclassified	10	10	100%
File Review	10	9	90%
Universe	10	10	100%
Customer Service CDAG 16			
Misclassified	10	10	100%
File Review	10	10	100%
Universe	10	10	100%

D. Fraud, Waste & Abuse (FWA) Investigations (November and December 2022)

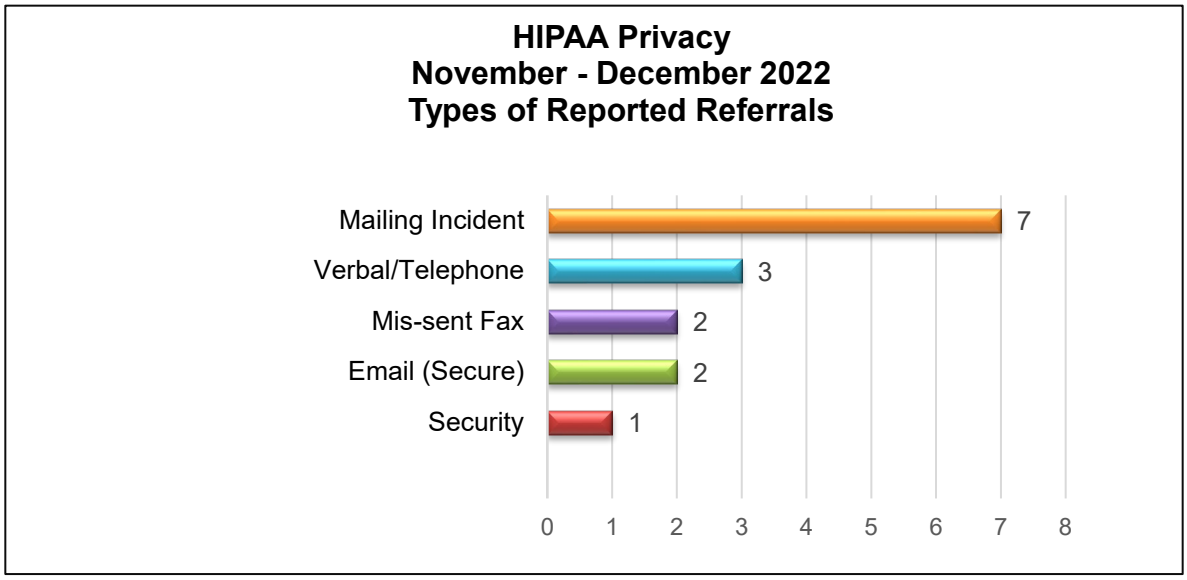


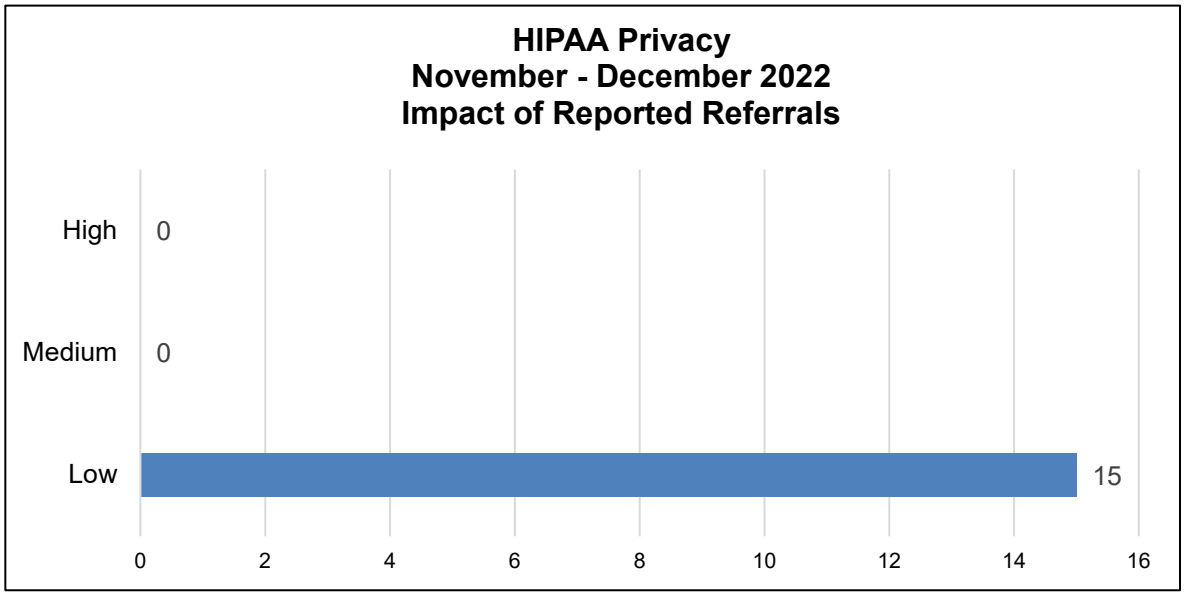


Total Number of New Cases Referred to DHCS (State)	5
Total Number of New Cases Referred to DHCS and CMS*	5
Total Number of Referrals (Subjects) Reported to Regulatory Agencies	**5**

*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: (November and December 2022)





PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	15
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

January 13, 2023

To: CalOptima Health

From: Potomac Partners DC & Strategic Health Care

Re: January Board of Directors Report

118TH SESSION CONGRESSIONAL LEADERSHIP

Newly elected and re-elected Members of the United States Senate were sworn into office by Vice President Kamala Harris on Tuesday, January 3rd, to start the 118th Session of Congress. Shortly after the swearing-in ceremonies, the Senate subsequently began a short recess period with plans to return on January 23rd. Senator Chuck Schumer (D-NY) will be the Senate Majority Leader, and Senator Mitch McConnell (R-NY) will be the Senate Minority Leader.

Meanwhile, the House of Representatives spent the first week of the 118th Session voting for a Speaker of the House. On Friday night, January 6th, Rep. Kevin McCarthy was elected as Speaker of the House on the 15th ballot, the first time a series of votes for Speaker has lasted this long since the 19th century. A group of 20 Republicans from the Freedom Caucus initially opposed McCarthy's bid for Speaker citing a lack of confidence in the process and the proposed "rules package" that will govern the parliamentary and legislative process in the House for the next two years. The negotiated rules package and summaries, showing changes made to the text, is included later in this report.

FISCAL YEAR 2023 APPROPRIATIONS (OMNIBUS)

Just before the end of the 117th Session, Congress has passed the Fiscal Year 2023 (FY23) omnibus, H.R. 2617 - *Consolidated Appropriations Act, 2023*. The bill was signed into law by the President on December 29th. It provides $1.7 billion in discretionary spending for the period of October 1, 2022 – September 30, 2023. In total, the regular 12 appropriations bills include $800 billion in non-defense funding, $68 billion (9.3%) above FY22 enacted spending. This is the highest level for non-defense funding ever and a larger increase in both dollar and percentage than fiscal year 2022. The bills also provide $858 billion in defense funding. The appropriations bill also includes $5 billion in mandatory funding for the Cost of War Toxic Exposures Fund established in the Honoring Our PACT Act of 2022.

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The omnibus also **preserves earmarks** that were included in the House and Senate drafts released earlier this year. **CalOptima Health received $2,000,000** in the bill under the Department of Health and Human Service, Health Resources and Services Administration (HRSA) account on page 280 of the Labor-HHS-Education title.

A short summary of the omnibus is included below:

Agriculture, Rural Development, Food and Drug Administration

- **$455 million** for the expansion of broadband services, including $348 million for the ReConnect Program, $138.6 million lower than the FY 2022 enacted levels, and $35 million for Community Connect Grants, equal to what was enacted in the FY 2022 appropriations bill.
- **$3.5 billion** in discretionary funding for the Food and Drug Administration (FDA), an increase of $226 million above the FY 2022 enacted level, to provide targeted increases to address the opioid crisis, medical supply chain issues, and funds to accelerate response to food-contagion outbreaks.

Commerce-Justice-Science

- **$770.8 million** for Byrne Memorial Justice Assistance Grants, $96.3 million above the FY 2022 enacted level, including $10 million for the Officer Training for Responding to People with Mental Illness and Disabilities Program, $20 million for the Project Safe Neighborhoods Program, and more than $400 million in community project funding to fight crime and improve public safety.
- **$445 million** for Comprehensive Addiction and Recovery Act grant programs, $30 million above FY 2022 enacted levels, to fund drug, mental health, and veteran treatment courts and substance abuse treatment programs administered by state and local correctional facilities.
- **$225 million** for Grants to Reduce the Sexual Assault Kit Backlog.

Labor, Health and Human Services, Education

- **$120.7 billion** for the **Department of Health and Human Services**, an increase of $9.9 billion over the FY 2022 enacted level. This includes $1.5 billion for the Advanced Research Projects Agency for Health (ARPA-H), an increase of $500 million above the FY 2022 enacted level, to accelerate research for diseases such as ALS, Alzheimer's disease, diabetes, and cancer.
- **$9.7 billion** for the **Health Resources and Services Administration (HRSA)**, an increase of $852 million above the FY 2022 enacted level, with $828 million for the Maternal and Child Health Block Grant, $509 million for Title VII Health Professions Education and Training, and $352 million for Rural Health Programs.

- **$9.2 billion** for the **Centers for Disease Control and Prevention (CDC)**, an increase of $760 million above the FY 2022 enacted level, with $350 million for public health infrastructure and capacity, and $175 million to modernize public health data surveillance and analytics.
- **$7.5 billion** for the **Substance Abuse and Mental Health Services Administration (SAMHSA),** $970 million above the FY 2022 enacted level.
- **$1.6 billion** to states to address the opioid epidemic through the State Opioid Response Grant.
- A **$100 million** increase for the Substance Abuse Prevention and Treatment Block Grant.
- **$111 million** for medication assisted treatment (MAT).
- **$505 million** for opioid overdose surveillance and prevention at CDC.
- **$80 million** to address the needs of children affected by the opioid crisis.
- **$145 million** to help affected rural communities combat the opioid epidemic.
- Sec. 4113 - **Extends all Medicare telehealth flexibilities** that were extended in the Consolidated Appropriations Act, 2022, through December 31, 2024.
- Sec. 5111. **Extends funding for CHIP** for two years through fiscal year 2029.
- Sec. 5112. Requires children to be provided with 12 months of continuous coverage in Medicaid and CHIP effective January 1, 2024.
- Sec. 5113. Makes permanent a state option to allow states to continue to provide 12 months of continuous coverage during the postpartum period in Medicaid or CHIP.
- Sec. 5114. Extends funding for the **Medicaid Money Follows the Person Rebalancing Demonstration** program at $450 million per year through fiscal year 2027.
- Sec. 5131 – Transitioning from **Medicaid FMAP Increase Requirements**.

Transportation, Housing, and Urban Development

- **$58.2 billion** for the Department of Housing and Urban Development, $4.5 billion above the FY 2022 enacted level. The bill also includes $3.6 billion for Homeless Assistance Grants, an increase of $420 million above FY 2022.

HOUSE RULES PACKAGE

On January 9th, the House approved a "Rules Package" by a vote of 220-213 that will dictate the rules of the House of Representatives for the 118th session, including floor procedures, the terms and conditions of debate on a measure, and the standing rules of the U.S. House. This session, the rules package has undergone some last-minute changes resulting from negotiations between the Freedom Caucus, a small group of Republicans who opposed Rep. McCarthy's bid for Speaker, and Speaker McCarthy. Differences in the original rules package and the final versions can be found below:

- Version 1 of H. Res. _: as published by Republican staff on January 1, 2023

- Version 1 of Section by Section: as published by Republican staff on January 1, 2023
- **Full text of the final rules package** can be found **here**.
- **Section-by-section analysis of the final rules package** can be found **here**.
- Comparative Print: Showing the differences between version 1 and final version of H. Res. _

The rules package includes several items designed to reduce long-term spending, grant the House investigatory powers into the origins of COVID-19, increase oil and gas production, rescind certain funding for the Internal Revenue Service, and more.

The House's legislative session calendar for 2023 is here.
The Senate's legislative session calendar for 2023 is here.

PUBLIC HEALTH EMERGENCY (PHE) DESIGNATION

On January 11th, Secretary of Health and Human Services Xavier Becerra renewed the Public Health Emergency (PHE) another 90 days, until at least April 11.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate Bridget E. McGowan Associate

January 20, 2023

LEGISLATIVE UPDATE

Edelstein Gilbert Robson & Smith LLC

General Update

The Legislature reconvened for the first day of 2023-24 Legislative Session on January 4. Now that they have returned to Sacramento, legislators will continue to introduce new bills and will have until February 17 to do so.

Prior to the first day of regular session, the Legislature convened on December 5 for an "Organizational Session." Along with swearing in the new members, the organizational session included formal votes for Caucus leadership and other positions like the Chief Clerk and Sergeant. Of particular interest this year was the vote to affirm the deal reached by the Assembly Democratic Caucus on the future of the Assembly Speakership. Assemblymember Rendon was reelected as Speaker, with Assemblymember Rivas voted in as Speaker-designee, slated to take over the position after June 30, 2023. This comes after a standoff within the caucus that originated in May when Assemblymember Rivas first challenged for the Speakership.

The CalOptima Health team came up to Sacramento for the organizational session and had a productive day meeting with members of CalOptima Health's legislative delegation and sharing updates on what the organization is doing for its members and the community.

In early January, CEO Michael Hunn and Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM also had the opportunity to present to the Assembly Democratic Caucus to provide background on CalOptima Health as an organization and how CalOptima Health is implementing CalAIM to address homelessness. We are told the presentation was a success and allowed for a dynamic discussion among the presenters and the Caucus.

Budget Update

On January 10, Governor Newsom presented his 2023-24 January Budget proposal. His budget presentation emphasized the somber fiscal outlook the state is facing, including the updated deficit figure of $22.5 billion.

In response to the deficit, the Governor proposed reductions and other cost saving measures in various areas, primarily concentrated in the climate and

transportation sectors. Many of the cuts are “trigger reductions” that would be restored if the state’s budget situation improves by January of next year.

Investments in healthcare were largely spared and the proposed budget maintains $10 billion in spending for CalAIM implementation and the Governor’s previous commitment to expand Medi-Cal to all low-income adults aged 26-49 regardless of immigration status.

Since the budget release, the Legislative Analyst’s Office (LAO) released a report on the 2023-24 Budget and an updated revenue outlook that anticipates a good chance that the revenue estimates will come in lower than the Governor’s estimates, forecasting a deeper budget deficit than the Administration's $22.5 billion. Given this, the LAO recommends that the Legislature plan for a larger deficit by further reducing one-time and temporary spending.

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2023–24 Legislative Tracking Matrix

With the recent commencement of the new 2023–24 sessions of the United States Congress and the California State Legislature, all unpassed legislation from the previous sessions has now expired. As legislators begin to introduce legislation in the new sessions, CalOptima Health will identify any bills that may impact its members, providers and stakeholders. The first edition of the 2023–24 Legislative Tracking Matrix will be released in the coming weeks.

2023 Federal Legislative Dates

January 3	118th Congress, 1st Session convenes
July 31–September 4	Summer recess for Senate
July 31–September 11	Summer recess for House
December 15	1st Session adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2023 State Legislative Dates

January 4	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 17	Last day for legislation to be introduced
March 30–April 10	Spring recess
April 28	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 5	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 19	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
May 30–June 2	Floor session only
June 2	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 14	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 14–August 14	Summer recess
September 1	Last day for fiscal committees to report bills in their second house to the Floor
September 5–14	Floor session only
September 8	Last day to amend bills on the Floor
September 14	Last day for each house to pass bills; final recess begins upon adjournment
October 14	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2023 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

Last Updated: January 20, 2023

Board of Directors Meeting
February 2, 2023

CalOptima Health Community Outreach Summary — January and February 2023

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To this end, our team attends community coalitions, collaborative meetings and advisory groups as well as supports our community partners' public activities.

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

On December 13, 2022, CalOptima Health hosted a virtual Community Alliances Forum aimed at bringing our community together to gain an understanding of justice-involved populations and increase awareness and support for them. The forum highlighted the unique health and transition needs of the justice-involved population with substance use disorder (SUD), the challenges and successes in achieving access to SUD treatment for this population, and how Orange County is mobilizing community resources to address the needs of this population through CalAIM. The event featured an extraordinary panel of speakers from Project Kinship, Health Management Associates, Orange County Health Care Agency and CalOptima Health. During the event, an individual who went through the justice system and transformed his life to give back to his community by serving others involved in the justice system offered a testimonial. A total of 184 community stakeholders attended the event, and their evaluations provided valuable feedback indicating that all attendees had a positive experience.

Summary of Public Activities

As of December 30, CalOptima Health plans to participate in, organize or convene 57 public activities in January and February. In January, there will be 33 public activities, including 20 virtual community/collaborative meetings, three community-based presentations, nine community events and one Health Network Forum. In February, there will be 24 public activities, including 15 virtual community/collaborative meetings, six community events, one community-based presentation, 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 one endorsement 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's name or logo on Serve the People's mobile food truck to increase access to nutritious food for CalOptima Health members.

For additional information or questions, contact CalOptima Health Community Relations Manager Tiffany Kaaiakamanu at 657-235-6872 or tkaaiakamanu@caloptima.org.

Updated 2022-12-30

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Community events hosted by CalOptima Health and community partners in January and February 2023:

January 2023			
1/10 9:30 –11 a.m.	**CalOptima Health Virtual Community Resource Fair: Resources to Support Housing in Orange County: Youth*** Virtual	At least five staff members attended.	• Health/resource fair • Open to community stakeholders; registration required
1/11 11a.m.–1 p.m.	**Food Distribution Resource Fair hosted by Big Brothers Big Sisters of Orange County†** Big Brothers Big Sisters of Orange County 1801 E. Edinger, Suite 101 Santa Ana	At least one staff member attended (in-person).	• Health/resource fair • Open to the public
1/11 3–4 p.m.	**Research Update for National Alzheimer's Awareness Month hosted by Alzheimer's Association†** Virtual	At least two staff members attended. Sponsorship fee: $500; included logo placement on event flyer, website and presentation.	• Forum • Open to the public
1/12 10–11 a.m.	**CalOptima Health Medi-Cal Overview Presentation in English** Buena Park Community Center 6688 Beach Blvd., Buena Park	At least one staff member presented (in-person).	• Community-based organization presentation • Open to members only
1/18 1:30–3 p.m.	**InfoSeries: A Local and National Snapshot on Homelessness for Older Adults*** Virtual	At least five staff members attended.	• Health/resource fair • Open to community stakeholders; registration required
1/19 2–3:30 p.m.	**CalOptima Health Virtual Community Resource Fair: Resources to Support Housing in Orange County: Families*** Virtual	At least five staff members attended.	• Health/resource fair • Open to community stakeholders; registration required
1/19 9–11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members attended.	• Forum • Open to health and human service providers
1/21–1/22 10 a.m.–5 p.m.	**Orange County Tet Festival hosted by Viet America Society†** Mile Square Regional Park 16801 Euclid St., Fountain Valley	At least 16 staff members attended (in-person). Sponsorship fee: $15,000; included resource table, three banner displays, 25 radio impressions, full size ad on flyer, and logo on the backdrop of the stage.	• Health/resource fair • Open to the public
1/23 9–10 a.m.	**CalOptima Health Medi-Cal Overview Presentation in English** Pathways of Hope 1231 E. Chapman Ave. Fullerton	At least one staff member presented (in-person).	• Community-based organization presentation • Open to members/community

* CalOptima Health-hosted
† Exhibitor/Attendee

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1/25 2–3:30 p.m.	**CalOptima Health Virtual Community Resource Fair: Resources to Support Housing in Orange County: Pregnant Women*** Virtual	At least five staff members attended.	• Health/resource fair • Open to community stakeholders; registration required
1/26 9–10 a.m.	**CalOptima Health Medi-Cal Overview Presentation in English** Westminster School District 14121 Cedarwood St. Westminster	At least one staff member presented (in-person).	• Community-based organization presentation • Open to members/community
1/28–1/29 10 a.m.–5 p.m.	**41st Annual UVSA Tet festival hosted by the Union of Vietnamese Student Associations†** OC Fair and Event Center 88 Fair Dr., Costa Mesa	At least 16 staff members attended (in-person). Sponsorship fee: $12,000; included resource table, logo and link on event website for one year, social media post, 40 admission tickets, four admission badges, three day parking hang tags, three banner displays, three runs on graphic ad on main stage, and half page color ad in event program book.	• Health/resource fair • Open to the public
1/31 9–10:30 a.m.	**CalOptima Health Virtual Community Resource Fair: Resources to Support Housing in Orange County: Adults*** Virtual	At least five staff members attended.	• Health/resource fair • Open to community stakeholders; registration required
February 2023			
2/4 9 a.m.–4 p.m.	**Orange County Black History Unity Festival hosted by the OC Heritage Council†** 205 W. Center St., Anaheim	At least one staff member to attend (in-person). Registration fee: $150; includes resource table at event.	• Health/resource fair • Open to the public
2/6–2/7 9 a.m.–4 p.m.	**Insure the Uninsured Project (ITUP) 27th Annual Conference on Cultivating an Equitable Future of Health†** Hybrid	At least one staff member to attend (in-person). Sponsorship fee: $5,000; includes resource table, company name on event signage, materials acknowledgment, company logo on ITUP website and communications, and two complimentary tickets.	• Conference • Open to the public
2/9 9 a.m.–Noon	**Homeless and Behavioral Health Provider Resource Fair hosted by the City of Huntington Beach†** Huntington Beach Central Library 7111 Talbert Ave., Huntington Beach	At least two staff members to attend (in-person).	• Health/resource fair • Open to the public
2/14 9–10 a.m.	**CalOptima Health Medi-Cal Overview Presentation in Spanish** Sonora High School 401 S. Palm St., La Habra	At least one staff member to present (in-person).	• Community-based organization presentation • Open to members/community

* CalOptima Health-hosted
† Exhibitor/Attendee

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2/16 9–11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members to attend.	• Forum • Open to health and human service providers
2/21 11 a.m.–2 p.m.	**Mental Wellness Fair hosted by Partners4Wellness†** UCI Student Center Pacific Ballrooms 311 W. Peltason Dr., Irvine	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
2/22 7 a.m.–5:30 p.m.	**Annual Health Care Forecast Conference hosted by UCI Paul Merage School of Business†** 100 Academy Way, Irvine	Sponsorship fee: $5,000; includes three complimentary conference registrations; three complimentary conference webinar registrations; three guests to attend the inaugural welcome reception featuring keynote speaker; resource table to provide brochures; social media announcement featuring sponsors; company logo recognition in pre-conference emails; company logo on all marketing emails, conference app, and website; and marketing toolkit for social media.	• Forum • Open to health and human service providers
2/27 5–6 p.m.	**Youth Mental Health and Suicide Prevention hosted by the Garden Grove Unified School District†** Pacifica High School 6851 Lampson Ave., Garden Grove	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
2/28 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 Health Board Action Agenda Referral

Action To Be Taken February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

11. Authorize Actions for Contracts for the Proposed Community Living and PACE Center in the City of Tustin

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno Nelson, Executive Director of Medi-Cal and CalAIM, (657) 900-1481

Recommended Actions

1. Authorize the Chief Executive Officer to enter into a sole source contract with Totum Corporation (Totum) to complete full scope design services, consisting of completing a building physical assessment, developing building design and space plans, completing construction documents, managing permit approvals, and providing design construction administration for the proposed Community Living and Program of All-Inclusive Care for the Elderly Center in the City of Tustin;
2. Authorize the Chief Executive Officer to solicit, select and contract for general contractor services and furniture, fixtures and equipment for the proposed Center in the City of Tustin; and
3. Authorize unbudgeted expenditures in an amount up to $18 million in undesignated reserves to fund the contracts with Totum and a vendor for general contractor services for the proposed Center in the City of Tustin.

Background

On June 2, 2022, the CalOptima Health Board of Directors (Board) authorized staff to negotiate the acquisition of real property at 14851 Yorba Street (Yorba site) and 165 North Myrtle Avenue (Myrtle site) in Tustin, California, for the purpose of developing two adjacent buildings into CalOptima Health's Community Living and Program of All-Inclusive Care for the Elderly (PACE) Center (Center). The Center would provide crucial support services to the older adult unhoused population of Orange County by providing PACE, recuperative care, and short-term post hospitalization housing.

On August 4, 2022, the Board authorized a contract with Totum to provide conceptual designs to submit with the Conditional Use Permit (CUP) application to the City of Tustin. CalOptima Health submitted the CUP application in October 2022. The submitted application included plans for the combined 66,054 square foot space over 3 floors to contain 119 recuperative and post hospital stabilization beds and a full PACE program and clinic.

Staff is currently working with Tustin City on the CUP approval. Completion of the CUP approval may include design modifications and additional assessments. Staff anticipate a Tustin City Planning Commission meeting in the first quarter of 2023.

Discussion

Upon approval of the CUP application, CalOptima Health will complete the purchase the Yorba and Myrtle sites and will begin building design and construction. CalOptima Health estimates the total cost

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at $18 million in undesignated reserve funds to complete the Center in Tustin. The estimated costs to complete the facility are as follows:

Cost Category	Estimate
1. Soft Costs (full scope design, including assessments, architecture and engineering, project management, local engagement, permits, and fees)	$2,000,000
2. Hard Costs (construction and building equipment)	$11,000,000
3. Furniture, Fixtures, & Equipment (FFE) (i.e., medical equipment, furniture, linens, etc.)	$2,000,000
4. Contingency (20%)	$3,000,000
TOTAL	**$18,000,000**

CalOptima Health requests the Board's authorization to negotiate and execute a sole source contract with Totum to complete all soft costs. Totum is uniquely qualified to provide this service to CalOptima Health. Totum is an architectural firm with experience in designing recuperative care centers and community living spaces. There are very few recuperative care centers and community living spaces, and the Center will combine facets of both. CalOptima Health needs the expertise of a firm like Totum to effectively complete this project. A contract with Totum will also facilitate efficiency as Totum will build upon the conceptual designs it provided for the CUP application. The following is a breakdown of the soft costs:

Scope of Work	Not to Exceed Fee
1. Building physical assessment (including both building and PACE)	$200,000
2. Architectural designs and construction documents	$1,200,000
3. Construction administration and local engagement	$300,000
4. Fees and permits	$300,000
TOTAL	**$2,000,000**

CalOptima Health also requests the Board authorize the Chief Executive Officer to solicit, select, and contract for hard costs and FFE using CalOptima's procurement process. The current plan is to open the community living portion of the site by July 2024, and the PACE site by January 2025.

Fiscal Impact

The recommended actions are unbudgeted. An appropriation of up to $18 million in undesignated reserves will fund these actions.

Rationale for Recommendation

A contract with Totum for full scope design services for the Center will allow CalOptima Health to develop the Center according to its mission and vision. Additionally, the Center will allow CalOptima Health to provide services to Orange County's unhoused older adults in an effective and dignified manner.

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Concurrence
James Novello, Outside General Counsel, Kennaday Levitt

Attachment
1. Entities Covered by this Recommended Action

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

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Attachment to the February 2, 2023, Board of Directors Meeting – Agenda Item 11

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
Totum Corporation	15130 Ventura Blvd., Suite A	Sherman Oaks	CA	91403

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
12. Approve Actions Related to the Homeless Health Initiatives

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741

Recommended Actions
1. Authorize the allocation of up to ~~$452,800~~ $498,400 from the restricted Homeless Health Initiatives (HHI) reserves to fund the shortfall in the Homeless Clinic Access Program (HCAP) Quality Initiative provider incentives billed through date of service December 31, 2022. *Rev. 2/2/2023*
2. Authorize the extension and expansion of the HCAP program with operational changes as described herein for thirty-six (36) months – effective February 1, 2023, or until total funding of approximately ~~$6.74~~ $6.70 million is exhausted, whichever is earlier.
3. Authorize reallocation of up to ~~$6.74~~ $6.70 million from the following CalOptima Health Board of Directors (Board)-approved HHIs to fund the extension and expansion of the HCAP program:
    a. Up to $2.06 million from Recuperative Care;
    b. Up to $4.32 million from CalOptima Homeless Response Team;
    c. Up to $0.28 million from Clinical Field Team Pilot Program (CFTPP) and Federally Qualified Health Centers (FQHC) Expansion Pilot Claims; and
    d. Up to ~~$84,000~~ $38,400 from the restricted HHI Reserves.
4. Authorize the Chief Executive Officer to develop, negotiate and execute contracts with Community Health Centers, homeless shelters, and other community partners to implement the extended and expanded HCAP program.

Background/Discussion
On April 4, 2019, the Board approved $100 million to create a restricted HHI Reserve to support delivery of care to Medi-Cal members experiencing homelessness. The HCAP is part of HHI and was approved by the Board in August 2019. Through HCAP, Community Health Centers (CHCs) were able to receive an incentive for providing scheduled preventive services at shelters and hotspots. CHCs provided this service at local homeless shelters through December 31, 2022. Invoices have exceeded the amount allocated to this project. CalOptima Health requests that the Board approve the allocation of up to ~~$452,800~~ $498,400 from the restricted HHI Reserve to fund the shortfall created by provider incentives billed through the end of the program on December 31, 2022. The funds requested are unallocated dollars from the "clinic health care services in all homeless shelters" category approved by the Board on June 27, 2019. *Rev. 2/2/2023*

CalOptima Health has received feedback from CHCs, local homeless shelters, and CalOptima Health members that HCAP has been successful in helping to meet urgent care needs for members experiencing homelessness while seeking shelter. It has also supported relationship building between members experiencing homelessness and CHC providers, encouraging the use of appropriate levels of care. Furthermore, this program operates in unison with CalOptima Health's Street Medicine Program,

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ensuring medical providers are successfully connecting with members experiencing homelessness in their own environment. Meeting members where they are is a strategy that research has proven to be effective in addressing the medical issues faced by those experiencing homelessness.

With this in mind, CalOptima Health will take several lessons learned from the HCAP program and will extend and expand the HCAP program to engage both homeless shelters and CHCs as partners to provide these medical services on-site in shelters for members experiencing homelessness. Program requirements are in development, and applications will be invited from partnerships in the coming months. In preparation for that, staff recommends the following budget actions totaling up to ~~$6.74~~ $6.70 million in funding for a thirty-six (36)-month period effective February 1, 2023, or until funding is exhausted, whichever is earlier: *Rev. 2/2/2023*

- Reallocation of up to $2.06 million from Recuperative Care. The funding source for this initiative is from Intergovernmental Transfers (IGT) 2, 3 and 6. CalOptima Health is required to use these funds to deliver "enhanced" services for Medi-Cal members. As such, staff proposes to use funds to provide incentive payments to homeless shelters for enhanced care coordination and clinic navigation.
- Reallocation of up to $4.32 million from CalOptima Homeless Response Team and up to $0.28 million from CFTPP and FQHC Expansion Pilot Claims. The funding source of these initiatives is IGT 8. CalOptima Health is required to use these funds to provide covered Medi-Cal services to Medi-Cal members. Staff proposes to use these funds to continue provider incentive payments to CHCs under the expanded HCAP program.
- Authorize allocation of up to ~~$84,000~~ $38,400 from the "clinic health care services in all homeless shelters" category in the restricted HHI Reserve approved by the Board on June 27, 2019. Upon approval, all remaining funds within the restricted HHI Reserve have been committed to Board-approved initiatives. *Rev. 2/2/2023*

Fiscal Impact

Recommended Action 1: There is no additional fiscal impact. An allocation of up to ~~$452,800~~ $498,400 from the "clinic health care services in all homeless shelters" category approved by the Board on June 27, 2019, will fund the shortfall in the HCAP Quality Initiative provider incentives billed through date of service December 31, 2022. *Rev. 2/2/2023*

Recommended Actions 2 – 5: There is no additional fiscal impact. Reallocations in an amount up to $6.66 million from Board-approved HHIs and an allocation of up to ~~$84,000~~ $38,400 from the "clinic health care services in all homeless shelters" category approved by the Board on June 27, 2019, will fund the extended and expanded HCAP program for thirty-six (36) months – effective February 1, 2023, or until funding is exhausted, whichever is earlier. *Rev. 2/2/2023*

Rationale for Recommendation

CalOptima recognizes the value HCAP-participating CHCs bring as they provide vital preventive, urgent care and on-call services to individuals experiencing homelessness. Pairing traditional canvassing-based street medicine with these shelter-based services ensures CalOptima Health providers have adequate opportunity to connect with members experiencing homelessness.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
2/22/2019	Consider Authorizing Actions Related to Homeless Health Care Delivery, Including, but not limited to, Funding and Provider Contracting		
4/4/2019	Consider Actions Related to Delivery of Care for Homeless CalOptima Members • Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot		$100 million
6/27/2019	Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal ($60 million identified for specific initiatives)		
8/1/2019	Consider Development of a CalOptima Homeless Clinic Access Program for Homeless Health Initiative		$1 million
3/5/2020	Consider Actions Related to Homeless Health Care Pilot Initiatives [extended CFTPP pilots through 12/31/2020]	1 year	
4/16/2020	Consider Authorizing Modifications to the CalOptima Homeless Clinic Access Program Homeless Health Initiatives in Response to COVID-19		$1 million
12/3/2020	Consider Approval of Actions Related to Homeless Health Care Pilot Initiatives [extended CFTPP pilots through 12/31/2021]	1 year	
12/20/2021	Consider Approval of Actions Related to Homeless Health Care Pilot Initiatives [extended CFTPP through 12/31/2022]	1 year	
5/5/2022	Consider Approval of Actions Related to Homeless Health Care Initiatives [approve additional funding for HCAP]		$700,000

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

13. Authorize Expansion of the CalOptima Health Outreach Strategy to Enroll Eligible CalOptima Health Members into CalFresh and other Public Assistance Programs and Support Redetermination Services

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Deanne Thompson, Executive Director, Marketing and Communications, (714) 954-2141

Recommended Action

1. Authorize expansion of the CalOptima Health Outreach Strategy to enroll potentially eligible CalOptima Health members not yet enrolled in the CalFresh program and other eligible public assistance programs and support redetermination services;
2. Authorize unbudgeted expenditures and appropriate up to ~~$3,000,000~~ $6,000,000 from existing reserves to expand the CalOptima Health Outreach Strategy and support redetermination services; and
3. Authorize the Chief Executive Officer (CEO) to execute agreements as necessary to implement proposed activities.

Rev. 2/2/2023

Background

The pandemic exacerbated food insecurity for CalOptima Health members and the community at large. CalOptima Health, in collaboration with the Orange County Social Services Agency (SSA), identified approximately 344,000 CalOptima Health members (approximately 259,000 households) as potentially eligible for, but not enrolled in, CalFresh, a food benefit program administered locally by SSA and other public assistance programs. As of October 1, 2022, CalFresh benefits increased in response to inflation and an increase in the cost of living; a single individual may be eligible for up to $281, and a family of four may be eligible for up to $939 per month. Access to the CalFresh benefit will significantly impact members' ability to purchase healthy and nutritious food.

On March 3, 2022, CalOptima Health's Board of Directors approved $2 million from reserves to implement a CalFresh Outreach Strategy, which included a warmline transfer from CalOptima Health to the SSA's CalFresh Call Center, CalFresh direct mailer to nearly 226,000 households, outbound call campaign, text message campaign, comprehensive advertising, and marketing campaign, and CalFresh enrollment events. To date, approximately 30,925 CalOptima Health members are newly enrolled in the CalFresh program and approximately $1,073,000 of the $2 million has not been spent and remains available.

CalOptima Health continues to prioritize access to food for its members and is looking to expand its efforts to enroll CalOptima Health members into CalFresh and other eligible public assistance programs, while also supporting redetermination services. Given the unwinding of the federal

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public health emergency slated for April 11, 2023, nearly 944,000 CalOptima Health members will be due for redetermination services.

Discussion

Staff recognizes that continued education, outreach, and enrollment in the CalFresh program and other eligible public assistance programs requires enhancing CalOptima Health's strategies to reach its members, community stakeholders, and providers. Per the SSA, since the implementation of the CalFresh Outreach Strategy in April 2022, there has been a significant increase in activity and enrollment in the CalFresh program. Staff is recommending expansion of the Outreach Strategy to provide direct enrollment services for CalFresh and other eligible public assistance programs for CalOptima Health's general membership, hard-to-reach populations, and those identified as under-enrolled in the CalFresh program, specifically children and families, older adults, and members experiencing homelessness. Strategies include (i) having CalFresh enrollers strategically located throughout the county, at CalOptima Health-hosted CalFresh/redetermination events, and community events hosted by community stakeholders, (ii) expanding CalOptima Health's marketing and advertising campaign by utilizing media platforms that resonate with hard-to-reach communities and ethnic communities, and (iii) implementing technology to support CalFresh enrollment and redetermination services.

Given the unwinding of the federal public health emergency currently slated for April 11, 2023, nearly 944,000 CalOptima Health members will be required to complete the redetermination process to keep their Medi-Cal benefits. CalFresh outreach and enrollment activities will be utilized to support redetermination services when engaging with CalOptima Health members. CalFresh community enrollers can have a dual role of completing CalFresh applications, while validating members' personal information to ensure their information is current. Staff sees this as an opportunity to expand and support SSA's efforts to ensure CalOptima Health's members' information is updated in order for continuity of their health care coverage.

Staff is requesting that the Board approve funds to expand the CalOptima Health Outreach Strategy to provide direct CalFresh and public assistance program education and enrollment, and support redetermination services at strategic locations throughout the county. The total estimated cost for implementing this strategy through December 2024 is approximately $3 million. Staff is requesting flexibility to use funds beyond 2024 as needed to successfully implement this strategy. These are estimated costs only and final costs will be dependent on final vendor negotiations, event locations, and additional marketing costs. Staff will procure vendor contracts in accordance with CalOptima Health Policy GA.5002: Purchasing Policy. Staff will return to the Board if additional funding is needed.

Funding will support the following activities:

- Contract with community stakeholders to provide CalFresh and public assistance program enrollment and redetermination services;

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- Training and consulting services;
- Outreach and enrollment events and activities;
- Direct mail, outbound call, and text message campaigns;
- Marketing and advertising campaigns; and
- Technology support and services.

Fiscal Impact

The recommended action is unbudgeted. An appropriation of up to ~~$3~~ $6 million from existing reserves will fund this action.

Rev. 2/2/2023

Rationale for Recommendation

CalOptima Health is prioritizing food security as a social determinant of health for CalOptima Health members. CalFresh provides an opportunity to support members' access to food to support their overall health and well-being. Staff recommends expansion of the Outreach Strategy and use of funds to increase capacity to enroll CalOptima Health members in the CalFresh program and other eligible public assistance programs. This expanded outreach effort will also support redetermination services, helping to engage with CalOptima Health members to ensure continued enrollment and continuity of care beyond 2023.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Board Action dated March 3, 2022 ~~2023~~ to Authorize CalFresh Outreach Strategy to Enroll Eligible CalOptima Members into the CalFresh Program to Address Food Insecurity

/s/ Michael Hunn — **Authorized Signature**

01/26/2023 — **Date**

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CalOptima Board Action Agenda Referral

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contacts

Michael Hunn, Interim Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Action

1. Authorize implementation of a CalFresh Outreach Strategy to promote enrollment of identified CalOptima members who are potentially eligible and not yet enrolled in the CalFresh program;
2. Authorize unbudgeted expenditures and appropriate up to $2,000,000 from existing reserves to implement the CalFresh Outreach Strategy; and
3. Authorize the Chief Executive Officer (CEO) to execute agreements for expenditures as necessary to implement proposed activities.

Background

The California Department of Health Care Services (DHCS) has received federal approval from the Centers for Medicare & Medicaid Services (CMS) on the California Advancing and Innovating Medi-Cal (CalAIM) waivers. This approval allows the State and managed care plans to implement a more integrated and whole person focused delivery model, including addressing social drivers of health.

During the pandemic, food insecurity was exacerbated for CalOptima members and the community at large. CalOptima, in collaboration with the Orange County Social Services Agency (SSA), identified approximately 344,000 CalOptima members (approximately 259,000 households) as potentially eligible, but not enrolled in CalFresh, a food benefits program administered locally by SSA. Through the CalFresh program, a single individual may be eligible for up to $250 per month in assistance and a family of four may be eligible for up to $835 per month.

To address food insecurity with CalOptima members, staff propose a CalFresh Outreach Strategy to encourage CalOptima member enrollment in CalFresh and educate CalOptima providers and community stakeholders about CalFresh. The goal is to have 100,000 CalOptima members who are eligible but not enrolled to join the CalFresh program by December 31, 2022.

Discussion

Staff recognizes that education, outreach, and enrollment in the CalFresh program requires a multi-prong approach with our members and providers. To address the needs and gaps identified in the Orange County safety net system, staff have developed CalOptima's CalFresh Outreach

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Strategy including:

- Establishing a warm-line transfer between CalOptima member-facing departments (e.g., Customer Service, Case Management and Population Health Management) and designated staff at SSA's CalFresh Call Center, for members identified by CalOptima as eligible for CalFresh;
- Direct member mailer;
- Outbound call campaign via contracted vendor;
- Text message campaign via contracted vendor;
- A series of CalFresh enrollment events at grocery stores, food banks and other targeted locations; and
- Developing and/or leveraging collateral materials and sharing widely via CalOptima's communication channels with all audiences (e.g., flyers, posters, toolkits).

Staff requests Board approval of the CalFresh Outreach Strategy to address the unmet health-related social need of food security among our members. This strategy will implement activities to educate CalOptima members, providers, community stakeholders and CalOptima staff about the CalFresh program to promote member enrollment in the program. Staff will provide your Board with routine updates on the enrollment progress. The total estimated cost for implementing these strategies is approximately $2 million. These are estimated costs only and final costs will be dependent on final vendor negotiations, event locations, and additional marketing costs.

The following table provides details on each activity:

Activities targeting 259,000 Households (344,000 members)	**Estimated Costs**
Print CalFresh flyers/posters	Up to $130,000
Member Mailer ▪ Fulfillment cost of a direct mailer ▪ First class mail	Up to $200,000
Call Campaign (cost estimate based on current contract pricing) ▪ 3 attempts to reach members ▪ Recorded line ▪ Secure consent to receive text messages as part of the call	Up to $1,000,000
Text Message Campaign • Unlimited one way texting, subject to approval by DHCS, to households who have provided consent (approx. 100k at this time)	Up to $200,000
CalFresh Enrollment Events (3-5 events) ▪ Cost for rentals, supplies, equipment, and logistics	Up to $150,000
Marketing ▪ Billboards in geo-targeted neighborhoods to reach members who are potentially eligible for CalFresh	Up to $275,000

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Total Estimated Costs	**$ 1,955,000**

Fiscal Impact

The recommended action is unbudgeted. An appropriation of up to $2,000,000 from existing reserves will fund this action.

Rationale for Recommendation

CalOptima has prioritized food security as a Social Determinant of Health to address for CalOptima members. CalFresh provides an opportunity to support our members' access to food to support their overall health and well-being. While the CalFresh program is not a Medi-Cal covered benefit, healthcare providers, care coordinators, health educators, and other support staff may provide referrals to community resources such as CalFresh as part of overall care coordination and preventive services. Staff recommends implementation of this strategy and use of funds to support the implementation of the CalFresh Outreach Strategy.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. CalFresh Outreach Strategy

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Carenet Healthcare Services	11845 IH-10 West, Suite 400	San Antonio	TX	78230
County of Orange Social Services Agency	500 N. State College Blvd.	Orange	CA	92868
mPulse	16530 Ventura Blvd., Suite 500	Encino	CA	91436

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CalOptima CalFresh Outreach Strategy

BACKGROUND/OPPORTUNITY

- OC Social Services Agency (SSA) data identified approximately **344,000** CalOptima members (approximately **259,000** distinct households) as potentially eligible for CalFresh and not currently enrolled as of December 2021
  - Note: A single individual **may be** eligible for up to $250 and a family of four **may be** eligible for up to $835 per month
- A warm transfer process has been established between CalOptima Customer Service and SSA
  - CR will test warm line transfer
  - Will pilot the warm line transfer process with PHM when materials have been developed and approved

GOALS/OBJECTIVES

Goal: Increase CalFresh enrollment by 100,000 CalOptima members by December 31, 2022

Objectives:

1. Launch targeted member-facing outreach campaign to increase CalOptima members' awareness and enrollment in CalFresh to address food insecurity
2. Partner with CalOptima Health Networks, Providers and Community Based Organizations
3. Educate member-facing CalOptima staff and CalOptima to encourage CalFresh enrollment

TACTICS

COLLATERAL DEVELOPMENT

Flyers

- Update the existing CalOptima CalFresh collateral to align with campaign
- Develop enrollment flyer

Posters

- Update and/or leverage SSA CalFresh poster to align with campaign for providers and CBOs

Toolkits

- Develop and/or leverage toolkits from SSA for providers and CBOs

Other collateral materials:

- Scripts for CalOptima staff, providers and Carenet
- Member direct mailer

To support development of messages, scripts and key concepts for campaign:

- Internal focus group with Customer Service, PHM, CM, PR and CR scheduled for 2/7
- Gathered community/member feedback on 2/2
- Will connect with PAC for provider feedback
- Will connect with MAC for community feedback

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DIGITAL/WEB DEVELOPMENT

Landing Page/Portal Content

- Develop dedicated landing page on the public-facing CalOptima website, Member and Provider portals with audience-specific information

Social Media Promotion

- Organic and paid posts/advertisements (targeted)

TARGETED MEMBER OUTREACH

CalFresh Direct Mailer

- Mail to target populations in-language with a focus on the following populations:
  - Children and families, older adults and members with chronic conditions such as congestive heart failure, COPD, coronary artery, diabetes, hypertension and obesity

CalFresh Enrollment Events

- Host series of CalFresh Enrollment Events in cities with the lowest CalFresh enrollment and enroll members [with Social Services Agency and/or community enrollers (10 total)]
  - Include community resources such as free diapers (Tom Tom Diaper Stork), food distribution (Second Harvest or Community Action Partnership)
  - Promote services provided by CalOptima's Population Health Management program and CalFresh Healthy Living
    - CalFresh Healthy Living live demonstrations throughout the day

Outreach calls via CalOptima member-facing departments and contracted vendor*

- Customer Service, Case Management and Population Health Management to promote CalFresh with identified eligible members
- 344,000 potentially eligible members will be flagged in Facets and GuidingCare
- CareNet to provide outbound calls to priority groups including children and families, older adults and members with chronic conditions (54k households with 1 chronic conditions and 34k households with 2+ chronic conditions)
  - **Action:** amend CareNet contract at March BoD

Text messaging campaign

- Bi-monthly in-language texts with call to action. Drive visits to landing page on CalOptima website, invitation to member-specific virtual information sessions about CalFresh
  - **Action:** confirm with Legal COVID emergency provision can be leveraged to distribute CalFRESH messaging via text without 'opt-in'

GENERAL COMMUNICATIONS

Member Newsletters

- Dedicated CalFresh article. Publication produced quarterly.

New Member Packets

- Include CalFresh information in CalOptima's new member packets.

Health Fairs and Vaccine Clinic Distribution

- Distribute CalFresh information wherever CalOptima maintains a presence.

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- CalOptima/SSA distribute CalFresh information at food distribution events/centers and SSA provide enrollment at these events

CalFresh Information Sessions

- Offer in English, Spanish and Vietnamese in April
- Record sessions and post on CalOptima website for follow-up promotional opportunities.

Community Announcements

- CalFresh-specific articles distributed to approximately 2700+ stakeholders

Provider Monthly Update/Health Network Weekly Communication (email)

- Include CalFresh information in monthly newsletter and weekly HN emails

MEDIA RELATIONS

Press Releases:

- Announcing launch of campaign and key elements
- Second release mid-campaign to re-energize and comment on status
- Close-out release announcing results
- Highlight Member and Provider success stories

Op-Ed:

- CMO authored Op-Ed regarding food insecurity as a social determinant of health

Event Media

- Pitch media around CalFresh Enrollment Events

ESTIMATED BUDGET/BOARD 'ASK'

Activities targeting 259,000 Households (344,000 members)	**Estimated Costs**
Print CalFresh flyers/posters	Up to $130,000
Member Mailer ▪ Fulfillment cost of a direct mailer ▪ First class mail	Up to $200,000
Call Campaign (cost estimate based on current contract pricing) ▪ 3 attempts to reach members ▪ Recorded line ▪ Secure consent to receive text messages as part of the call	Up to $1,000,000
Text Message Campaign • Unlimited one way texting, subject to approval by DHCS, to households who have provided consent (approx. 100k at this time)	Up to $200,000
CalFresh Enrollment Events (3-5 events) ▪ Cost for rentals, supplies, equipment, and logistics	Up to $150,000
Marketing ▪ Billboards in geo-targeted neighborhoods to reach members who are potentially eligible for CalFresh	Up to $275,000
Total Estimated Costs	**$ 1,955,000**

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TIMELINE

TACTIC	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN
Collateral Development												
Direct Mailer												
Web/Portal Updates												
Outreach Calls												
Text Messaging												
Social Media Promotion												
Community Announcements												
Member Newsletter				Spring			Sum mer					
CalFresh Information Session (member audience)												
CalFresh Information Session (CBO audience)												
Provider Monthly Update (email)												
HN Weekly Communication												
CalFresh Enrollment Events												
Press Release												
Op-Ed												

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CalOptima Health Board Action Agenda Referral

Action To Be Taken February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

14. Authorize Contract with Vendor to Assist with Member Health Needs Assessment 2023 Activities

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operations Officer, (714) 923 8834

Recommended Actions

1. Authorize Chief Executive Officer to execute a contract with Harder+Company Community Research, Inc. (Harder+Company) to assist with the Member Health Needs Assessment 2023 activities in an amount not to exceed $1,250,000; and
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $250,000 from existing reserves for the contract with Harder+Company.

Background

In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: (1) Same Day Treatment Authorizations; (2) Real-Time Claims Payments; and (3) Annual Assessments of Members' Social Determinants of Health. The Member Health Needs Assessment (MHNA) will provide the foundational data for CalOptima Health's annual social determinants of health assessment. On November 3, 2022, the CalOptima Health Board of Directors approved the scope of work and unbudgeted expenditures for the CalOptima Health 2023 MHNA. The MHNA will be utilized to inform strategic development (e.g., health equity, social drivers of health, homeless health, etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on specific needs of Orange County's Medi-Cal beneficiaries.

In selecting the recommended vendor, a request for proposal (RFP) process for consultant services was issued by CalOptima Health on November 8, 2022, and a total of two proposals were received. A proposal evaluation committee comprised of staff from the CalAIM, Office of the CEO, Strategic Development, and Vendor Management departments – plus an external subject matter expert reviewed the submitted proposals. The consultants were also interviewed by the evaluation committee. After the evaluation of proposals and the interviews, the proposal with the highest overall score was selected.

Vendor	Proposal Score	Interview Score	Combined Scores
Harder+Company	4.68	4.74	4.71
Advance OC	3.67	3.78	3.73

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Discussion
Staff recommends Harder+Company as the selected vendor due to completeness of its proposal, as well as its knowledge and experience in completing community health needs assessments with local organizations, health plans, and other public health care agencies. Harder+Company, along with its subcontractor, Social Science Research Center at California State University, Fullerton (CSUF), has in-depth experience and subject matter expertise in the development and administration of multiple survey tools and methods as well as data analysis and final reporting and recommendations. The Social Science Research Center (SSRC) at CSUF will assist Harder+Company in collecting the member survey and developing tools and support analysis. In addition, due to SSRC's local university setting and expertise, Harder+Company will work with staff to connect to local community-based organizations.

Harder+Company will assist staff with the activities associated with the 2023 MHNA, including (1) development of a best practice model project plan, (2) development of survey instruments and facilitation guides, (3) administration of member and provider/key informant surveys (mail/online, telephone, in-person and facilitation at community town halls/forums and focus groups), (4) data sampling, collection and analysis combined with evaluation of internally produced clinical/survey data and external secondary data sources, and (5) development of the final health needs assessment report and recommendations.

Fiscal Impact
A previous Board action on November 3, 2022, authorized and appropriated up to $1 million from existing reserves to fund the CalOptima Health 2023 MHNA. An appropriation of up to $250,000 from existing reserves will fund the unbudgeted shortfall amount to execute the contract with Harder+Company.

Rationale for Recommendation
The 2023 MHNA will support CalOptima Health's health equity and social drivers of health strategies to improve the overall health of CalOptima Health members. Harder+Company had the highest score from their proposal and interview. It also successfully assisted CalOptima Health with 2017-18 MHNA, as well as the evaluation of CalOptima Health's Shape Your Life Program in 2019.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Previous Board Action November 3, 2022, "Approve Actions Related to the CalOptima Health Member Needs Assessment 2023"

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Board Action

Board Meeting Dates	Action	Not to Exceed Amount
November 3, 2022	Approve Actions Related to the CalOptima Health Member Needs Assessment 2023	Up to $1 million from existing reserves

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

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Attachment to the February 2, 2023 Board of Directors Meeting – Agenda Item 14

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Harder + Company Community Research, Inc.	3965 5th Avenue, Suite 420	San Diego	CA	92103

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 3, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item
8. Approve Actions Related to the CalOptima Health Member Health Needs Assessment 2023

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Government Affairs and Strategic Development, (657) 900-1096

Recommended Actions
1. Approve the scope of work (SOW) for the CalOptima Health 2023 Member Health Needs Assessment (MHNA) and release a request for proposal.
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $1 million from existing reserves for the CalOptima Health 2023 MHNA.

Background
In 2017-18, CalOptima Health conducted a comprehensive MHNA of approximately 5,800 members to identify the focused needs of Orange County's Medi-Cal beneficiaries – in particular, ethnic minorities and their health needs and interests. The results of the 2017-18 assessment highlighted key findings in the areas of social determinants of health, mental health, primary care, provider access, and dental care.

Assessments such as Population Needs Assessment, Health Effectiveness Data and Information Set (HEDIS) reports, and member satisfaction surveys are periodically conducted to identify the health risks, beliefs, and practices of CalOptima Health's Medi-Cal members. However, these assessments and surveys do not represent the full scope and depth of the health needs of CalOptima Health members. In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: 1) Same Day Treatment Authorizations; 2) Real-Time Claims Payments; and 3) Annual Assessments of Members' Social Determinants of Health. The MHNA will provide the foundational data for CalOptima Health's annual social determinants of health assessment.

Discussion
Given the inequities revealed through the COVID-19 pandemic and an increase in CalOptima Health's membership, staff recommends engaging the professional services of a research consultant to conduct another MHNA in Q1 2023. The MHNA will be an expanded version of the original assessment completed in 2017-18, surveying at least 10% of CalOptima Health's membership, to help CalOptima Health identify additional and/or confirm the needs of members, barriers to accessing care, gaps in services, and disparities in health among members and the general community.

The 2023 MHNA will assist CalOptima Health with:
- Implementing Department of Health Care Services population health strategies (e.g., population health management strategy, support health and opportunity for children and families,

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comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives.
- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.
- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions.

Staff recommends that the Board authorize $1 million from existing reserves to conduct the 2023 MHNA as the results of the MHNA will be utilized to inform strategic initiative development (e.g., health equity, social determinants of health, homeless health etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on the specific needs of Orange County's Medi-Cal beneficiaries.

Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $1 million from existing reserves will fund this action.

Rationale for Recommendation
The recommended actions will support CalOptima Health's health equity and social determinants of health strategies to improve the overall health of CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed CalOptima Health Member Health Needs Assessment 2023 Scope of Work

/s/ Michael Hunn *10/27/2022*
Authorized Signature **Date**

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SCOPE OF WORK
Member Needs Health Assessment 2023

I. OBJECTIVE

CalOptima Health is seeking to engage the professional services of a community research consultant with knowledge of multi-cultural populations and strategies for improved program engagement to conduct a comprehensive Member Health Needs Assessment (MHNA) 2023.

The MHNA 2023 will be an expanded version of the original assessment completed in 2017-18, ensuring a diverse group of at least 10% of CalOptima Health members at the time the survey is conducted are surveyed. Given the inequities revealed through the COVID-19 pandemic, the MHNA 2023 assessment will result in a final report that includes recommendations on how to address the needs of members and newly identified populations, barriers to access care, gaps in services and disparities in health among members. The project shall incorporate coordination and collaboration (as feasible) with external partners (e.g. Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

The MHNA 2023 will assist CalOptima Health with:

- Implementing DHCS population health strategies (e.g., Population Health Management Strategy, Support Health and Opportunity for Children and Families, Comprehensive Quality Strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives
- Improving member health outcomes by identifying opportunities to improve health care access specific to each ethnic community
- Identifying and establishing opportunities for meaningful engagement with new partnering organizations regarding health and well-being, especially for underserved, difficult-to-reach and newly identified populations (increase capacity and extend services)
- Analyzing social determinants of health impacting CalOptima Health members and designing strategies, programs and interventions to address them (e.g., food and nutritional assistance, medically prescribed food boxes, linkages to housing support and other community and social support services, etc.)
- Identifying opportunities for partnership with social service type providers
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions
- Identifying and recommending unique services for new populations, such as the justice-involved and foster care populations

The anticipated launch date for this project is February 2023. A final report shall be prepared and presented to the Board by the fourth quarter of 2023.

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II. SCOPE OF WORK

1. PRODUCTS/SERVICES

A. Project Plan and Budget

1. Proposal project plans must clearly articulate VENDOR approach and address the following elements:
    a. Development of survey instruments and associated facilitation guides,
    b. Facilitation of in-person and/or virtual community town halls/forums and focus group meetings,
    c. Data collection and analysis,
    d. Development of draft report by the third quarter of 2023, executive summary, final report and presentation to the Board by the fourth quarter of 2023.
    e. Include detailed timeline with duration of tasks (by number of days) and VENDOR resources and responsibilities.
    f. Proposed number of survey collection to ensure results are statistically significant and representative of CalOptima Health members.
2. Proposal must include a detailed project budget and justifications based on proposed project plan, timeline, direct labor costs (including hourly rates), travel, subcontracts (if applicable), supplies/materials, etc.
3. Proposals must outline how VENDOR will safeguard and store member information and protected health information that may be obtained throughout the course of the project.

B. Survey Instruments and Facilitation Guides

1. VENDOR shall determine appropriate methodologies and resources to be used for development of the MHNA 2023 survey instruments, group facilitation guides and/or other assessment tools. VENDOR will provide recommendations and seek input from CalOptima Health staff and Committee on development and finalization of survey instruments, facilitation guides, presentations, etc.
2. The final survey instruments (e.g., member, provider, key informant) and facilitation guides may leverage information gathered by VENDOR, through focus groups, other CalOptima Health surveys and clinical data, other internal data collection efforts and external secondary data sources e.g. Advance OC 2020 Social Progress Index, the 27th Annual Report on the Conditions of Children in Orange County (Orange County Children's Partnership), 2021-2022 Orange County Community Indicators Report, 2022 Report on Aging in Orange County, (Orange County Strategic Plan for Aging), etc..

C. Survey Administration and Group Meeting Facilitation

1. VENDOR shall recommend the best practice of survey administration for members, such as: mailed and online surveys, telephone interviews, text messaging, in-person data collection components, etc.
    a. Mailed/online/text messaging member survey and telephone scripts will be translated into Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese (additional languages may be included depending on preliminary research findings) by CalOptima Health.

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b. If selected, telephone interviews are to be conducted by VENDOR, and must be conducted in English, Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese by VENDOR.
c. Provider surveys may be mailed and/or provided as an online survey option.
d. The VENDOR shall have enough trained, experienced interviewers capable to conduct the identified volume of interviews and other data collection activities in the identified languages.

2. CalOptima Health staff will work collaboratively with VENDOR to promote member surveys (if applicable) at:
   a. In-person and/or virtual community town halls/forums and focus groups,
   b. Community resource and health fair events,
   c. New member orientations,
   d. Health education seminars,
   e. Faith-based group meetings,
   f. Other events/activities as identified, etc.

   CalOptima Health staff can utilize existing community relationships to make introductions for the VENDOR to connect with these organizations. VENDOR shall coordinate the events.
3. CalOptima Health staff can provide VENDOR with points of contact to administer provider and community leader/key informant interviews (if applicable) either virtually and/or at:
   a. Provider offices,
   b. Network forums,
   c. Community organization offices, and
   d. Other locations where providers and community leaders/key informants congregate.

   VENDOR will lead group facilitation, data collection and distribution of nonmonetary gift cards (if applicable) at such events.
4. VENDOR is responsible for tabulation of data (e.g., member, provider and key stakeholder data) collected through the agreed upon methods.
5. VENDOR is responsible for evaluation and analysis of all data collected and synthesis with CalOptima Health clinical or other data, as well as other secondary source data to inform identification of key findings in the MHNA report and executive summary, of which will summarize findings and include recommendations.
6. VENDOR will provide all raw data to CalOptima Health.

D. Member Incentives
1. If applicable, VENDOR shall receive and secure member incentives (i.e., digital nonmonetary gift cards) from CalOptima Health. Distribute and track incentive to member upon receipt of completed survey (mailed, telephone, text and/or in-person completion).
   a. Establish a mechanism for safekeeping of the gift cards from loss, theft, or delivery to non-CalOptima Health Medi-Cal members. The mechanism for safekeeping of the gift cards shall be mutually agreed upon between VENDOR and CalOptima Health.
   b. Only use the gift cards consistent with this scope of work. A maximum of one incentive per survey respondent will be awarded and for participation in one focus group, if applicable.

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c. Coordinate with CalOptima Health staff to validate Medi-Cal eligibility and CalOptima Health membership prior to distributing the gift cards.
d. Return to CalOptima Health all gift cards that were not distributed to the designated CalOptima Health members, within thirty (30) calendar days of completion of all member surveys and focus groups.
e. VENDOR will establish an automated method to report to CalOptima Health following the delivery of the gift card, of which the minimum requirements include:
    i. The date of delivery or mailing and number of gift cards received by VENDOR from CalOptima Health.
    ii. A list of eligible members who received the gift card, including but not limited to member name, member CalOptima Health ID, and the date member participated in the survey or focus group.
    iii. Whether the gift card was hand delivered or mailed.
    iv. The number of gift cards remaining to be distributed.
f. VENDOR shall reasonably ensure use of the gift cards are solely used as contemplated in this Agreement and in compliance with DHCS requirements (gift cards is not to be used to purchase firearms, tobacco, alcohol, etc.). CalOptima Health retains the right to recover any gift card(s) or face value of such gift card(s) if it (or any of its regulators) determines that, as a result of VENDOR's negligence, the gift card(s) were not provided in accordance with (1) the terms of this Agreement; or (2) applicable federal and state laws, regulations, guidance and/or funding source requirement. This Section shall survive the termination of this Agreement.

E. Member Health Needs Assessment 2023 Report and Executive Summary
1. Once survey administration, data collection and analysis are finished, VENDOR will seek input and feedback from CalOptima Health executives, develop a draft written report, executive summary and final written report of findings and recommendations for CalOptima Health, and will present findings to the Board of Directors (the Board) in the form of a public presentation.
2. The executive summary and final report will be used for internal and external publication. The report shall include details on main issues that current CalOptima Health members encounter, the barriers to those issues, potential solutions and methods of prevention (if available). Additionally, the report shall include consideration(s) and recommendation(s) of newly identified populations, such as the justice-involved and foster care populations.

   The Board will be provided regular updates by CalOptima Health staff on the progress of the MHNA 2023 activities. CalOptima Health staff will share the draft written report with the Board and with the MHNA 2023 Committee for review and comment. If applicable, VENDOR will incorporate comments into the draft report to generate the final report, executive summary and presentation.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

15. Approve an Amendment to the Kaiser Foundation Health Plan Inc. Medi-Cal Health Maintenance Organization Contract to Extend Current Capitation Rates

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Action

Approve an amendment to the Kaiser Foundation Health Plan Inc. Medi-Cal Health Maintenance Organization Contract for Health Care Services to extend current capitation rates from July 1, 2023, through December 31, 2023.

Background and Discussion

Staff requests the CalOptima Health Board of Directors' authorization to amend the Kaiser Foundation Health Plan Inc. (Kaiser) health network contract to extend current capitation rates from July 1, 2023, through December 31, 2023. Kaiser is a fully delegated health maintenance organization (HMO) health network under its Contract with CalOptima Health. Although Kaiser's current contract is effective through June 30, 2028, it is scheduled to sunset on December 31, 2023, following the approval of California State Assembly Bill 2724 (AB 2724). AB 2724 authorized a direct contract between Kaiser and the California Department of Health Care Services, establishing Kaiser as a full-risk Medi-Cal managed care plan, beginning January 1, 2024.

Under Kaiser's current contract, capitation rates for member aid categories, including Temporary Assistance for Needy Families, Seniors and Persons with Disabilities, Medi-Cal Expansion, and Whole Child Model are effective through June 30, 2023. Staff requests the Board's approval to amend Attachment E of Kaiser's contract to extend current capitation rates from July 1, 2023, through December 31, 2023, to ensure continuity of care for members through the end of the calendar year.

Fiscal Impact

Management will include expenses for the recommended action in the CalOptima Health Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation

Approval of an amendment to extend Kaiser's current capitation rates through December 31, 2023, will support continuity of member care for the remainder of their contract term, and avert the costly and time-consuming renegotiation process for the short duration which Kaiser remains under contract with CalOptima Health.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Entities Covered by this Recommended Board Action
2. Proposed Amendment to Contract for Health Care Services

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan Inc.	393 E. Walnut St.	Pasadena	CA	91188

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AMENDMENT XIII TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT XIII TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of _____ (unless otherwise stated below), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, **Kaiser Foundation Health Plan, Inc.** ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend the Contract to continue the current Capitation Rates in Attachment E through December 31, 2023.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E – Amendment XII shall be deleted in its entirety and replaced with the attached Attachment E – Amendment XIII "Capitation Rates".

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and **Kaiser Foundation Health Plan, Inc.** have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	_____
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT E – AMENDMENT XIII

Capitation Rates

Payments by CalOptima to HMO for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

I. Temporary Assistance for Needy Families (TANF) and Seniors and Persons with Disabilities (SPD)
Effective July 1, 2020 through December 31, 2021

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation	Total Capitation
TANF					
	00-00 M & F				
	01-14 M & F				
	15-18 F				
	15-18 M				
	19-39 F				
	19-39 M				
	40-64 M & F				
	65- M & F				

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation	Total Capitation
SPD					
	00-00 M & F				
	01-14 M & F				
	15-18 F				
	15-18 M				
	19-39 F				
	19-39 M				
	40-64 M & F				
	65- M & F				

II. TANF and SPD
Effective January 1, 2022 through December 31, 2023

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Total Capitation
TANF				
	00-00 M & F			
	01-14 M & F			
	15-18 F			
	15-18 M			
	19-39 F			
	19-39 M			
	40-64 M & F			
	65- M & F			

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Total Capitation
SPD				
	00-00 M & F			
	01-14 M & F			
	15-18 F			
	15-18 M			
	19-39 F			
	19-39 M			
	40-64 M & F			
	65- M & F			

III. Adult Expansion Members (MCE)
Effective July 1, 2020 through January 31, 2021

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation	Total Capitation
MCE					
	19-39 F				
	19-39 M				
	40-64 M & F				
	65- M & F				

IV. Adult Expansion Members (MCE)
Effective February 1, 2021 through December 31, 2021

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation	Total Capitation
MCE					
	19-39 F				
	19-39 M				
	40-64 M & F				
	65- M & F				

V. Adult Expansion Members (MCE)
Effective January 1, 2022 through December 31, 2023

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Total Capitation
MCE				
	19-39 F			
	19-39 M			
	40-64 M & F			
	65- M & F			

VI. Supplemental Capitation
Behavioral Health (BHT)
Effective January 1, 2022 through December 31, 2023

Age in years and Gender Group	Supplemental Capitation
0-6 M&F	
7-20 M&F	

- Payment will be processed within 30 days from Kaiser's BHT supplemental file submission.

VII. Whole Child Model Members
Effective July 1, 2020 through December 31, 2023

Type	Administrative Services Capitation
CCS eligible Members assigned to HMO	

CalOptima Health Board Action Agenda Referral

Action To Be Taken February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Authorize the Chief Executive Officer to Execute a Contract Amendment with The Burgess Group, LLC to Implement a Batch Modeling Solution in Support of CalOptima Health's Digital Transformation Strategy

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
Eric Rustad, Executive Director, Financial Analysis, (657) 235-6801

Recommended Actions

1. Approve new item, "Batch Modeling Solution" under Medi-Cal: Non-Salary Operating Expenses – Purchased Services in Attachment B1: Fiscal Year (FY) 2022-23 Digital Transformation Administrative Budget;
2. Authorize the Chief Executive Officer (CEO) to execute a contract amendment with The Burgess Group, LLC, a subsidiary of HealthEdge Software, Inc., to add a batch modeling solution; and
3. Authorize unbudgeted expenditures and appropriate funds in an amount up to $150,000 from the Digital Transformation and Workplace Modernization Reserve to fund the contract amendment through June 30, 2023.

Background

As part of CalOptima's Workplace Modernization and Digital Transformation Strategy, Information Technology Services will be evaluating and deploying multiple solutions. The solutions coincide with CalOptima's Cloud First strategy and take regulatory, compliance, and security measures into consideration. The projects and products that CalOptima implements will result in value-based care and improvements for member, provider, and employee experiences. These enhancements will provide CalOptima with the ability to be robust and agile, and to scale as a future-focused healthcare organization.

Discussion

Currently, CalOptima Health manually groups and reprices encounter and claim volume on a case-by-case basis. This involves building and maintaining complicated financial models. Being able to automate much of this process will improve efficiency and accuracy, as well as better serve internal and external customers. Internal resources could then be allocated from manual model building to focusing on analytics, including rate setting strategy, cost-of-care initiatives, contract negotiations support, provider benchmarking, and case mix indexing.

Staff researched encounter repricing solutions to aid analytics. In January 2023, CalOptima Health executed a new five-year contract with The Burgess Group, LLC to implement a new cloud platform claims pricing tool. Since CalOptima Health has a long-standing relationship with The Burgess Group, LLC, staff determined the best option is to amend their current contract to add a batch modeling solution. Staff recommends executing a contract amendment with The Burgess Group, LLC to expand

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their scope of work by adding a batch modeling solution to the existing claims pricing platform. This will enable CalOptima Health to automate encounter volume repricing.

Fiscal Impact
The recommended action is unbudgeted. 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 $150,000 from the reserve will fund the contract amendment through June 30, 2023. The estimated annual fiscal impact is $300,000. Management will include non-salary operating expenses for subsequent contract years in future operating budgets.

Rationale for Recommendation
Implementing a batch modeling solution to automate encounter volume repricing will create greater efficiencies within CalOptima Health's financial analytic operations.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Fiscal Year 2022-23 CalOptima Health Operating Budget, Attachment B1: Digital Transformation Administrative Budget Details
2. Previous Board Action dated August 4, 2022, Authorize the Chief Executive Officer to Execute a New Contract with The Burgess Group, LLC to Implement a New Cloud Platform in Support of CalOptima's Digital Transformation Strategy, and Ratify an Amendment Extending the Current Contract with The Burgess Group, LLC
3. Contract No. 22-10967 with The Burgess Group, LLC
4. Entities Covered by this Recommended Board Action

Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
August 4, 2022	Extension amendment of contract	6/30/22 – 12/31/22	$525,000
	New contract	Five-year term, with 3 one-year extension options	FY 2022-23 six-month period of $981,000

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

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Attachment B1: Digital Transformation Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY 2022-23 Input	Authorization	Appropriation
Other Operating Expenses	SOC (Security Operation Center) as a Service	1,576,000	X	X
Other Operating Expenses	Privileged and Identity Access Management	375,000	X	X
Other Operating Expenses	Data Protection and Digital Forensics & Incident Services	368,000	X	X
Other Operating Expenses	Cloud Government/Storage Subscription (Non Digital)	230,000	X	X
Other Operating Expenses	End Point Protection/Detection/Response Services	200,000	X	X
Other Operating Expenses	Zero Trust Network Architecture	168,000	X	X
Other Operating Expenses	Training & Seminar - Professional & Organizational Development and Education - System and Software Update Training - Process Improvement Training - Financial and Reporting Software Upgrade and Training - Training Classes for Facility Management, Environmental and Safety Issues - Training Classes for Professional Certifications and Continuing Legal Education	163,200	X	X
Other Operating Expenses	Anti-Phishing/SPAM and Various Subscriptions	77,000	X	X
Other Operating Expenses	Professional Dues and Member Fees for Various Professional Associations	53,760	X	X
Other Operating Expenses	Application Software Maintenance - IT Development Tools (Data Modeling, Architecture, Technical Libraries, Documentation, Technical Frameworks, Electronic Data Interchange, Software Development Testing)	41,520	X	X
Other Operating Expenses	Travel - Conferences/Seminars and Meetings for Managers and Staff - State Meetings Related to Regulatory and Legislative Issues, Strategic Development - Association Meetings - Vendor Site Visits, Field Staff Visits - Mileage and Parking Reimbursement for Community Events and Presentations, Provider Offices and Member Enrollment	39,600	X	X
Other Operating Expenses	Office Supplies for Various Departments' Needs for Everyday Operations	300	X	X
Professional Fees	Portal, Website Support and Quality Assurance Support for Enhancements of Software Development and Frameworks	600,000	X	X
Professional Fees	Core Systems Upgrade Consultation, Technical Training and Other Core Application Support	434,500	X	X
Professional Fees	Business Intelligence Related Support for Enhancement of Software Development and Frameworks	300,000	X	X
Professional Fees	Workflow Management Support	250,000	X	X
Professional Fees	Member and Provider Centric Artificial Intelligence and Machine Learning Solution Planning and Execution	240,000	X	X
Professional Fees	Data Warehouse Support for Enhancement of Software Development and Frameworks	216,000	X	X
Professional Fees	EDI and System Integration Support for Enhancement of Software Development and Frameworks	192,000	X	X
Purchased Services	Network Operations and CAPEX Related Services	160,000	X	X
	Total Non-Salary Operating Expenses	**5,684,880**		

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Authorize the Chief Executive Officer to Execute a New Contract with The Burgess Group, LLC to Implement a New Cloud Platform in Support of CalOptima's Digital Transformation Strategy, and Ratify an Amendment Extending the Current Contract with The Burgess Group, LLC

Contacts

Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
Nora Onishi, Director, Information Technology Services, (714) 246-8630

Recommended Actions

1. Authorize the Chief Executive Officer to execute a new contract with The Burgess Group, LLC (The Burgess Group), a payment reimbursement system vendor, for an initial term not to exceed five years, with three one-year extension options, exercisable at CalOptima's sole discretion, with each extension option subject to prior Board of Directors (Board) approval; and
2. Ratify an amendment with The Burgess Group extending the current contract for an additional six months from July 1, 2022, to December 31, 2022.

Background

The Burgess Reimbursement System (BRS) was originally contracted on January 1, 2008, to support CalOptima's claims adjudication process with its first CMS Medicare Advantage D-SNP plan, OneCare. This software solution originally provided two key functions: (1) Correct CMS Medicare pricing for claims; and (2) current, up-to-date fee schedules to maintain accuracy. The Burgess Group has added system enhancements to its BRS software portfolio and incorporated the California Medi-Cal pricing schedules. CalOptima currently utilizes BRS for the Medi-Cal acute in-patient APR-DRG schedule for hospital claims payment and has built a tight integration with BRS and CalOptima's core claims system facets, supporting claims administration auto-adjudication of Medicare and Medi-Cal in-patient hospital claims. BRS has provided CalOptima with CMS pricing accuracy to support claims payment for over 14 years.

Discussion

At the December 6, 2018, Board meeting, The Burgess Group was one of several vendors approved for an extension of the existing contract through June 30, 2022.

In July 2020, The Burgess Group proposed a new platform software as a service (SaaS) model as a result of Microsoft ending support for the current BRS version in 2022. The model change necessitates a new contract between CalOptima and The Burgess Group. Considering the length of time CalOptima has contracted with The Burgess Group and as part of the recommended procurement process, CalOptima decided to explore other vendors. CalOptima released a request for proposal (RFP) to review the current market for pricing solution vendors. Staff completed the RFP selection in August of 2021.

CalOptima's review committee consisted of stakeholders from the Finance, Claims, GARS, and Information Technology Services departments. Consistent with CalOptima's procurement process,

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CalOptima conducted a review of bids and scored the applicants to select a vendor. CalOptima received four bids from vendors on the RFP. The approved scoring criteria used was based on five points per category and used a weighted average, placing the greatest weight on application functionality, and was as follows:

Criteria	Weighted Average
Completeness of Proposal	10%
Application Functionality	30%
Related Experience in Industry	20%
Qualifications of Vendor Team, Locations	15%
Price	15%
Contract Response	10%

Based on proposal reviews from four vendors, the results for the RFP are as follows:

RFP 22-012 Claims Pricing Solution Services		
Vendor	Score	Rank
The Burgess Group	4.16	1
Cognizant/Trizetto	2.91	2
PayerCompass	2.66	3
NTT Data	2.56	4

The Burgess Group was re-selected by CalOptima Staff based on the scoring above.

In the December 20, 2021, Board special meeting, the Board approved a request for reallocation of funds. The original budget for Fiscal Year (FY) 2021-2022 was expected to have transitioned to the new contract after the first quarter of 2021. Due to multiple circumstances, the proposed new contract negotiation took longer than expected.

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Fiscal Impact
The recommended actions are budgeted items. The CalOptima FY 2022-23 Operating Budget approved by the Board on June 2, 2022, included $525,000 to fund the extension of the current contract with The Burgess Group from July 1, 2022, through December 31, 2022, and $981,000 to fund the new contract through June 30, 2023.

Rationale for Recommendation
Based on the scoring above, staff recommends that the Board approve execution of a new contract with The Burgess Group. Staff also recommends that the Board ratify the contract amendment extending the current contract to allow time to implement the platform changes. The extension is required as a result of contract negotiations with The Burgess Group along with the Statement of Work (SOW) and Business Associate Agreement (BAA). These negotiations took longer than expected and were delayed further during the transition of legal services and ensuring that CalOptima was protected in commitments on both sides.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Pricing_Solution_SOW_RFP_22-012
3. Previous Board Action dated September 1, 2016: "Consider Extension of Contracts Related to CalOptima's Core Systems
4. Previous Board Action dated December 6, 2018: "Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems
5. Previous Board Action dated December 20, 2021: "Consider Authorization of Proposed Budget Reallocation of Fiscal Year 2021-22 Operating Budget Funds and Authorization of Unbudgeted Expenditures and Appropriation of Funds for Information Services Items

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
September 1, 2016	Extension amendment of contract	1/1/2017 – 12/31/2019	Annual cost of $ 811,700
December 6, 2018	Extension amendment of contract	1/1/2020 - 6/30/2022	Annual cost of $ 811,700

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Board Meeting Dates	Action	Term	Not to Exceed Amount
December 20, 2021	Reallocation of funds	1/1/2022 – 6/30/2022	$120,000

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
The Burgess Group, L.L.C.	1701 Duke Street, #300	Alexandria	VA	22314
HealthEdge	30 Corporate Drive	Burlington	MA	01803

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RFP 22-012 Claims Pricing - Scope of Work

1. Objective

The purpose of this RFP is to identify and implement a claims pricing tool which will support and enhance CalOptima's ability to accurately and efficiently process Medicare and California's Medicaid (Medi-Cal) claims. The solution must be able to support CalOptima's current requirements, as well as, new or changing requirements mandated by federal and state regulators.

2. Scope of Work

CalOptima seeks to procure a software-as-a-service (SaaS), solution capable of delivering real-time and batch-processed medical claims pricing calculations, using up-to-date payment policies, rates, and provisions as defined by the Centers for Medicare and Medicaid Services (CMS) and, California's Department of Health Care Services (DHCS). The solution must be integrated with CalOptima's claims administration system (Facets) to apply pricing calculations during batch processing, as well as, during the manual adjudication process. In addition, CalOptima requires the ability to seek pricing results using a web application.

CalOptima would like to secure a contract with a vendor on or before October 31, 2021 and start implementation efforts on or before December 1, 2021. Implementation of an integrated solution will need to be complete no later than February 1, 2022.

3. Requirements

In order to meet its current and future business needs, CalOptima will select a solution that aligns most with the functional and technical capabilities delineated in this section.

All materials submitted by the vendor become the property of CalOptima and may be evaluated by any employee or agent of CalOptima. CalOptima reserves the right to proceed or not to proceed with plans to acquire information systems.

a. Comments Column:

Please answer each question as completely and concisely as possible. Be sure that the responses provide sufficient detail to objectively evaluate the response while not providing irrelevant information. Insert narrative responses within the "Vendor Response" column. Any unclear or incomplete answers may be disregarded and considered non-responsive.

If the response requires a relevant attachment, note it within the response field, identify the attachments by the requirement number and provide the attachments in electronic form with your response.

b. Requirements that cannot be met:

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If a requirement cannot be met please indicate “cannot be met as requested” and provide the performance level offered or an alternative option.

Please respond to each item completely, concisely and accurately. Failure to provide appropriate data may eliminate the evaluation of this proposal.

Item #	System Requirements/Core Functions	Vendor Response
1.1	Must support the following Medicare Provider Type, Pricing Schedules, Rates and Methodologies with ongoing regulatory updates:	
	a) Professional • Resources Based Relative Value Scale (RBRVS)	
	b) Anesthesia • American Society of Anesthesiologists (ASA)	
	c) Merit-based Incentive Payment System (MIPS) including: • Option to apply a custom % to MIPS Adjustments on portion paid by Medicare • Option to turn on/off positive, negative and neutral MIPS adjustments • Option to apply 100% MIPS adjustments for Medicare Waived Coinsurance services • Ability to “bypass” MIPS adjustment based on Facets field (for integration)	
	d) Acute Inpatient Hospital • Medicare Severity Diagnoses Related Group (MS-DRG) Rates and Weights	
	e) Hospital Outpatient Department • Ambulatory Payment Classification (APC) Rates and Weights	

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Item #	System Requirements/Core Functions	Vendor Response
	• Hospital Outpatient Payment Rates • Comprehensive APC Complexity Adjustments Rates	
	f) Ambulatory Surgery Center (ASC) • ASC Payment Rates	
	g) Critical Access Hospital (CAH)	
	h) End-Stage Renal Disease (ESRD) • ESRD Outlier Services	
	i) Federally Qualified Health Center (FQHC) • FQHC Rates	
	j) Home Health Agency (HHA) • Billable Services	
	k) Hospice	
	l) Inpatient Psychiatric Facility (IPF) • Age Adjustments • Comorbidity Codes and Adjustments • Diagnosis-Related Group (DRG) Adjustment Factors	
	m) Inpatient Rehabilitation Facility (IRF) • Case Mix Group (CMG) Rates and Weights	
	n) Long Term Care Hospital • DRG Rates and Weights	
	o) Skilled Nursing Hospital (SNF) • Resource Utilization Groups (RUG) Rates • Patient-Driven Payment Model (PDPM) Rates	
	p) Ambulance • Ambulance fee schedule • Price fractional mileage (based on Facets field for integration)	

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Item #	System Requirements/Core Functions	Vendor Response
	• Price based on pick up zip code (based on Facets field for integration)	
	q) Durable Medical Equipment (DME)/Parenteral and Enteral Nutrition (PEN) • Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule • PEN Fee Schedule	
	r) Other • Drugs and Immunizations • Clinical Lab Fee Schedule • Drugs – Not Otherwise Classified (NOC) • National Drug Code (NDC) – Average Sales Price (ASP) mapping	
1.2	Must support Medicare Claims Payment Policies with ongoing regulatory updates:	
	a) Medicare Code Edits (MCE) • Option to apply MCE for informational purposes only • Option to not run or apply MCE to reimbursement results • Option to not pay claim if MCE edit is present	
	b) Non-Medicare Certified National Provider Identifier (NPI) Pricing • Option to not apply non-Medicare certified NPI pricing	
	•	
	d) DME • Medically Unlikely Edits • Option to not enforce DMEPOS CB Pricing rules	
	e) SNF	

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Item #	System Requirements/Core Functions	Vendor Response
	• CMS Medicare Administrative Contractors (MACs) • Health Insurance Prospective Payment System (HIPPS) Codes • Lab National Coverage Determinations (NCD) by Diagnosis • Lab NCD by Service • Local Coverage Determination (LCD) by Diagnosis • LCD by Service	
	f) Long-Term Care (LTC) • Minimal Care Evaluation Studies (MCE) by Diagnosis •	
	g) Inpatient Psychiatric Facility • MCE by Diagnosis •	
	h) Home Health Agency • CMS MACs • HIPPS Codes • Patient-Driven Groupings Model (PDGM) HIPPS Codes • LCD by Diagnosis • LCD by Service • National Correct Coding Initiative (NCCI) for Outpatient Providers	
	i) Federally Qualified Health Center (FQHC) • FQHC Qualifying Visits • Outpatient Code Editor	
	j) End-Stage Renal Disease • CMS MACs • Lab NCD by Diagnosis • Lab NCD by Service	

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Item #	System Requirements/Core Functions	Vendor Response
	• LCD by Diagnosis • LCD by Service • NCCI for Outpatient Providers	
	k) Critical Access Hospital • CMS MACs • Lab NCD by Diagnosis • Lab NCD by Service • LCD by Diagnosis • LCD by Service • Medically Unlikely Edits • Outpatient Code Editor	
	l) Ambulatory Surgery Center • CMS MACs • LCD by Diagnosis • LCD by Service • Medically Unlikely Edits • National Correct Coding Initiative • Payment Status Indicators	
	m) Hospital Outpatient Department • CMS MACs • Lab NCD by Diagnosis • Lab NCD by Service • LCD by Diagnosis • LCD by Service • Medically Unlikely Edits • NCCI for Outpatient Providers • Payment Status Indicators • Outpatient Code Editor (OCE) ○ Option to Apply OCE edit to all reimbursement results ○ Option to Ignore OCE edit for all reimbursement results	

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Item #	System Requirements/Core Functions	Vendor Response
	○ Option to Apply OCE edit for informational purposes only	
	n) Acute Inpatient Hospital • MCE by Diagnosis • MCE by Procedure • PDA Exempt Codes	
	o) Professional • CMS MACs • Lab NCD by Diagnosis • Lab NCD by Service • LCD by Diagnosis • LCD by Service • Medically Unlikely Edits • National Correct Coding Initiative	
1.3	Must support Medi-Cal Provider type/Pricing/Payment Policy with ongoing regulatory updates:	
	a) Medi-Cal Inpatient • All Patient Refine Diagnosis Related Groups (APR-DRG) Rates and Weights • California Inpatient Ancillary Codes Payment Policies ○ Option to not apply Transitional Rates • Provider Listing with pricing related information – CA Inpatient Providers	
	b) Medi-Cal Home Health	
	c) Medi-Cal Hospice	
	d) Medi-Cal Long Term Care	
	e) Medi-Cal Outpatient	
	f) Medi-Cal Professional	
	g) Medi-Cal Anesthesia	
1.4	Must provide authorized users secure access to a web-based user interface.	

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Item #	System Requirements/Core Functions	Vendor Response
1.5	Web application has the capacity to look up and export code listings, including: • Healthcare Common Procedure Coding System (HCPCS) Level II Codes • HIPPS Codes • ICD10-CM Diagnosis Codes • ICD10-PCS Procedure Codes • Medicare Waived Coinsurance services	
1.6	Web application includes the functionality to look up and export current and historical rates and pricing related information rates, including: • Professional ○ Anesthesia calculator ○ Anesthesia Conversion Factor ○ CMS Locality table ○ Combined Rate table with Rate Source (Physician, Physician Assistant, Nurse Midwife, Clinical Social Worker) (by locality) ▪ Source of rate: RBRVS, DME, LAB, Drug, Anesthesia, PEN, Ambulance, ASC, Outpatient Prospective Payment System (OPPS), Outpatient Mental Health Payment Level, Screening Mammography, Locality Neutral) ○ Professional Rate table (Physician, Physician Assistant, Nurse Midwife, Clinical Social Worker) (by locality) ○ RBRVS Rates by Service and Modifier table	

Item #	System Requirements/Core Functions	Vendor Response

1.7	Web application includes the functionality to look up and export provider listing with pricing-related information, including:
	• Acute Inpatient Hospital
	  ○ Inpatient Prospective Payment System (IPPS) Providers
	• Hospital Outpatient Department
	  ○ OPPS Providers
	• Ambulatory Surgery Center
	  ○ ASC Providers
	• Critical Access Hospital
	  ○ CAH Providers
	• End-Stage Renal Disease
	  ○ ESRD Providers
	• Federally Qualified Health Center
	  ○ FQHC Providers
	• Home Health Agency
	  ○ HHA Providers
	• Hospice
	  ○ Hospice Providers
	• Inpatient Psychiatric Facility
	  ○ IPF Providers
	• Inpatient Rehabilitation Facility
	  ○ IRF Providers
	• Long Term Care Hospital
	  ○ LTC Providers
	• Skilled Nursing Hospital
	  ○ SNF Providers	

1.8	Ability to return pricing specific to claim type upon manually entering (non-PHI) data elements into web application pricing tool.	
1.9	For the purposes of claims modeling or claims repricing, describe functions within	

Item #	System Requirements/Core Functions	Vendor Response
	the web application which allow users to submit an external claims data file for pricing claims via batch process, with all of the various pricing schedules as previously defined.	
1.10	Must provide standard, out of the box pricing and payment policies which follow Medicare and Medi-Cal guidelines • Any and all Medicare and Medi-Cal published pricing and payment policy information should automatically be incorporated into pricing tool.	
1.11	Must update pricing tool with any and all Medicare and Medi-Cal published pricing and payment policy information without client intervention.	
1.12	Describe how frequently published pricing and payment policy information are incorporated into the application.	
1.13	Describe the frequency by which your clients are notified of product releases (including, content and system updates). Summarize the type of content that are included in your product release notices.	
1.14	Must allow users to turn off payment policies either globally or on a per-policy basis.	
1.15	Ability to apply a unique payment policy to a rate structure.	
1.16	Medicare and Medi-Cal pricing must be independent of each other.	

Item #	Integration Requirements	Vendor Response
2.1	Automatically pass required (non-PHI) data elements from Facets to and from pricing tool for auto-pricing of the claim through daily batch process.	
2.2	Automatically return pricing to Facets in real-time.	
2.3	Pricing to occur real time with batch-loaded claims.	

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Item #	Integration Requirements	Vendor Response
2.4	Must provide the ability to manually pass (non-PHI) data elements from Facets to pricing tool to return pricing real time.	
2.5	Automatically return and retain pricing detail per claim, for both claim line and claim level, to Facets to include all pricing information.	
2.6	Ability to return pricing detail on a claim line without overlaying exception pricing in Facets.	
2.7	Return the most critical pricing explanation code to Facets claim line.	
2.8	Automatically determine the provider type/rate to price against based on the data elements on the claim in Facets, and when applicable other areas of Facets, such as but not limited to member zip code and/or provider record.	
2.9	Ability to look to other areas of Facets as applicable to determine payment, including but not limited to claim history, provider record, ambulance fractional mileage, ambulance pick up zip code.	
2.10	Ability to price to a different provider type than customary. For example, price outpatient hospital at Clinical Lab schedule.	
2.11	Ability to price to a different geographical area other than provider zip code. For example, price an Area 18 zip code at Area 26 rates.	
2.12	Pricing results of exact same claim data should be exactly the same regardless of manually entering data into stand-alone pricing tool or through integration	
2.13	Ability to return roll-up pricing (MS-DRG, APR-DRG) to Facets at a claim level.	
2.14	Ability to return claim line pricing at line level to Facets.	
2.15	Ability to return MIPS adjustment pricing specific to Medicare portion to primary for DUAL Facets module and not affect coordination of secondary amounts.	

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Item #	Integration Requirements	Vendor Response
2.16	Ability to map and return pricing tool explanation codes/remarks to a Facets explanation code.	
2.17	Ability to provide calculation details and values for each claims transactions processed in a daily data extract to CalOptima to load into our tables. Data elements to pass are collaboratively determined, but must contain elements to support our response to Provider questions or audit questions.	
2.18	Must provide edit messages back to Facets when the solution is unable to return price based on missing claims data.	
2.19	Ability to incorporate coinsurance value into a separate field in Facets. • Ability to exclude coinsurance value for Medicare Waived Coinsurance services values	

Item #	Technical Requirements	Vendor Response
3.1	SaaS solution must be hosted in the United States.	
3.2	Must provide a test environment for Facets non-production environments.	
3.3	Must deliver the ability to “transfer” configuration between test pricing tool and production pricing tool, and from production pricing tool to test pricing tool	
3.4	Secure integration is required. Describe the overall topology of the hosted solution and explains how it functions.	
3.5	In regards to technical requirements, please describe all client hardware and third party software requirements to implement your hosted solution, if any.	
3.6	In regards to technical requirements, please describe the kind of extension programs that CalOptima will need to install in order to integrate Facets with real-time pricing services, if any.	

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Item #	Technical Requirements	Vendor Response
3.7	Must be able to validate installation of extension programs, if any. Describe your company's standard process for verifying that all application components are properly installed.	

Item #	System & Training Documentation	Vendor Response
4.1	Must deliver a user application manual that provides operator-level information.	
4.2	Must provide clear cut instructions for installation, assuming an extension program must be installed.	
4.3	Must provide technical documentation and instructions as needed.	
4.4	Must provide training onsite (or virtual) at CalOptima facilities during the project timeline. Describe the training approach and schedule your firm recommends for initial training of the CalOptima implementation team.	
4.5	Must provide user level training on the solution to review and troubleshoot issues.	
4.6	In regards to system & training documentation, please describe any regularly held seminars, webinars, or user group meetings available to users of your system and content.	

Item #	Technology	Vendor Response
5.1	Must be compatible with Microsoft Windows platform; Windows 10 or newer, and Citrix clients (XenApp 7.15 and higher)	
5.2	Vendor integration tools must be compatible with Microsoft SQL Server 2017 or newer.	
5.3	Must support integration with Facets version 5.6 or newer.	
5.4	Vendor must support role-based security access and administration (assuming	

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Item #	Technology	Vendor Response
	administration services exist for hosted solution)	

Item #	HIPAA Compliance	Vendor Response
6.1	Vendor and its cloud-hosting partner must utilize an industry recognized security framework like HITRUST, PCI, NIST, etc.	

Item #	Implementation / Professional Services	Vendor Response
7.1	Describe the standard process used by your company to implement your products and services at a new client site. Provide a sample implementation work plan including: • Tasks required • Relative sequence of tasks and any key dependencies between tasks • Responsible parties for each task (vendor and CalOptima) • Include major areas of subcontractor work • Estimated time to complete each task • Vendor testing process • Coordination of user acceptance testing	
7.2	Based on your knowledge of CalOptima, please list specific client resource requirements for implementation you believe are necessary to meet the above timeline, including: • Approximate percentage of time each resource should be dedicated to the implementation phase by month • Roles and responsibilities of each resource	
7.3	Provide information on average customization, time and costs for other	

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Item #	Implementation / Professional Services	Vendor Response
	clients during an implementation, if any. Provide customization that clients have requested post-implementation, if applicable.	
7.4	Provide an example of standard Service Level Agreement (SLA) in vendor contracts. SLA must include both incentives and penalties for performance thresholds.	

Item #	Production Support Requirements	Vendor Response
8.1	Please provide all staffing resources and skills required to support production environment.	

Item #	Customer Service and Support	Vendor Response
9.1	Describe your company's support organization, addressing specifically: • Number of support personnel by title (programmer, support rep, account rep) • Title, training and experience of persons responding to calls about technical issues • Routing and escalation procedures of technical issues • Call tracking, resolution and call monitoring procedures. • The location of your customer service and support staff	
9.2	Indicate your support organization's ability to accommodate CalOptima's business hours. That is, 8 a.m. to 5 p.m. PST, Monday through Friday.	
9.3	Describe how your support organization accommodates urgent support requests during non-business hours and/or holidays.	

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9.4	Describe the method and frequency by which your clients are notified of software defects identified by support personnel or other clients. (Will you make your current internal defect tracking log available to CalOptima?)	
9.5	Customer Support must be able to respond to questions and clarifications related to pricing. Describe your standard response time to client inquiries.	

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Item #	Security (client & member)	Vendor Response
10.1	User authorization and authentication is required. Please detail the methodology provided by solution. Describe registration process for new users.	
10.2	Role-based access control is required. Describe how role-based access control is administered within the web application.	
10.3	Audit trail is required for user access, usage tracking, and auditing purposes. Describe availability of access and usage logs.	
10.4	Secure interface to Facets is required. Explain and detail the design and methodologies used by the proposed solution (e.g., HTTPS, API, AES 256 etc.)	

Item #	Miscellaneous	Vendor Response
11.1	Describe the reporting capabilities that are available within the solution, if any. Include specific types of reports that are available out-of-the-box, reports that can be customized by the user, or ability to extend reporting as needed by the organization.	
11.2	Please explain how client staff will be able to access the solution for analytical and reporting purposes.	

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Extension of Contracts Related to CalOptima's Core Systems

Contact
Len Rosignoli, Chief Information Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions
Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors as listed below through the dates indicated in the attached Tables 1, 2, and 3:
    a. Burgess-Burgess Reimbursement System (Medicare/Medi-Cal Fee Schedules and Claims Pricing)
    b. Medecision (Provider Portal (CalOptima Link)
    c. Edifecs-XEngine (Claims Electronic transaction standardization tool)
    d. Microstrategy (Enterprise Business Analytics and Intelligence)
    e. Office Ally (Claims Clearinghouse)
    f. Change Healthcare (Claims Clearinghouse)
    g. HMS (Medi-Cal Cost Containment)
    h. SCIO Health Analytics-My Socrates (Third Party Liability and Subrogation Recovery Services)
    i. OptumInsight (Credit Balance Recovery Services)
    j. MCG-CareWebQI (Evidence-based Clinical Guidelines
    k. Intelli-Flex (Telephone system and supporting Customer Service applications)
    l. TW Telcom/Level III (CalOptima's carrier for telecommunications as well as Internet connectivity); and

2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attached Tables 1, 2, and 3.

Background
CalOptima contracts with many vendors that provide a variety of software solutions to support the overall business model. Two Core Systems are central to this infrastructure while many other supporting solutions surround the Core.

Within the managed care industry, this is standard practice, as no commercially-available single solution is able to meet the demands of the industry for all functions. The trend over the past ten years or more has been to utilize this approach by using the Core for what those systems handle best, and to use specialty solutions to surround the Core. CalOptima, as well as the other 15 Local Health Plans of California, and virtually all health plans, use this approach.

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At the center and in the Core for CalOptima are two systems:

- TriZetto Facets – This solution handles the key functions of enrollment of members, health benefit configuration, claims processing and adjudication, and customer service.
- Altruista Guiding Care – This solution handles the key functions of Care Management, including Case Management, Utilization Management, Authorizations/Referrals, Disease Management, and Appeals & Grievances.

Supporting Systems include:

a. Burgess Reimbursement System – This solution provides two key functions. It enables continuous monitoring of the hundreds of claims reimbursement Medicare fee schedules maintained by the Federal Centers for Medicare and Medicaid Services (CMS) ensuring that CalOptima's Medicare fee schedules are up-to-date as soon as Medicare makes a change. It also uses sophisticated algorithms to calculate the reimbursement pricing for all CalOptima Medicare related claims. In the future, this solution will be expanded to perform the same functions for the Medi-Cal fee schedules and claims pricing.
b. Medecision - Aerial Care Coordination - This solution is the current CalOptima provider portal – more commonly known to the CalOptima provider partners as CalOptima Link. This portal enables the over 5,000 provider users to verify eligibility, review claims status, view patient rosters, and submit service authorization requests.
c. Edifecs – XEngine – This tool supports quality for the CalOptima Facets Claims process. XEngine is a tool that helps to validate compliance with regulatory transaction standards and streamline operational efficiency.
d. Microstrategy – This is the current CalOptima Business Intelligence and Analytics solution. Many routine analytics processes developed within Microstrategy have become part of the standard operations of CalOptima, providing data analytics to support all business functions.
e. and f. Office Ally and Change Healthcare – These vendor solutions are known as Claims Clearinghouses. Essentially, providers in the community interact with their systems to submit claims for payment to a variety of health plans/payers. The Office Ally Clearinghouse services the vast majority of California providers. Office Ally also provides Claims Submission, Electronic Health Record, and Practice Management solutions at no cost to provider offices, including hundreds of CalOptima provider offices. Change Healthcare (formerly known as Emdeon) is the largest claims Clearinghouse in the Country. In 2015, Change Healthcare handled over 8.5 billion transactions, covering $1.7 trillion in claims.
g. Health Management Systems (HMS) – HMS is a cost containment service vendor. For CalOptima, as well as the California Department of Health Care Services (DHCS), HMS is contracted to identify, audit and recover improper Medi-Cal payments. HMS' mission is to help protect the integrity of government-sponsored health and human services programs. HMS provides similar services to 23 states including 41 state Medicaid programs.
h. SCIO Health Analytics - My Socrates – My Socrates is a subrogation service solution used to support CalOptima's Medicare Claims processing. This service handles and identifies third-party liability, for example, subrogation with motor vehicle accidents, often a contributor to total claims cost. SCIO's services reach more than 400 million medical claims and 1.3 billion prescription claims nationwide.
i. OptumInsight – For CalOptima, OptumInsight provides Credit Balance Recovery services. There is a Medicare regulation dictating that providers may not retain any overpayments. An overpayment is where a health insurer reimburses a provider in excess of what should be

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reimbursed, most often caused by billing or processing errors. There are a variety of significant penalties that can be assessed if overpayments are not identified and handled appropriately. This service helps CalOptima recover overpayments and its provider partners to identify procedural and system issues that create credit balances to identify opportunities to prevent future overpayments.

j. MCG, part of the Hearst Health Network – CareWebQI – This solution is embedded and tightly integrated within the Altruista Guiding Care solution for Care Management. CareWebQI provides electronic, automated access to evidence-based best practices and clinical criteria for the support and documentation of care management decisions.

The next two solutions support the overall Information Technology Infrastructure:

k. Intelliflex – This is the vendor that provides CalOptima's Avaya telephone System. The Avaya equipment is used for all employees. In addition, Avaya Contact Center and TelStrat Call Recording services are tightly embedded into CalOptima's Customer Service Operation, helping maintain regulatory compliance and policy adherence.

l. TW Telecom / Level 3 – This is CalOptima's carrier for telecommunications as well as Internet connectivity. This vendor supports this particular area of the County.

Discussion

The vendors listed in the attached table represent the solutions described above with contracts expiring over the next six months.

Many of these solutions are tightly embedded/integrated into either Facets and/or Altruista (the Core Systems) – see Table 1. Unless Facets or Altruista were to be replaced, replacing these tightly integrated solutions is infeasible without substantial investment and significant disruption to operations. Some also represent the most viable solution considering CalOptima's operating environment. See Table 2. Those falling into this category will not enter the competitive bidding process at this time.

Other solutions are less tightly integrated, less costly, less complex to replace, and are handled by competing vendors within the marketplace. For these vendors, a competitive bidding process is planned, and the approximate date to issue the RFI or RFP is listed in Table 3.

Fiscal Impact

The CalOptima Fiscal Year 2016-17 Operating Budget includes the annual fees for the listed contracted vendors related to CalOptima's core and supporting systems through June 30, 2017. Management will include expenses for the recommended contract extension periods on or after July 1, 2017, in future CalOptima Operating Budgets.

Rationale for Recommendation

Extension of the contracts for these systems that support the Core Systems will ensure there is no disruption to the services provided by each of the solutions and allow continuity of operations throughout the organization and with CalOptima's member and provider community.

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Concurrence
Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer

Attachment
Proposed Contract Extensions

/s/ Michael Schrader — *8/25/2016*
Authorized Signature — **Date**

Attachment - Proposed Contract Extensions

Table 1 – Solutions tightly integrated with Facets and/or Altruista

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
a. Burgess – Burgess Reimbursement System	Medicare/Medi-Cal Fee Schedules and Claims Pricing	1/1/2008	12/31/2016	12/31/2019	N/A	$811,700
b. Medecision – Aerial Care Coordination	Provider Portal (Calopima Link)	3/23/2011	9/1/2016	12/31/2019	N/A	$1,531,935
c. Edifecs – XEngine	Claims Electronic transaction standardization tool	3/9/2011	3/30/2017	12/31/2019	N/A	$93,702
d. Microstrategy	Enterprise Business Analytics and Intelligence	9/13/2011	9/19/2016	9/19/2019	N/A	$155,000

Table 2 – Solutions defined as “most viable” based on market standards, lack of competition, or related to State consistency

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
e. Office Ally	Claims Clearinghouse	7/1/2004	12/31/2016	12/31/2020	N/A	$474,579
f. Change Healthcare	Claims Clearinghouse	10/12/2000	10/18/2016	12/31/2020	N/A	$94,916
g. HMS	Medi-Cal Cost Containment	5/15/2008	5/14/2017	5/14/2020	N/A	$398,646
k. Intelli-Flex	Telephone system and supporting Customer Service applications.	12/7/2009	1/1/2017	12/31/2019	N/A	$306,936

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Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
l. TW Telecom / Level III	CalOptima's carrier for telecommunications as well as Internet connectivity.	2/15/2012	1/1/2017	12/31/2021	N/A	$720,000

Table 3 – Solutions with sufficient market competition with approximate RFP issue years listed

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
h. SCIO Health Analytics - My Socrates	Third Party Liability and Subrogation Recovery Services. (No cost, only contingency fee on percentage of recoveries).	2/19/2010	12/31/2016	12/31/2018	2017	Recovered in FY 2015-2016: $219,258.00 Fee (25%): $54,814.50 Net Recovery: $164,443.50
i. OptumInsight	Credit Balance Recovery Services. (No cost, only contingency fee on percentage of recoveries).	11/1/2011	12/31/2016	12/31/2018	2017	Recovered in FY 2015-2016: $44,834.00 Fee (12%): $5,380.08 Net Recovery: $39,453.92
j. MCG – CareWebQI	Evidence-based Clinical Guidelines	4/1/2008	3/31/2017	3/31/2021	2019	$641,300

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CalOptima Board Action Agenda Referral

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors as listed below through the dates indicated in the attachment:
    a. Altruista Guiding Care
    b. Burgess Reimbursement System
    c. Edifecs XEngine
    d. Catalyst Solutions
    e. Medecision
    f. Star MTM
    g. Ansafone
    h. Ceridian Dayforce
    i. Silk Road Open Hire and Wingspan

2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attachment, Table 1.

Background

CalOptima contracts with many vendors that provide a variety of software solutions to support the overall business model. Two core systems are central to this infrastructure while many other supporting solutions surround the core.

Within the managed care industry, this is standard practice, as no commercially-available single solution meets the demands of the industry for all functions, especially when considering the varying lines of business, government regulations, and the uniqueness of each health plan. The trend over the past ten years or more has been to utilize this approach by using a core administrative processing system surrounded by specialty solutions. CalOptima, as well as the other 15 Local Health Plans of California, and virtually all health plans, use this approach.

The two core systems for CalOptima are:

1. Cognizant Facets – This solution handles the key functions of enrollment of members, health benefit configuration, claims processing and adjudication, provider contract reimbursement, and customer service.

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2. Altruista Guiding Care – This solution handles the key functions of Care Management, including Case Management, Utilization Management, Authorizations/Referrals, Disease Management, as well as Appeals & Grievances.

The systems included in this staff recommendation are:

a. Altruista Guiding Care – As mentioned above, this is one of CalOptima's two core systems. CalOptima originally contracted with Altruista in April of 2014 for a term of seven total years, including an initial term and five one-year optional renewal terms extending to 4/6/2021. The system was live as of April 2015. There are two years remaining on the current contract, supporting the decision to recommend approval to extend for those two years, to 4/6/2021. Replacement of this core system was a substantial investment in money and time. It can take years for a core system of this type to fully stabilize. There are additional features yet to be explored, including the Population Health modules. No later than during Fiscal Year (FY) 2019-2020, a Request for Information (RFI) will be issued, primarily to remain informed and evaluate the marketplace for systems of this type, to help determine how long this system will remain or when it may be considered for replacement through a Request for Proposal (RFP) process.

b. Burgess Reimbursement System – This solution provides two key function. One - it enables continuous monitoring of the hundreds of claims reimbursement Medicare fee schedules maintained by the Federal Centers for Medicare and Medicaid Services (CMS) ensuring that CalOptima's Medicare fee schedules are up-to-date as soon as Medicare makes a change. Two - it uses sophisticated algorithms to calculate the reimbursement pricing for all CalOptima Medicare related claims. In the future, this solution will be expanded to perform the same functions for the Medi-Cal fee schedules and claims pricing. This system is very tightly integrated within the Facets core system software.

c. Edifecs – XEngine – This tool supports quality for the CalOptima Facets Claims process. XEngine is a tool that validates and ensures compliance with regulatory transaction standards and streamlines operational efficiency.

d. Catalyst Solutions – This vendor provides essential supplemental maintenance services and support of the Facets system based on their depth of knowledge of Facets and the inner workings of the software.

e. Medecision - Aerial Care Coordination - This solution is the current CalOptima provider portal – more commonly known to the CalOptima provider partners as CalOptima Link. This portal enables thousands of provider office users to verify eligibility, review claims status, view patient rosters, and submit service authorization requests. This will ultimately be replaced by the new CalOptima Provider Portal.

f. Star MTM – This vendor provides the system and services to support the Pharmacy Medication Therapy Management process required by The Centers for Medicare and Medicaid Services (CMS) for both the OneCare and OneCare Connect lines of business. This process is tightly integrated within the overall administration of CalOptima's pharmacy benefit. An RFP will be issued during FY 2020-2021 to re-evaluate this service.

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g. Ansafone – This vendor provides critical services supporting both CalOptima's Customer Service function and the Medical Affairs function. Ansafone provides after-hours call center support for both general customer service calls as well as more specific medical affairs calls. Ansafone also periodically conducts designed member outreach calls, as needed. An RFP for this service will be issued during FY 2018-2019 to evaluate the marketplace and to determine if CalOptima will retain the existing vendor or consider other alternatives.

h. Ceridian Dayforce – This is the primary Human Resources (HR) system handling employee benefits and payroll.

i. Silk Road Open Hire and Wingspan – Open Hire is the current HR applicant tracking and recruitment system. Wingspan is the current performance management system where all CalOptima employee performance evaluations are stored.

These three HR systems are tightly woven into the support and management of the CalOptima employees and are mission-critical for ongoing smooth operations. CalOptima has been on these systems for nearly ten years. During FY2019-20, CalOptima will issue an RFP for these functions to evaluate the marketplace to determine if a replacement is warranted, and if a single comprehensive HR solution can be procured rather than separate systems.

Discussion
The vendors listed in the attached table represent the solutions described above with contracts expiring in 2019 or sooner.

Many of these solutions are tightly embedded/integrated into either Facets and/or Guiding Care or are mission critical to the Human Resources function. Replacing any of these solutions would require a substantial additional investment, time commitment, and significant disruption to operations.

Fiscal Impact
The CalOptima FY 2018-19 Operating Budget includes the annual fees for the listed contracted vendors related to CalOptima's core and HR systems through June 30, 2019. Management will include expenses for the recommended contract extension periods on or after July 1, 2019, in future CalOptima Operating Budgets.

Rationale for Recommendation
Extension of the contracts for these systems will ensure there is no disruption to the services provided by each of the solutions and allow continuity of operations throughout the organization and with CalOptima's member and provider community, and its employees.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. Proposed Contract Extensions – Table 1
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader
Authorized Signature

11/28/2018
Date

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Attachment – Table 1 - Proposed Contract Extensions

Vendor – Solution Name	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Comments	Annual Cost Based on Fiscal Year 2018-19 Fees
Altruista Health – Guiding Care	Core Care Management Solution	4/6/2014	4/6/2019	4/6/2021	2 years remaining on the original contract	$1,485,000
Burgess – Burgess Reimbursement System	Medicare/Medi-Cal Fee Schedules and Claims Pricing	1/1/2008	12/31/2019	6/30/2022	Tightly Integrated with Facets	$442,162
Edifecs – XEngine	Electronic transaction standardization tool	3/9/2011	12/31/2019	12/31/2021	Tightly Integrated with Facets	$90,000
Catalyst Solutions	Facets Support Services	4/21/2014	12/31/18	6/30/2022	Integral supplemental maintenance services for Facets	$35,000
Medecision – Aerial Care Coordination	Provider Portal (CalOptima Link)	3/23/2011	12/31/2019	12/31/2020	Eventually to be replaced with Provider Portal	$1,560,000
Star MTM	Pharmacy Medication Therapy Management Services	11/1/2014	3/21/2020	3/21/2022	Tightly Integrated into the Pharmacy process. Expect to issue RFP during Fiscal Year 2020-2021.	$156,000
Ephonamation.com, Inc., DBA Ansafone	After hours customer service call center; after hours medical affairs call center; member outreach.	9/1/2016	8/31/2019	8/31/2020	Tightly integrated within Customer Service and Medical Affairs. RFP to be issued during Fiscal Year 2018-2019.	$213,000
Ceridian - Dayforce	The main Human Resources System for Benefits and Payroll	6/29/2008	6/30/2019	12/31/2021	Plan to issue RFP during Fiscal Year 2019-2020	$254,000

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Vendor – Solution Name	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Comments	Annual Cost Based on Fiscal Year 2018-19 Fees
Silk Road – Open Hire and Wingspan	Human Resources Support Systems – Performance Management, Applicant Tracking	6/19/2009	6/30/2019	12/31/2021	Plan to issue RFP during Fiscal Year 2019-2020	$58,500

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Altruista Health, Inc.	11800 Sunrise Valley Dr Suite 1000	Reston	VA	20191
Burgess Group, LLC	1701 Duke St	Alexandria	VA	22314
Edifecs, Inc.	1756 114th Ave SE	Bellevue	WA	98004
Catalyst Solutions, LLC	2353 S Broadway	Denver	CO	80210
Medecision, Inc.	550 E Swedesford Rd Building D, Suite 220	Wayne	PA	19087
Star MTM, LLC DBA Clinical Support Services	701 Seneca St	Buffalo	NY	14210
Ephonamation.com, Inc., DBA Ansafone Communications	145 E Columbine Ave	Santa Ana	CA	92707
Ceridian Corporation	3311 E Old Shakopee Rd	Minneapolis	MN	55425
SilkRoad Technology, Inc.	100 S Wacker Dr Suite 425	Chicago	IL	60606

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 20, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

30. Consider Authorization of Proposed Budget Reallocation of Fiscal Year 2021-22 Operating Budget Funds and Authorization of Unbudgeted Expenditures and Appropriation of Funds for Information Services Items

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Nora Onishi, Director, Information Services, (714) 246-8630

Recommended Actions

1. Authorize the reallocation of $120,000 for The Burgess Group, LLC, to different budget categories within the budget for the same vendor as follows:
    a. $50,000 from Medi-Cal: "Other Operating Expenses: Maintenance" to expense category "Medi-Cal: Purchased Services;" and
    b. $70,000 from "Medi-Cal: Other Operating Expenses: Maintenance" to expense category "OneCare Connect: Purchased Services."

2. Authorize unbudgeted expenditures and appropriate funds from existing reserves for Information System expenses based on existing contracts with the referenced vendors in amounts up to:
    a. $8,000 to expense category "OneCare Connect: Purchased Services" for Infocrossing, A WIPRO Company; and
    b. $60,000 to expense category "Medi-Cal: Other Operating Expenses: Purchased Services" for Imagenet, LLC.

Background

Pursuant to CalOptima Policy GA. 5003: Budget and Operations Forecasting, budget allocation changes that are not otherwise specifically delegated to the Chief Executive Officer require approval of the Board of Directors. Under CalOptima Policy GA.3202: CalOptima Signature Authority, for an expenditure to be authorized, it must appear in a budget line item as part of the Operating or Capital Budgets, or by way of an individual Board of Directors' action. To ensure compliance with CalOptima policies, there are four budget items for Information Services that require Board of Directors' approval, as follows:

1. The Burgess Group, L.L.C. is a contracted vendor that supports CalOptima's regulatory standard fee schedule pricing for claims through the Burgess Reimbursement System (BRS). This solution enables continuous monitoring of the hundreds of claims reimbursement Medicare fee schedules maintained by the Centers for Medicare & Medicaid Services (CMS), ensuring that CalOptima's Medicare fee schedules are up to date when Medicare makes changes. BRS uses algorithms to calculate the reimbursement pricing for all CalOptima Medicare-related claims. The BRS solution performs the same functions for the Medi-Cal fee schedules and claims pricing. Recently, staff conducted a Request for Proposal (RFP) and re-selected this vendor's upgraded platform to provide these services.

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2. Infocrossing, A WIPRO Company, is a CMS third party vendor that supports CalOptima's process to submit enrollment and disenrollment updates to CMS. Infocrossing provides CMS data files for membership reconciliation for OneCare, OneCare Connect, and PACE. CalOptima's Infocrossing budget for the past two years has averaged approximately $2,000 per month, with a total annual budget of $24,000.

3. Imagenet, LLC. is a CalOptima vendor that provides imaging, scanning, data extraction and document archive solutions for various departments, including Claims Administration and Customer Service. The Grievance and Appeals Resolution Services (GARS) Department has utilized this vendor in the past for the archiving of documents and plans to utilize the scanning and data extraction options to facilitate entry of information into the GARS tracking system. This vendor's scanning and data extraction options allow staff to more efficiently utilize their time in handling and addressing member and provider cases, rather than manually scanning records.

Discussion

When the budget was developed in March of 2021, staff used the most accurate information available at the time. The proposed changes reflect more current information and take into consideration changes in volume as well as other developments and program requirements.

1. **The Burgess Group, L.L.C.:** The RFP and re-selection of BRS will change the budget categories associated with the use of BRS. The new platform changes the contract from a license and purchased service agreement to a full software as a service (SAAS) agreement that incorporates the claims run rate. Purchased services would only apply if CalOptima exceeded the contract threshold. During the FY 2021-2022 budget process, staff anticipated that CalOptima would be up and running on the new contract terms within the first quarter of this fiscal year. Therefore, the amount authorized and appropriated in the adopted budget only included a limited amount in the purchased services category for the fiscal year. Staff now anticipates the contracting process to be executed by the third quarter of this fiscal year. Therefore, staff requests a budget reallocation totaling $120,000 to more accurately align budget amounts with the appropriate expense categories to be consistent with the current version of the contract.

2. **Infocrossing, A WIPRO Company:** In May 2021, CMS identified a gap in CalOptima's data submissions and requested that CalOptima review and resubmit its encounter transactions. In July and August 2021, CalOptima staff created resubmission files totaling almost 325,000 encounter transactions covering calendar years 2016 through 2018. Staff completed the analysis and resubmitted the required transactions to fulfill the identified data gap from CMS. Staff requests an additional $8,000 for the OneCare Connect Budget to cover these unplanned costs for Infocrossing associated with the resubmission of additional encounters for services within Calendar Years 2016-2018. The resubmission of encounter data records is a CMS regulatory requirement and may help improve CalOptima's risk scores with the additional data set.

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3. **Imagenet, LLC.:** With the increase in CalOptima's membership, there has been an increase in provider appeal cases. These appeal submissions often include the attachment of medical records and other relevant documentation consisting of up to hundreds of pages that need entry into CalOptima's system. The request to increase funding for Imagenet is based on the last ten months' volume of cases, as well as anticipated increases in the volume of OneCare and OneCare Connect non-contracted provider appeals due to regulatory requirements. Use of the current vendor for scanning and data extraction allows staff to focus on addressing and resolving cases in a timely manner. Staff requests approval and appropriation of $60,000 for Imagenet, LLC to address costs associated with scanning and data extraction services. This will ensure timely entry of provider appeal cases for resolution and will maintain compliance with regulatory timelines.

Fiscal Impact

Recommended Action #1: The recommended action is budget neutral. Unspent budgeted funds from expense category "Medi-Cal: Other Operating Expenses: Maintenance" approved in the FY 2021-22 Operating Budget will fund the total budget reallocation of $120,000 for this action.

Recommended Action #2: The recommended action to authorize expenditures and appropriate funds is unbudgeted. An appropriation and authorization of up to $68,000 from existing reserves will fund this action.

Rationale for Recommendation

The Burgess Group, LLC: The reallocation of funds will ensure budget categories are properly aligned with the current operating contract supporting CalOptima's fee schedule pricing.

Infocrossing, A Wipro Company: The resubmission of encounter data records is a CMS regulatory requirement and may help improve CalOptima's risk scores with the additional data set.

Imagenet, LLC: The appropriation and authorization of funds to cover scanning and data extraction services will ensure timely entry of provider appeal cases and compliance with regulatory timelines.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Entities Covered by this Recommended Board Action
2. Summary of Contract History
3. Board Action date October 7, 2021: Consider Extension of Contracts Related to CalOptima's Key Operational Systems
4. Contract and amendments Board Action dated December 6, 2018: Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems

/s/ Michael Hunn *12/15/2021*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
The Burgess Group, L.L.C.	1701 Duke Street, 3rd Floor	Alexandria	VA	22314
Infocrossing, A WIPRO Company	2 Tower Center	East Brunswick	NJ	08816
Imagenet, LLC	5401 W. Kennedy Blvd.	Tampa	FL	33609

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APPENDIX TO AGENDA ITEM 30

Summary of Contract History

Vendor	Contract Number(s)	History of Contract Changes (Summary)	Last Approval
1. The Burgess Group, LLC.	OC 03194	There have been 17 amendments to the contract. The amendments included date extensions along with services modifications required to meet CalOptima and regulatory requirements.	Board Approval December 6, 2018
2. Infocrossing, A Wipro Company	PO 06195	There have been eight amendments to the contract. The amendments included date extensions along with service modifications required to meet Centers for Medicare & Medicaid Services (CMS) regulatory requirements. An additional extension was most recently approved at the October 7, 2021, Board of Directors meeting. The amendment is in progress.	Board Approval October 7, 2021
3. Imagenet, LLC	18-10184	There have been seven amendments to the contract. The amendments include service additions to accommodate changes to regulatory and business requirements as well as exercising options to extend the contract. An additional extension was most recently approved at the October 7, 2021, Board of Directors meeting. The amendment is in progress.	Board Approval October 7, 2021

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Authorizing Extension of Contracts Related to CalOptima's Key Operational Systems

Contacts
Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Nora Onishi, Director, Information Services, (714) 246-8630

Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Recommended Actions
Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors through the dates indicated in the attached Tables 1, 2 and 3:
    a. Cognizant TriZetto Software Group, Inc.
    b. Catalyst Solutions, LLC
    c. Edifecs, Inc.
    d. Imagenet, LLC
    e. LexisNexis Risk Solutions FL Inc, and Enclarity, Inc.
    f. Symplr
    g. Change Healthcare Technologies, LLC
    h. Ceridian Corporation
    i. Silk Road Technology, Inc.
    j. Varis, LLC
    k. SmartComms, LLC
    l. InfoCrossing, A WIPRO Company
    m. Intuitive Technology Group, Inc.
    n. Lumen Technologies
2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attached Tables 1, 2 and 3.

Background
CalOptima contracts with several vendors that provide a variety of software solutions to support CalOptima's overall business model. There are two core systems, Facets and Guiding Care, that are central to CalOptima's infrastructure while many other supporting solutions surround them.

Within the managed care industry, it is standard practice to have multiple systems because no commercially available single solution can meet the demands of the industry for all necessary functions. The trend over the past ten years or more has been to utilize each core application for what that system handle best, and to use specialty solutions to supplement the core. CalOptima, along with virtually all other local health plans in the state, use this approach.

Primary and supporting systems include:

a. **Cognizant TriZetto Software Group, Inc. –** Facets is CalOptima's core business system that manages Membership/eligibility data, Customer Service, Claims and Provider Dispute

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Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Requests. In 2018, CalOptima initiated a Request for Information (RFI) to review available systems within the industry to determine whether it would make sense for CalOptima to replace the current system. There is no one system that handles everything well, and although we identified systems that can perform some functions better than CalOptima's current core system, there are trade-offs to consider. To replace a core system like this would require a minimum of two to three years to issue a Request for Proposal (RFP), enter into a contract and implement the transition. In addition, the cost would be at a minimum of $10–15 million (based on information from other county organized health systems (COHS) that have recently gone through this process). In further review and discussion with Gartner[1], the recommendation was to consider procuring supplemental systems to offset some of the functionality gaps within the core system. At the February 2020 meeting of the Finance and Audit Committee (FAC) of the Board, staff recommended staying with our current core system and to consider supplemental functions to fill any gaps. One such supplemental initiative include the Provider Data Management System RFP that is currently in progress. Staff recommends approval of extending the Facets contract for three additional years with the options to extend the agreement for two additional one-year terms (through June 2027) in order to provide staff with sufficient time to implement supplemental systems and re-evaluate whether the functional gaps have been fully addressed.

b. **Catalyst Solutions, LLC** is a vendor utilized for technical support for Facets. This vendor has supported many of our Facets upgrades over the years. The vendor is extremely familiar with our infrastructure and the Facets product. Catalyst Solutions' contract was extended by the Board on December 6, 2018, in line with the Facets Core System extension, due to the vendor's knowledge of CalOptima's infrastructure and the application. Staff recommends extending the contract for three additional years with the options to extend the agreement for two additional one-year terms (through June 2027) in alignment with the Facets contract.

c. **Edifecs, Inc.** is a software tool that supports quality for the CalOptima Facets Claims processes. XEngine through Edifecs is a tool that validates and ensures compliance with regulatory transaction standards and streamlines operational efficiency. This vendor has provided solutions that are tightly integrated with our core system. Staff recommends approval of extending the contract for three and a half additional years with the option to add two one-year extensions (through June 2027) to match the extension date of the Facets contract.

d. **Imagenet, LLC** is the vendor that provides imaging, scanning, data lift and document archive solutions. Multiple departments utilize their scanning and image data lift to provide data files for claims and enrollment selection processes. Along with that, Imagenet provides the electronic data imaging archives for provider documents and Medication Therapy Management (MTM) letter documentation, as well as historical Grievance and Appeals documentation. This vendor has provided solutions that are tightly integrated with our core system. Staff recommends approval of extending the contract for three and a half additional years with the option to add two one-year extensions (through June 2027) to match the extension date of the Facets contract.

e. **LexisNexis Risk Solutions FL Inc. and Enclarity, Inc.** provides a solution to validate Provider Data used at CalOptima, including demographic data and identification of providers that are on Federal exclusion lists. This software is tightly integrated to the core system. Staff

[1] Gartner is a leading technical research and advisory company that provides senior CalOptima leaders with the indispensable business insights and advice to achieve the mission-critical priorities.

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Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

recommends approval of extending the contract for an additional two years and eight months with the option to add three one-year extensions (through June 2027) to match the extension date of the Facets contract.

Provider Credentialing and Contracting Systems:

The following two contracts are for provider credentialing (Symplr) and provider contracting (Change Healthcare Technologies). Staff is currently in the RFP process to select and implement an integrated solution for Provider Data Management, Contracting and Credentialing. This integrated solution will potentially replace the current Credentialing and Contracting systems if new vendor(s) are selected consistent with the Board-approved Purchasing policy. Due to the complexity of this effort, staff estimates that the integrated solution implementation will be completed by the end of 2024. Staff recommends approval of extending both contracts annually for up to two additional years (through December 2024) to allow sufficient time for completion of the RFP and implementation of the selected system.

a. **Symplr** provides provider credentialing software. As noted above, staff plans to complete the RFP process and implement a new solution by the end of 2024. Staff recommends approval of extending the contract for one additional year and sixteen days with an option for two additional one year extensions.(through December 2024).
b. **Change Healthcare Technologies, LLC** is a provider contract management software system. As noted above, staff plans to complete the RFP process and implement a new solution by the end of 2024. Staff recommends approval of extending the contract for an additional one year and one day with an option for two additional one year extensions (through December 2024).

Human Capital Management (HCM) Systems:

The following three systems support our Human Resources (HR) function. CalOptima's HR Department currently utilizes several disparate systems to assist in managing employee information and applicant tracking. The RFP planned for FY 2019–2020 to replace these three systems was deferred due to other priorities related to the COVID pandemic. Staff is currently preparing a Human Capital Management (HCM) solution RFP to be issued in Fall 2021 to review products in the marketplace. This RFP seeks an integrated solution to support several HR and Finance functions, including, but not limited to, core HR functions, benefits, workforce management, payroll, applicant tracking and recruitment, and performance management, which are currently provided by several different systems. By allowing a one-year extension to these three systems below, staff will have time to complete the RFP, contract with the successful vendor, and implement a new solution for HCM.

a. **Ceridian Corporation-** Dayforce is the primary HR and Finance system handling employee benefits and payroll. As noted above, by allowing a one-year extension to this contract, staff will have sufficient time to complete the HCM RFP and implement a new solution. Staff recommends approval of extending the contract for one additional year (through January 6th 2023).
b. **Silk Road Technology, Inc.-** OpenHire is the current HR applicant tracking and recruitment system. WingSpan is the current employee performance management system where all CalOptima staff performance evaluations are created and stored. As noted above, by allowing a one-year extension to this contract, staff will have sufficient time to complete the HCM RFP and implement a new solution. Staff recommends approval of extending the contract for one additional year (through December 2022).

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Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Other Systems

a. **Varis LLC** provides overpayment identification and post-payment recovery services of potential overpayment of services that utilized Diagnosis Related Group (DRG) for Inpatient Medicare and Medi-Cal and Outpatient or Ambulatory Payment Classification (APC) payment guidelines to determine the claims payment amount. To summarize the audit review process, Varis conducts the data and clinical analysis based on CalOptima's paid files and review of medical records, as needed, and identifies the dollar recovery amounts based on their audit findings. By allowing a one-year extension, staff will have time to complete the RFP process, and if the same vendor is not selected, it will allow sufficient time to contract and implement a new solution. Staff recommends approval of extending the contract for one additional year (through September 24th, 2023).

b. **SmartComms, LLC** provides system generated letters for claims requests as well as claims denials. This solution was originally selected to support the Care Management vendor solution. With the decision to process a RFP to select a Care Management solution, the letter generating solution may change with that direction. Staff recommends approval of extending the contract for one additional year (through December 30th, 2022) to allow time to complete the Care Management System RFP which will impact the letter communication system.

c. **InfoCrossing, A WIPRO Company** is a CMS third party vendor that supports our process to submit enrollment and disenrollment updates to CMS. The vendor provides CMS data files for membership reconciliation for OneCare, OneCare Connect, and PACE. WIPRO supports file transfers between CalOptima and CMS. This vendor has maintained our stability to process regulatory file requirements to CMS. With the Duals Demonstration coming to an end and the transition of member planning in progress, it would be best to stay with the existing vendor to assure stability in transition. Staff recommends approval of extending the contract for an additional three years, two months and three days, to cover the period of the transition and the first year thereafter (through December 31st, 2024). Post transition, staff will issue an RFP to review the available systems in the market.

d. **Intuitive Technology Group, Inc.** Tableau is an enterprise-wide reporting and analysis tool that provides staff with the capability to review and analyze clinical, financial, and other data to monitor and improve performance. In addition to costs associated with selecting and implementing a new tool, to replace a system like this, it would require the use of a new tool for staff to perform data analysis and to be re-trained to re-create the many reports and dashboards developed over the last four years. Staff's recommendation is to approve extending the contract for three additional years (through November 28th, 2024).

e. **Lumen Technologies** is CalOptima's carrier for telecommunications as well as Internet connectivity. This vendor supports this particular area of the County. Internet and telecommunication stability during the pandemic has been essential to keep our communications functioning. We have not experienced any major issues with the vendor during the pandemic. Staff's recommendation is to approve extending the contract for three additional years (through 12/31/2024).

Discussion

The vendors listed above and in the attached tables represent the solutions described and contracts expiring in 2021 and 2022. Replacing any of these solutions in the short term would require substantial additional investment, time commitment, as well as significant disruption to operations.

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Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Many of these solutions are tightly embedded and integrated into either Facets or Guiding Care (the core systems):

I. Table 1. Unless core systems are replaced, replacing these tightly integrated solutions is not feasible without substantial investment and significant disruption to the operations. Some of the vendors also represent the most viable solution considering CalOptima's operating environment.

II. Table 2. The vendors in this category have expiring contracts, but due to the complications related to the COVID-19 pandemic during the past 18 months, staff needs additional time to complete the RFP processes and selection of new vendors. Extending these contracts as proposed will allow sufficient time for selection and implementation of new systems and avoid potential gaps in services.

III. Table 3. This table lists the technical solutions that provide support to the infrastructure and stability for the above systems. Extending these vendor solution contracts will allow additional time to complete the other RFP processes and determine whether an RFP to change technical directions is needed.

Fiscal Impact

The CalOptima Fiscal Year 2021–22 Operating Budget, approved by the Board on June 3, 2021 includes the annual fees for the listed contracted vendors related to CalOptima's core and supporting systems through June 30, 2022. Management will include expenses for the recommended contract extension periods on or after July 1, 2022, in future CalOptima operating budgets.

Rationale for Recommendation

Extension of the contracts for these systems will ensure there is no disruption to the services provided by each of the solutions and allows continuity of operations throughout the organization that impact CalOptima's member and provider community.

Concurrence

Gary Crockett, Chief Counsel

Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Attachments

1. Tables of Proposed Contract Extensions
2. Entities Covered by this Recommended Board Action
3. Appendix: Summary of Contract History
4. Board Action dated June 3, 2021: Consider Approval of the CalOptima Fiscal Year 2021–22 Operating Budget
5. Board Action dated March 5, 2020: Consider Authorization of Expenditures in the CalOptima Fiscal Year 2019–20 Operating Budget for Claims Editing Solution and Recovery Services
6. Board Action dated December 6, 2018: Consider Extension of Contract Related to CalOptima's Core System, Facets
7. Board Action dated December 6, 2018: Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems
8. Board Action dated September 1, 2016: Consider Extension of Contracts Related to CalOptima's Core Systems

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

09/29/2021 — **Date**

Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Tables — Proposed Contract Extensions

Table 1 — Solutions tightly integrated with the two core systems (Facets and/or Altruista)

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Annual Cost Based on Fiscal Year 2021–22 Budget
a. Cognizant TriZetto Software Group, Inc.	Core business applications supporting membership, claims	2/22/2000	6/30/2022	6/30/2027	$1,915,000
b. Catalyst Solutions, LLC	Technical consultant support for Facets	4/21/2014	6/30/2022	6/30/2027	$28,000
c. Edifecs, Inc.	Electronic transaction standardization software	03/09/2011	12/31/2021	6/30/2027	$114,100
d. Imagenet, LLC	Archiving and document imaging services	11/21/2017	12/31/2021	6/30/2027	$350,000
e. Lexis Nexis Risk Solutions Fl Inc. and Enclarity, Inc.	Provider exclusion software	5/01/2015	10/31/2021	6/30//2027	$324,000

Table 2 — Solutions defined as essential systems with contracts that need extending to allow time for RFP selection and contract negotiation with implementation of the selected vendor to replace existing systems, and to assure there are no gaps in service.

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Annual Cost Based on Fiscal Year 2021–22 Budget
f. Symplr	Credentialling system	11/29/2011	12/15/2021	12/31/2024	$119,000
g. Change Healthcare Technologies, LLC	Contract management software system	12/30/2016	12/30/2021	12/31/2024	$355,000
h. Ceridian Corporation	Employee payroll	6/29/2008	1/06/2022	1/06/2023	$384,000
i. Silk Road Technology, Inc.	HR recruitment tracking (Open Hire) and HR performance management (Wingspan)	06/19/2009	12/31/2021	12/31/2022	$81,000
j. Varis LLC	High dollar and forensic claims review	9/25/2017	9/24/2022	9/24/2023	$1,450,000
k. SmartComms, LLC	Letter generation software	12/31/2016	12/30/2021	12/30/2022	$145,000
l. InfoCrossing, A WIPRO Company	CMS enrollment/eligibility verification and CMS file reconciliation	05/01/2005	10/28/2021	12/31/2024	$24,000

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Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Table 3 — Technical solutions that maintain service level consistency.

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Annual Cost Based on Fiscal Year 2021–22 Budget
m. Intuitive Technology Group, Inc.	Business intelligence software — Tableau	11/22/2017	11/28/2021	11/28/2024	$238,505
n. Lumen Technologies	Internet connectivity	02/15/2012	12/31/2021	12/31/2024	$984,000

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Cognizant Trizetto Software Group, Inc.	300 Frank W Burr Blvd.	Teaneck	NJ	07666
Catalyst Solutions, LLC	6400 S. Fiddlers Green Circle	Greenwood Village	CO	80111
Edifecs, Inc	1756 114th Ave. SE	Bellevue	WA	98004
Imagenet, LLC	5401 W. Kennedy Blvd.	Tampa	FL	33609
LexisNexis Risk Solutions FL Inc. and Enclarity, Inc.	1105 N Market St, Ste 501	Wilmington	DE	19801
Symplr	315 Capitol St., Suite 100	Houston	TX	77002
Change Healthcare Technologies, LLC	100 Airpark Center Dive East	Nashville	TN	37217
Ceridian Corporation	3311 E Old Shakopee Rd	Minneapolis	MN	55425
Silk Road Technology, Inc	100 S. Wacker Dr, Suite 425	Chicago	IL	60606
Varis, LLC	3915 Security Park Dr, Ste B	Rancho Cordova	CA	95742
SmartComms, LLC	250 Commercial Street	Manchester	NH	03101
InfoCrossing, A WIPRO Company	2 Tower Center	East Brunswick	NJ	08816
Intuitive Technology Group, Inc.	4530 W 77th Street, Suite 255	Edina	MN	55435
Lumen Technologies	100 CenturyLink Dr.	Monroe	LA	71203

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Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

APPENDIX TO AGENDA ITEM 16

Summary of Contract History

Vendor	Contract Number(s)	History of Contract Changes (Summary)	Last Approval
a. Cognizant TriZetto Software Group, Inc.	00-849-2197	There have been 48 amendments to the contract. These amendments have included time extensions, functional enhancements to support changes to regulatory and business requirements over the years, and administrative changes. Staff conducted multiple RFIs to survey the market for claims processing and customer service systems. Most recently, at the February 2020 meeting of the Finance and Audit Committee (FAC) of the Board, staff recommended to stay with our current core systems and to consider supplemental functions to fill the gap.	Board Approval December 6, 2018
b. Catalyst Solutions, LLC	14005	There have been 9 amendments to the contract. The amendments included date extensions along with technical support for system configuration changes required to meet regulatory and business requirements.	Board Approval December 6, 2018
c. Edifecs, Inc.	MC 01759	This contract has been extended 10 times. The extensions have included date extensions along with licensing modifications and technical support to accommodate changes to regulatory and business requirements.	Board Approval December 6, 2018
d. Imagenet, LLC	18-10184	There have been 7 amendments to the contract. The amendments include service additions to accommodate changes to regulatory and business requirements and the exercise of options to extend the contract that was included in the original contract.	Budget Approval June 3, 2021
e. Lexis Nexis Risk Solutions FL Inc. and Enclarity, Inc.	15-0964/ 15-0973	There have been 6 amendments to the contract. The amendments include date extensions, administrative changes and pricing updates.	Budget Approval June 3, 2021

Vendor	Contract Number(s)	History of Contract Changes (Summary)	Last Approval
f. Symplr	MC 01611	There have been 9 extensions to the contract. The extensions have included date extensions along with licensing modifications and technical support to accommodate changes to regulatory and business requirements.	Budget Approval June 3, 2021
g. Change Healthcare Technologies, LLC	17-10538	There have been 2 amendments to the contract. The amendments include technical support services related to the implementation and upgrade of the software.	Budget Approval June 3, 2021
h. Ceridian Corporation	MC 03232	There have been 12extensions to the contract. The extensions have included software license modifications and technical support services related to the implementation and upgrade required to meet regulatory and business requirements.	Board Approval December 6, 2018
i. Silk Road Technology, Inc.	MC 02042	There have been 10 extensions to the contract. The extensions have included technical support services related to the implementation and upgrade of the software.	Board Approval December 6, 2018
j. Varis, LLC	17-10537	There have been 2 amendments to the contract. The amendments were for date extensions.	Board Approval March 5, 2020
k. SmartComms, LLC	17-10511	There have been 2 amendments to the contract. The amendments include technical service additions to support implementation and the exercise of options to extend the contract that was included in the original contract.	Budget Approval June 3, 2021
l. InfoCrossing, A WIPRO Company	PO 06195	There have been 8 amendments to the contract. The amendments included date extensions along with service modifications required to meet CMS regulatory requirements.	Budget Approval June 3, 2021
m. Intuitive Technology Group, Inc.	18-10487	There have been 2 amendments to the contract. The amendments include additional licenses to support organizational growth and the exercise of options to extend the contract that was included in the original contract.	Budget Approval June 3, 2021

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors as listed below through the dates indicated in the attachment:
    a. Altruista Guiding Care
    b. Burgess Reimbursement System
    c. Edifecs XEngine
    d. Catalyst Solutions
    e. Medecision
    f. Star MTM
    g. Ansafone
    h. Ceridian Dayforce
    i. Silk Road Open Hire and Wingspan

2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attachment, Table 1.

Background

CalOptima contracts with many vendors that provide a variety of software solutions to support the overall business model. Two core systems are central to this infrastructure while many other supporting solutions surround the core.

Within the managed care industry, this is standard practice, as no commercially-available single solution meets the demands of the industry for all functions, especially when considering the varying lines of business, government regulations, and the uniqueness of each health plan. The trend over the past ten years or more has been to utilize this approach by using a core administrative processing system surrounded by specialty solutions. CalOptima, as well as the other 15 Local Health Plans of California, and virtually all health plans, use this approach.

The two core systems for CalOptima are:

1. Cognizant Facets – This solution handles the key functions of enrollment of members, health benefit configuration, claims processing and adjudication, provider contract reimbursement, and customer service.

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2. Altruista Guiding Care – This solution handles the key functions of Care Management, including Case Management, Utilization Management, Authorizations/Referrals, Disease Management, as well as Appeals & Grievances.

The systems included in this staff recommendation are:

a. Altruista Guiding Care – As mentioned above, this is one of CalOptima's two core systems. CalOptima originally contracted with Altruista in April of 2014 for a term of seven total years, including an initial term and five one-year optional renewal terms extending to 4/6/2021. The system was live as of April 2015. There are two years remaining on the current contract, supporting the decision to recommend approval to extend for those two years, to 4/6/2021. Replacement of this core system was a substantial investment in money and time. It can take years for a core system of this type to fully stabilize. There are additional features yet to be explored, including the Population Health modules. No later than during Fiscal Year (FY) 2019-2020, a Request for Information (RFI) will be issued, primarily to remain informed and evaluate the marketplace for systems of this type, to help determine how long this system will remain or when it may be considered for replacement through a Request for Proposal (RFP) process.

b. Burgess Reimbursement System – This solution provides two key function. One - it enables continuous monitoring of the hundreds of claims reimbursement Medicare fee schedules maintained by the Federal Centers for Medicare and Medicaid Services (CMS) ensuring that CalOptima's Medicare fee schedules are up-to-date as soon as Medicare makes a change. Two - it uses sophisticated algorithms to calculate the reimbursement pricing for all CalOptima Medicare related claims. In the future, this solution will be expanded to perform the same functions for the Medi-Cal fee schedules and claims pricing. This system is very tightly integrated within the Facets core system software.

c. Edifecs – XEngine – This tool supports quality for the CalOptima Facets Claims process. XEngine is a tool that validates and ensures compliance with regulatory transaction standards and streamlines operational efficiency.

d. Catalyst Solutions – This vendor provides essential supplemental maintenance services and support of the Facets system based on their depth of knowledge of Facets and the inner workings of the software.

e. Medecision - Aerial Care Coordination - This solution is the current CalOptima provider portal – more commonly known to the CalOptima provider partners as CalOptima Link. This portal enables thousands of provider office users to verify eligibility, review claims status, view patient rosters, and submit service authorization requests. This will ultimately be replaced by the new CalOptima Provider Portal.

f. Star MTM – This vendor provides the system and services to support the Pharmacy Medication Therapy Management process required by The Centers for Medicare and Medicaid Services (CMS) for both the OneCare and OneCare Connect lines of business. This process is tightly integrated within the overall administration of CalOptima's pharmacy benefit. An RFP will be issued during FY 2020-2021 to re-evaluate this service.

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g. Ansafone – This vendor provides critical services supporting both CalOptima's Customer Service function and the Medical Affairs function. Ansafone provides after-hours call center support for both general customer service calls as well as more specific medical affairs calls. Ansafone also periodically conducts designed member outreach calls, as needed. An RFP for this service will be issued during FY 2018-2019 to evaluate the marketplace and to determine if CalOptima will retain the existing vendor or consider other alternatives.

h. Ceridian Dayforce – This is the primary Human Resources (HR) system handling employee benefits and payroll.

i. Silk Road Open Hire and Wingspan – Open Hire is the current HR applicant tracking and recruitment system. Wingspan is the current performance management system where all CalOptima employee performance evaluations are stored.

These three HR systems are tightly woven into the support and management of the CalOptima employees and are mission-critical for ongoing smooth operations. CalOptima has been on these systems for nearly ten years. During FY2019-20, CalOptima will issue an RFP for these functions to evaluate the marketplace to determine if a replacement is warranted, and if a single comprehensive HR solution can be procured rather than separate systems.

Discussion
The vendors listed in the attached table represent the solutions described above with contracts expiring in 2019 or sooner.

Many of these solutions are tightly embedded/integrated into either Facets and/or Guiding Care or are mission critical to the Human Resources function. Replacing any of these solutions would require a substantial additional investment, time commitment, and significant disruption to operations.

Fiscal Impact
The CalOptima FY 2018-19 Operating Budget includes the annual fees for the listed contracted vendors related to CalOptima's core and HR systems through June 30, 2019. Management will include expenses for the recommended contract extension periods on or after July 1, 2019, in future CalOptima Operating Budgets.

Rationale for Recommendation
Extension of the contracts for these systems will ensure there is no disruption to the services provided by each of the solutions and allow continuity of operations throughout the organization and with CalOptima's member and provider community, and its employees.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. Proposed Contract Extensions – Table 1
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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Attachment – Table 1 - Proposed Contract Extensions

Vendor – Solution Name	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Comments	Annual Cost Based on Fiscal Year 2018-19 Fees
Altruista Health – Guiding Care	Core Care Management Solution	4/6/2014	4/6/2019	4/6/2021	2 years remaining on the original contract	$1,485,000
Burgess – Burgess Reimbursement System	Medicare/Medi-Cal Fee Schedules and Claims Pricing	1/1/2008	12/31/2019	6/30/2022	Tightly Integrated with Facets	$442,162
Edifecs – XEngine	Electronic transaction standardization tool	3/9/2011	12/31/2019	12/31/2021	Tightly Integrated with Facets	$90,000
Catalyst Solutions	Facets Support Services	4/21/2014	12/31/18	6/30/2022	Integral supplemental maintenance services for Facets	$35,000
Medecision – Aerial Care Coordination	Provider Portal (CalOptima Link)	3/23/2011	12/31/2019	12/31/2020	Eventually to be replaced with Provider Portal	$1,560,000
Star MTM	Pharmacy Medication Therapy Management Services	11/1/2014	3/21/2020	3/21/2022	Tightly Integrated into the Pharmacy process. Expect to issue RFP during Fiscal Year 2020-2021.	$156,000
Ephonamation.com, Inc., DBA Ansafone	After hours customer service call center; after hours medical affairs call center; member outreach.	9/1/2016	8/31/2019	8/31/2020	Tightly integrated within Customer Service and Medical Affairs. RFP to be issued during Fiscal Year 2018-2019.	$213,000
Ceridian - Dayforce	The main Human Resources System for Benefits and Payroll	6/29/2008	6/30/2019	12/31/2021	Plan to issue RFP during Fiscal Year 2019-2020	$254,000

Vendor – Solution Name	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Comments	Annual Cost Based on Fiscal Year 2018-19 Fees
Silk Road – Open Hire and Wingspan	Human Resources Support Systems – Performance Management, Applicant Tracking	6/19/2009	6/30/2019	12/31/2021	Plan to issue RFP during Fiscal Year 2019-2020	$58,500

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Altruista Health, Inc.	11800 Sunrise Valley Dr Suite 1000	Reston	VA	20191
Burgess Group, LLC	1701 Duke St	Alexandria	VA	22314
Edifecs, Inc.	1756 114th Ave SE	Bellevue	WA	98004
Catalyst Solutions, LLC	2353 S Broadway	Denver	CO	80210
Medecision, Inc.	550 E Swedesford Rd Building D, Suite 220	Wayne	PA	19087
Star MTM, LLC DBA Clinical Support Services	701 Seneca St	Buffalo	NY	14210
Ephonamation.com, Inc., DBA Ansafone Communications	145 E Columbine Ave	Santa Ana	CA	92707
Ceridian Corporation	3311 E Old Shakopee Rd	Minneapolis	MN	55425
SilkRoad Technology, Inc.	100 S Wacker Dr Suite 425	Chicago	IL	60606

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CONTRACT NO. 22-10967
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
THE BURGESS GROUP, LLC
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of the date last signed below, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and The Burgess Group, a Limited Liability Company, hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a CONTRACTOR to provide Claims Pricing Solution, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

C. CONTRACTOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services; and

D. CONTRACTOR desires to perform these services for CalOptima; and

E. CalOptima and CONTRACTOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto; and (ii) CalOptima's Request for Proposal ("RFP") 22-012, inclusive of any revisions, amendments and addenda thereto. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 18, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference. Ancillary Services. Burgess agrees to provide such implementation and non-standard support services ("Ancillary Services"), as are described in a Statement of Work ("SOW") executed by the Parties.

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Intentionally deleted.

3.1.1.4 Intentionally deleted.

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 Intentionally deleted.

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per occurrence: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 Intentionally deleted.

3.1.5.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Intentionally deleted.

b) Intentionally deleted.
c) Intentionally deleted.
d) Intentionally deleted.
e) Intentionally deleted.
f) Intentionally deleted.

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

3.2.3 The Insurance Company agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this clause. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9 Thirty (30) days prior written notice of cancellation be given to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

3.6 "Occurrence," as used herein, means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 Contractor shall defend, indemnify, and hold CalOptima, its officers, employees, and agents harmless from and against any and all liability, loss, expense (including reasonable attorneys' fees), or claims for injury or damages arising out of the performance of this Agreement but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of Contractor, its officers, employees or agents.

4.2 CalOptima shall defend, indemnify, and hold Contractor, its officers, employees, and agents harmless from and against any and all liability, loss, expense (including reasonable attorneys' fees), or claims for injury or damages arising out of the performance of this Agreement but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of CalOptima, its officers, employees or agents.

4.3 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation, California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.4 CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except Claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.5 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations,

including but not limited to those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.6 It is not the intent of the Parties that the provisions of this Section and the Indemnification provision(s) set forth in the Business Associate Protected Health Information Disclosure Agreement executed by the Parties shall be in conflict. In the event of any conflict, the Indemnification provision(s) in the Business Associate Protected Health Information Disclosure Agreement shall be interpreted to relate only to matters within the scope of that Agreement. "If Applicable"

4.7 The terms of this Section shall survive the termination of this Contract.

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5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control, and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees in connection with this Contract, and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima Policies relating to services under the Contract that are in effect when this Contract is signed or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

9.1 During the performance of this Contract, CONTRACTOR and its subcontractor(s) shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. CONTRACTOR and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include a similar nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict of interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer

or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; and

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.5 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict of Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall complete Exhibit I, attached hereto and incorporated by this reference.

12. Equal Opportunity.

12.1 CONTRACTOR and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("DHCS"), setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

12.2 CONTRACTOR and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

12.3 CONTRACTOR and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of CONTRACTOR and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

12.4 CONTRACTOR and its Subcontractors will comply with all applicable provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

12.5 CONTRACTOR and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

12.6 In the event of CONTRACTOR and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

12.7 CONTRACTOR and its Subcontractors will include the applicable provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for

noncompliance, provided, however, that in the event CONTRACTOR and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or CONTRACTOR as a result of such direction by DHCS, CONTRACTOR and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Standard of Performance; Warranties.

13.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

13.3 CONTRACTOR expressly warrants that during the Term the Software will materially conform to the functionality set forth in the Documentation. As the sole recourse of CalOptima and the sole liability of CONTRACTOR for a breach of the foregoing representation and warranty, CONTRACTOR will take commercially reasonable steps to correct any failure of the Software to so conform, at no additional charge and in a timely manner. CalOptima shall give notice to CONTRACTOR of any observed defects. As the sole recourse of CalOptima and the sole liability of CONTRACTOR for a breach of the Subscription Service availability covenant, and subject to CalOptima remaining in compliance with the terms of this Agreement, CONTRACTOR shall provide to CalOptima service credits in accordance with and subject to the terms of EXHIBIT N. This Service availability covenant shall not be deemed to be breached if failure of performance or availability of the Service has resulted from CalOptima's accident, abuse, misuse or negligence of any kind in the use, handling or operation of the Service or Software, including any use not consistent with the Documentation or the terms of this Agreement.

13.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

13.5 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

13.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair and replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

14.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

14.1.5 CalOptima agrees to promptly pay when due all sales, service, and other taxes arising from this Agreement and CalOptima's access to and use of the Service and Software, except for taxes based on the net income of CONTRACTOR. Upon written request from CONTRACTOR, CalOptima shall provide records that show payment of or exemption from any such applicable taxes.

14.2 Contractor Travel Policy. CONTRACTOR agrees to abide by the terms of the CalOptima Travel Policy, attached hereto as Exhibit C, and incorporated herein by this reference.

15. Disclaimer of Warranties.

15.1 ANY WRITTEN OR ORAL INFORMATION OR REPRESENTATIONS PROVIDED BY CONTRACTOR AGENTS, EMPLOYEES, CONSULTANTS OR SERVICE PROVIDERS WITH RESPECT TO THE USE OR OPERATION OF THE SUBSCRIPTION SERVICE, SOFTWARE, AND THIRD PARTY CONTENT WILL IN NO WAY INCREASE THE SCOPE OF CONTRACTOR' WARRANTY. CONTRACTOR EXERCISES NO CONTROL WHATSOEVER OVER THE CONTENT OF THE INFORMATION PASSING THROUGH THEIR SYSTEM. CALOPTIMA AND AUTHORIZED USERS MUST EXERCISE THEIR OWN DUE DILIGENCE BEFORE DISTRIBUTING AND/OR RELYING ON INFORMATION TRANSMITTED TO OR FROM THE SUBSCRIPTION SERVICE, AND MUST DETERMINE THAT THEY HAVE ALL NECESSARY RIGHTS TO COPY, USE, PUBLISH, OR OTHERWISE DISTRIBUTE SUCH INFORMATION UNDER COPYRIGHT AND OTHER APPLICABLE LAWS. CONTRACTOR WILL NOT BE LIABLE FOR ANY CONSEQUENCES OF PROVIDING ACCESS TO AND USE OF THE SUBSCRIPTION SERVICE OR SERVICES HEREUNDER, INCLUDING THOSE SUFFERED AS A RESULT OF DELIVERING OR ACCESSING INFORMATION OR CONTENT, SUCH AS ACCESSING INFORMATION WITH OFFENSIVE, INACCURATE OR INAPPROPRIATE CONTENT, THE POSSIBILITY OF CONTRACTING COMPUTER VIRUSES, OR UNAUTHORIZED ACCESS TO OR ALTERATION, THEFT, OR DESTRUCTION OF ANY DATA, FILES, PROGRAMS,

PROCEDURES, OR INFORMATION THROUGH ACCIDENT, FRAUDULENT MEANS OR DEVICES, OR ANY OTHER METHOD, REGARDLESS OF WHETHER SUCH DAMAGE OCCURS AS A RESULT OF CONTRACTOR' NEGLIGENCE.

15.2 EXCEPT AS SPECIFICALLY DESCRIBED IN SECTION 13.3 HEREOF, THE SUBSCRIPTION SERVICE, SOFTWARE AND THIRD PARTY CONTENT FOR WHICH A SUBSCRIPTION IS GRANTED HEREUNDER IS PROVIDED "AS IS" WITH ALL FAULTS, AND THE ENTIRE RISK AS TO SATISFACTORY QUALITY, PERFORMANCE, ACCURACY, RESULTS, AND EFFORT WITH RESPECT TO THE SOFTWARE AND SUBSCRIPTION SERVICE IS WITH CALOPTIMA. NEITHER CONTRACTOR NOR ANY OF ITS AFFILIATES, SERVICE PROVIDERS, OR CONTENT PROVIDERS REPRESENT OR WARRANT THAT THE SOFTWARE OR SUBSCRIPTION SERVICE OR CALOPTIMA'S USE THEREOF WILL BE UNINTERRUPTED OR ERROR-FREE. CONTRACTOR AND EACH SERVICE PROVIDER (INCLUDING HOSTING PROVIDERS) AND CONTENT PROVIDER DISCLAIMS ALL OTHER EXPRESS OR IMPLIED WARRANTIES REGARDING THE SOFTWARE, SUBSCRIPTION SERVICE, AND THIRD PARTY CONTENT, INCLUDING ALL IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR ANY PARTICULAR PURPOSE. CALOPTIMA ACKNOWLEDGES AND AGREES THAT CALOPTIMA IS SOLELY RESPONSIBLE FOR ITS OWN DETERMINATIONS ON THE PROPER PREPARATION, PROCESSING, AND PRICING OF CLAIMS FOR PAYMENT OR REIMBURSEMENT FOR HEALTH CARE SERVICES AND PRODUCTS, AND APPLICATION OF MEDICARE, MEDICAID, AND OTHER RATES AND POLICY INFORMATION TO SAME.

16. Term. This Contract shall commence on the date last signed below, and shall continue in full force and effect for a period of three (3) years from that date, ("Initial Term"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to two (2) additional consecutive one (1) year terms ("Extended Terms"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term, the remaining option(s) shall automatically lapse. As used in this Contract, the word "Term" shall include the Initial Term and any and all Extended Term(s), to the extent CalOptima exercises its option pursuant to this paragraph.

17. Termination.

17.1 Termination without Cause. CalOptima may terminate this Contract at any time twelve (12) months after the Start Date, in whole or in part, for its convenience and without cause, by giving CONTRACTOR ninety (90) days written notice hereof. Upon termination, CalOptima shall pay CONTRACTOR, a prorated amount as and for a termination fee, equal to fifty percent (50%) of the annual Subscription Fee, Medi-Cal APR-DRG Fee and Medi-Cal Professional Fee for Anesthesia Claim provided in Exhibit B its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

17.2 Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

17.2.1 CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

17.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items,

including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

17.2.3 In the event of Termination for Unavailability of Funds, as provided in this Section, and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify CONTRACTOR in writing and CalOptima shall have the right to reinstate this Contract for that period for which funds are received by CalOptima or the unexpired term of this Contract as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Contract two (2) times during the Term of this Contract.

17.3 Termination for Default. Subject to a thirty (30) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within thirty (30) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

17.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 25, (Confidentiality).

17.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

17.5.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise), and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules. Upon termination or expiration of this Agreement (a) access to the Service by CalOptima and Authorized Users shall be terminated, (b) all undisputed amounts owed to Burgess or fees accrued for the Subscription and/or services performed under this Agreement, shall become due and payable hereunder, and (c) the Subscription and any and all rights or other licenses granted to Subscriber by Burgess under this Agreement shall immediately terminate. CalOptima shall: (i) return to CONTRACTOR via certified mail, all copies of the Documentation and CONTRACTOR Confidential Information that CalOptima maintains in tangible form; or if infeasible, (ii) within thirty (30) calendar days from the date of termination or expiration provide written notice to CONTRACTOR certifying that CalOptima has deleted all copies of such information from all computer servers, computer terminals, and electronic storage devices of CalOptima, Authorized Users, and any other party acting on its or their behalf; and (iii) adhere to such terms of this Agreement which by the subject matter thereof are intended to survive termination.

18. Modifications. CalOptima reserves the right to modify the Contract at any time should such modification be required by CMS or applicable law or regulation. This Contract maybe altered, amended, or modified only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of

amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for its performance.

19. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

20. Confidential Material.

20.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

20.2 For the purposes of this Section 20, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

20.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required

disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

20.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

20.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access, use and disclosure of Protected Health Information is referenced below in Section 25, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

21. Record Ownership and Retention.

21.1 Unless otherwise stated elsewhere, the originals of all letters, documents, reports, and any other products and data prepared or generated for the purposes of this Contract shall be delivered to, and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

21.2 Intellectual Property Rights. CalOptima agrees that the Service, Software, Documentation and related services are proprietary products and services and that all right, title and interest in and to the Service, Software, Documentation and related services, including all associated intellectual property rights, are and shall at all times remain with CONTRACTOR and its third party licensors. The Software contains trade secret and proprietary information owned by CONTRACTOR or its third party licensors and is protected by United States copyright laws and international trade provisions. CalOptima must treat the Service like any other copyrighted material and CalOptima may not copy or distribute the Service, Software, or Documentation electronically or otherwise for any purpose.

21.3 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

21.4 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

21.5 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

21.6 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

22. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

23. Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other in any press release, advertising, promotional, marketing or similar publicly disseminated material without first submitting such material to the other Party and obtaining the other Party's express written approval of the material and consent to such use.

24. Business Associate Protected Health Information Disclosure Agreement. CONTRACTOR agrees to and shall enter into a Business Associate Protected Health Information Disclosure Agreement with CalOptima, with a Security Requirements Attachment for DHCS Data and Protected Health Information/Personal Information (PHI/PI) if CONTRACTOR will create, receive, maintain, use, or transmit DHCS data or PHI/PHI, which agreement shall be incorporated herein by this reference. CONTRACTOR acknowledges and agrees that CalOptima reserves the right to modify the Business Associate Protected Health Information Disclosure Agreement at any time should such modification be required by applicable law or regulation.

25. Confidentiality of Member Information.

25.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating

from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

25.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its Subcontractors, CONTRACTOR:

25.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

25.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

25.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

25.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

25.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

26. Offshore Performance.

26.1 Due to security and identity protection concerns, direct services under this Contract shall not be performed by offshore subcontractors, unless otherwise authorized in writing by CalOptima.

26.2 CONTRACTOR shall complete, sign, and return Exhibit H, entitled "Attestation Concerning the Use of Offshore Subcontractors," which is attached hereto and incorporated herein by this reference, and shall submit an executed Offshore Subcontractor Attestation no less than annually thereafter.

26.3 CONTRACTOR acknowledges that CalOptima requires CONTRACTOR to obtain approval from it of CONTRACTOR's use of any offshore subcontractor whereby offshore subcontractor will have access to any type of confidential CalOptima Member information, including, but not limited to, protected health information. CONTRACTOR represents and warrants that it has disclosed to CalOptima any and all such offshore subcontractors within Exhibit H and that it has obtained

CalOptima's written approval to use such offshore subcontractors prior to the effective date of this Contract.

26.4 Any new subcontract with an offshore entity under which the offshore entity will have access to any confidential CalOptima Member or other protected health information must be approved in writing by CalOptima prior to execution of the subcontract. CONTRACTOR is required to submit future Offshore Contractor Attestations to CalOptima's Purchasing Department within thirty (30) calendar days after it has signed a contract with any subcontractor that may be using an offshore subcontractor to perform any related work.

26.5 Unless specifically stated otherwise in this Contract, the restrictions of this Section do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Contract.

26.6 The provisions of this Section apply to work performed by subcontractors at all tiers.

27. FDR Compliance. FDR Compliance requirements are not applicable under this Contract.

28. Medicare Advantage Program. To the extent applicable, CONTRACTOR agrees to abide by the terms of "Addendum 1, Medicare Advantage Program," attached hereto as Exhibit G and incorporated herein by this reference.

29. Time is of the Essence. Time is of the essence in performance of this Contract.

30. CalOptima Designee. The Chief Executive Officer of CalOptima, or his designee, shall have the authority to act for and exercise any of the rights of CalOptima, as set forth in this Contract, subsequent to and in accordance with the authority granted by the Board of Directors.

31. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

32. Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. In the event any party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

33. Force Majeure. When satisfactory evidence of a cause beyond a party's control is presented to the other party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the party not performing, a party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including, but not limited to, any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local government, war, acts of terrorism, or a material act or omission by the other party.

34. CalOptima Primary Contact. CalOptima shall identify, and name, an appropriate individual, with corresponding contact information, including electronic mail address as the "CalOptima Primary Contact" with whom CONTRACTOR should communicate matters regarding the Service, such as maintenance notifications, and who has the authority to make requests including release of CalOptima data, both internally to CONTRACTOR and to the CalOptima, restoration of data, and other configuration changes. CalOptima can update the CalOptima Primary Content upon reasonable written notice to CONTRACTOR.

CalOptima Primary Contact:
Nora Onishi
714-246-8630
505 City Parkway West, Orange CA 92868
nonishi@caloptima.org

35. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

To CONTRACTOR:	To CalOptima:
HealthEdge Software, Inc.	CalOptima
30 Corporate Dr.	505 City Parkway West
Burlington, MA 01803	Orange, CA 92868
Attention: EVP & General Counsel	Attention: Maria Medina

36. Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima. CONTRACTOR shall insert the substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Contract.

37. Unavoidable Delays.

37.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

37.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5) working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

37.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

38. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the parties hereto acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

39. Attorneys' Fees. Should either party to this Contract institute any action or proceeding to enforce or interpret this Contract or any provision hereof, or for damages by reason of any alleged breach of this Contract, otherwise arising under this Contract, or for a declaration of rights hereunder, the prevailing party in any such action or proceeding shall be entitled to receive from the other party all costs and expenses, including, without limitation, reasonable attorneys' fees incurred by the prevailing party in such action or proceeding.

40. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

41. Headings. The section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

42. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power, or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

43. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

44. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this

Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

45. Debarment and Suspension Certification.

45.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

45.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

45.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

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

45.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 45.2.2 herein;

45.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

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

45.2.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

45.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

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

45.5 If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

46. Lobbying Restrictions and Disclosure Certification.

46.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

46.2 Certification and Disclosure Requirements.

46.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit E, Part 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 42.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

46.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit E, Part 2, entitled "Certification Regarding Lobbying") if such recipient has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 42.3 of this provision if paid for with appropriated funds.

46.2.3 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 46.2.2 herein. An event that materially affects the accuracy of the information reported includes:

46.2.3.1 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;

46.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

46.2.3.3 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.

46.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 46.2.1 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.

46.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 46.2.1 of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

46.3 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.

47. Air and Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR § 15.5. CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 et seq.), as amended.

48. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

49. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

50. Third Party Beneficiaries. Except for Third Party Content Providers, there are no intended third party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

51. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

52. 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.

53. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

54. Definitions:

54.1 Authorized User(s)" means individual(s) (i) who are employees of CalOptima, or (ii) who are engaged by CalOptima as independent contractors, and who access the Subscription Service through CalOptima solely for CalOptima's internal use and agree to be bound by the terms of this Contract in accordance with Addendum 1, Section 2.4(c).

54.2 "Affiliate" means each entity that is controlled by a party through majority ownership of voting securities or non-corporate interests of the entity.

54.3 "CalOptima Data" means any data, information, files, text or other content that Subscriber or its Authorized Users input into the Software, and any output that Subscriber or its Authorized Users generate using the Software.

54.4 "Content Provider" means the AMA, 3M, or any other licensor of content that is included with the Software.

54.5 "CalOptima Issue" means the failure of CalOptima to perform, any delay by CalOptima is performing, or any inadequacy in CalOptima's performance of any CalOptima obligation.

54.6 "Covered Lives" means the number of persons who are enrolled within CalOptima program, includes enrollees and their covered dependents.

54.7 "Connection Transfer Method" or "CTM" means the connection method specified in EXHIBIT A by which CalOptima accesses the Subscription Service.

54.8 "Member" means a person who is enrolled in a CalOptima program or any of their covered family members, sometimes referred to as the insured or insured person.

54.9 "Software" means the Source software described in Exhibit A.

54.10 "Start Date" means the date on which each Component, as set forth in Exhibit A, exclusive of any testing period (including, but not limited to, proof of concept or pre-production pilot), is officially and formally made available for Subscriber's productive use.

54.11 "Subscription Service" means CalOptima's use of the hosted copy of the Software via remote access.

54.12 "Third Party Content" means the AMA Editorial Content, the 3M Software, and any other content or software licensed to CONTRACTOR by a Content Provider that is included with the Software.

54.13 "Transaction" is the process of receiving a single set of healthcare data (e.g., one medical claim), processing such data, and receiving a response detailing the results of the processing of the data. A Transaction is counted each time a single set of healthcare data is submitted for processing. A single set of healthcare data submitted a second time corresponds to a new distinctly identifiable Transaction.

[Remainder of page left intentionally blank. Signatures on following page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 22-10967 on the day and year last shown below.

The Burgess Group LLC	CalOptima
By: DocuSigned by: Ryan Mooney 2A62EC65EE1F4BB...	By: DocuSigned by: Nancy Huang D22E3B87032946F...
Print Name: Ryan Mooney	Print Name: Nancy Huang
Title: EVP, GM Burgess	Title: CFO, CalOptima
Date: 7/8/2022	Date: 08/09/2022

By:	By: DocuSigned by: Michael Hunn EDDDDCC19C894FB...
Print Name:	Print Name: Michael Hunn
Title:	Title: CEO
Date:	Date: 08/09/2022

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required.

Exhibit A

SCOPE OF WORK

1. Scope of Work

1.1 Source is a cloud-based platform for managing payment integrity, comprehensive reimbursement terms, data modeling, and real time analytics. It coordinates the complex workflow of contract-level automation while providing business intelligence insight into daily claims reimbursement transactions.

1.2 The Subscription Service provides access to the current version of the Software with the Software Components specified in Section 3 of this Exhibit A, and all new or modified revisions, updates, modules and features for provider types and modules that CONTRACTOR adds to such Software Components during the Term for use by subscribers generally (at no additional cost where applicable), as described in Section 3 of this Exhibit A and/or the Documentation. The Service includes support and maintenance for the Software as described in Exhibit N, Section 2. The Subscription Service includes functionality for CalOptima to store CalOptima Data only if CalOptima selects and pays for the Production Audit Trail component. Software Components and Third Party Content may be modified from time to time by CONTRACTOR by advanced written notice to CalOptima.

2. SOFTWARE ACCESS.

The Subscription Service includes access to the Software in the manner described in the Documentation and Section 3 of this Exhibit A using a browser-accessible interface provided by CONTRACTOR, and subject to the terms of Exhibit N, Sections 2.3, Addendum 1, Section 2.5, and data encryption requirements specified in the Documentation.

3. SOFTWARE COMPONENTS

3.1 ☒ **Design Module**
- ☒ Rates
- ☒ Standard Payment Policies
- ☐ Edits Exception Handling Rates
- ☐ Custom Edits Development

3.2 ☒ **Production Module**
- ☒ Production Audit Trail
  - ☒ Audit retention (3 years)
  - ☒ Cold Storage (10 years)
- ☐ Advanced Audit Archive
- ☐ Member Claims History (up to 39 months)
- ☐ Provider Portal

3.3 ☒ **Analytics Module**
- ☒ Daily Production Metrics
- ☒ Data Research
- ☐ Performance Impact Analytics
- ☐ Predictive Policy Modeling
- ☐ CMS Benchmarking
- ☐ Contract and Claims Data Modeling
- ☐ Regulatory Update Impact Analysis
- ☐ Retroactive Medicare Update Manager
- ☐ Retroactive Configuration Change Analysis

3.4 ☒ **Editing Components**

- ☒ Medicare Edit Groups
  - ☒ Medicare Inpatient
  - ☒ Medicare Outpatient
  - ☒ Medicare Sub-Acute
  - ☒ Medicare Professional
  - ☒ Medicare Supplier
  - ☐ Clinical, Billing and Validation Edits
- ☒ State Medicaid Edits – California Inpatient APR-DRG and Professional Anesthesia claims

3.5 ☒ **Pricing Components**

- ☒ Medicare Pricer Groups
  - ☒ Inpatient
  - ☒ Outpatient
  - ☒ Sub-Acute
  - ☒ Professional
  - ☒ Supplier
  - ☒ Custom Pricers
- ☒ State Medicaid Pricing – California Inpatient APR-DRG and Professional Anesthesia claims

3.6 ☒ **Third Party Ecosystem Components**

- ☒ American Medical Association CPT Codes
- ☒ 3M APR-DRG and California Inpatient Pricer
- ☐ MediQuant LCD/NCD Policies
- ☐ RJ Health High-Cost Drug Billing Guidelines & Edits
- ☐ RJ Health AWP Drug Pricing
- ☐ Concert Genetics Genetic Testing Guidelines & Edits
- ☐ CERiS Itemized Bill Review Workflow

4. **THIRD PARTY CONTENT.** The Subscription includes a license to use the following Third Party Content:

4.1 Content as described in Exhibit M as Editorial Content, which is governed by a CPT Distribution License Agreement ("CPT License"), in effect from time to time between the American Medical Association ("AMA") as licensor and Burgess as licensee, and is subject to the terms of Exhibit M-1.

4.2 Other content which is licensed to Burgess by a Content Provider and described in additional subparts of Exhibit M hereto (which shall be effective upon written notice to CalOptima), and which is governed by the terms of the license agreement between such Content Provider as licensor and Burgess as licensee ("Content License").

CalOptima acknowledges and agrees that this Agreement is subject to (a) the CPT License and any other Content License remaining in full force and effect, (b) the terms of Exhibit M hereof, including without limitation the limitations and disclaimers of warranty and liability set forth therein, and (c) upon notice to CalOptima, any additional or amended terms which are required by a Content Provider under a Content License.

5. CONNECTION TRANSFER METHOD (CTM).

5.1 Real-time JSON integration to Facets (via Burgess Facets Integration Component)

5.2 Integrations to one (1) core claims systems

6. Number of Authorized Users: 120

Exhibit A-1
STATEMENT OF WORK
for
Source Implementation

The following additional terms and conditions apply to the Ancillary Services to be provided in connection with the Subscription Services. These terms and conditions are additive to those contained in the Contract. In the event that these terms and conditions conflict with those in the Contract, these terms and conditions shall prevail. Capitalized terms used herein without definition shall have the meanings given such terms in the Contract. The parties agree as follows:

1. DESCRIPTION OF SERVICES

1.1. Implementation Plan:

1.1.1. Contractor and CalOptima will collaborate for the Ancillary Services, which for the purposes of this SOW include the implementation of the Subscription Service. Contractor will provide planning and discovery services with respect to performing the activities necessary to facilitate the successful implementation of the Subscription Service pursuant to the mutually agreed upon project plan.

1.1.2. The Parties will work together to develop an implementation plan for each of the Software Components identified in **Exhibit A** of the Contract and pursuant to a rollout schedule for the available Medicare and California Medicaid edits and pricers supporting the provider types herein.

1.2. Provider types included:

1.2.1. **Medicare Content**

1.2.1.1. Medicare Inpatient.

- Critical Access.
- Inpatient (DRG).
- Inpatient Psychiatric.
- Hospice Services.
- Long-Term Care.
- Inpatient Rehabilitation.
- Inpatient Rehabilitation Facility

1.2.1.2. Medicare Outpatient.

- Ambulatory Surgery Centers.
- Critical Access.
- Community Mental Health Centers.
- ESRD.
- Federally Qualified Health Centers.
- Hospital Outpatient (OPPS).
- Medicare Post-Acute.
- Home Health Agencies.
- Skilled Nursing Facilities.

1.2.1.3. Medicare Professional.

- Ambulance.
- Clinical Laboratory.
- Drugs & Immunizations.
- Durable Medical Equipment & PEN.
- Physician & Non-Physician (Including Nurse Practitioner, Clinical Social Worker, and Physician's Assistant

1.2.2. California Medicaid Content

1.2.2.1. APR-DRG (IP Hospital)

1.2.2.2. California Medicaid Anesthesia (available Anesthesia edits and pricers for professional claims).

1.2.2.3. California Medicaid Long-Term Care Provider Type (available edits and pricers)

1.3. Contractor will establish, review and document program and project procedures including: Roles, responsibilities, change management, issue and risk mitigation plan, and protocols.

1.4. Contractor will develop, update, and maintain project plan for this implementation that includes: timelines, tasks, and approved signoffs. The mutually agreed upon project plan shall be incorporated by reference.

1.5. Contractor will provide project management for the Ancillary Services identified hereunder that includes tracking on–going tasks, establishing recurring update meetings, assuring timely delivery, and implementing and managing any scope changes.

1.6. Based on mutually agreed schedule, Contractor will schedule and lead recurring meetings on a weekly basis, at minimum, to review, organize, prioritize and discuss action items and status of the Services hereunder and provide meeting minutes including takeaways and next steps.

1.7. As set forth in Addendum 1, Computer Software Licensing, Article 3, Section 3.3, Contractor will provide web-based user training ("Training") for features and content and user settings and configuration which includes the following.

1.7.1. Contractor shall provide up to sixteen (16) hours of web-based, train-the-trainer, video and/or other training about the Software (i.e., features and content and user settings and configuration), related to the use of the Software. This training does not include in-depth training on the Medicare and California Medicaid editing and pricing calculations and methodologies, which are subject to a separate EXHIBIT A-1, SOW. Should training cause Contractor to exceed the travel and expense budget set forth in Section 9 of this EXHIBIT A-1, SOW, the Parties shall mutually agree to such additional.

1.8. Contractor shall schedule training to occur, pursuant to the project plan, as needed and as reasonably requested by Subscriber.

1.9. Contractor shall provide delivery of Documentation, at no additional cost to Subscriber, five (5) business days prior to the commencement of the Training.

1.10. Contractor shall provide implementation support up to and through the Start Date of each Component, and for post-implementation support through the first sixty (60) days of production use of the Software, which includes all user inquiries for the Software, fixes, patches and updates as necessary for the Software to function substantially in accordance with its Documentation.

1.11. Contractor to lead/participate in discovery sessions sufficient to gather data points necessary to deliver the project plan.

1.12. Contractor to review, analyze, define, and document with CalOptima installation of Subscription Service requirements, along with security clearance of the Software URL as needed for all training sessions.

1.13. Contractor to support user acceptance testing ("UAT Testing") of the Service.

1.14. Transition of daily service needs sixty (60) days after Start Date to Contractor's support services, including hand-over procedures and introductions to the support services team.

2. Project Milestone: Contractor shall enable all facilities, services, and content in accordance with the implementation schedule and divide the implementation project into three (3) milestones as set forth below. The provided content will be enabled during each implementation window for data mapping, User Acceptance Testing ("UAT"), and other project tasks necessary for go-live on the established timeframes. CalOptima acknowledges that UAT must be completed sixty (60) days prior to go-live to ensure on-time project completion.

2.1. **Milestone One:** includes initial project planning, technical setup, and delivery of facilities, services, and licensed Medicare content, including CA Medicaid (Medi-Cal) APR-DRG, by September 30, 2022.

2.2. **Milestone Two:** includes initial project planning, technical setup, and delivery of facilities, services, California Medicaid (Medi-Cal) Anesthesia and Long-Term Care content by December 31, 2022.

3. **OUT OF SCOPE**:

3.1. Burgess will not create, install, upgrade, configure, or host any third-party, or custom Subscriber software.

3.2. Medicaid and Medicare Payment Methodology training is out of scope. Any requests for Payment Methodology training will be subject to a Change Order and associated fees

4. **PROJECT PLAN:** The Parties shall mutually agree upon the approved scope and schedule baselines, in a form substantially similar to Attachment 1 ("Sample Project Plan") for the Implementation Services culminating in Subscriber's production access to and use of the Software. Dates and durations are subject to change based on available resources, and written milestones set by Subscriber.

5. **CONTRACT DELIVERABLES**:
5.1. BURGESS
5.1.1. Initiate
5.1.1.1. Project Charter.
5.1.2. Plan

5.1.2.1. Project planning support, including development review of project plan and resource allocation planning and support.
5.1.2.2. Discovery session and specifications review
5.1.3. Execute
5.1.3.1. Integration: Infrastructure, connectivity, security, configuration, and architecture documentation.
5.1.3.2. Data mapping: Provide access to the Contractor Facets XCOM extension component, along with assisting in understanding all Contractor Source documentation related to claim system integration.
5.1.3.3. User interface: assist CalOptima in understanding how to setup message mapping and configurations.
5.1.3.4. Training: data mapping; data mapping Q&A; Edits and Pricers; Configuration Development
5.1.4. Test
5.1.4.1. Testing support for CalOptima developed test case
5.1.4.2. Provide guidance on the types of test cases and scenarios
5.1.5. Close
5.1.5.1. Project sign off.
5.1.5.2. Project debrief.
5.1.5.3. Production and post-production deployment support.
5.1.5.4. Transition CalOptima to Customer Support
5.1.6. Reports. Contractor will provide the following reports, in form and substance as agreed to by the Parties
5.1.6.1. Reports on weekly or other periodic status meetings for the Implementation Services held in accordance with the Project Plan, listing the status of open tasks and action items identified in the Project Plan and responsibilities of Contractor and CalOptima Project Managers to address same.
5.1.6.2. Reports on the status and completion of acceptance testing of the Service in accordance with the Project Plan.
5.1.6.3. Notice stating completion of training of Subscriber's Authorized Users via web conferencing as laid out in the Project Plan.

5.2. CalOptima
5.2.1. Initial Plan
5.2.1.1. Project plan review and approval, including development and review of project plan and resource allocation planning and support.
5.2.1.2. Specifications review.

5.2.2. Execute
5.2.2.1. Configuration of Medicare Advantage and CA Medicaid edits and pricers per scope above.
5.2.2.2. Test case development.
5.2.2.3. User acceptance testing.
5.2.2.4. Provide test data for user acceptance testing.
5.2.2.5. Review and approval of project plan and supporting documentation

5.2.3. Close
5.2.3.1. Project sign off.
5.2.3.2. Debrief.

6. **GENERAL ASSUMPTIONS** The estimates of time for each task are based on certain assumptions:
6.1. Durations reflected and amount(s) due are estimated, and work will be performed and delivered on a fixed fee basis. CalOptima shall not exceed the Estimated totals of this SOW without prior written agreement by the Parties. No aspect of the scope of this SOW is implied.

6.2. Reasonable network and system access to configure servers, install forwarders, configure source devices, read logs, access data and applications, and allow necessary inter-system communication is all made available to CalOptima resources upon commencement of the work within this SOW.

6.3. Customer resources with appropriate knowledge of requirements and resources are available during the implementation.

6.4. Customer resources with functional and domain knowledge are available for feedback and consultation during the implementation.

6.5. Any CalOptima specific onboarding security terms not identified in the Contract must be agreed upon and identified in this SOW as an Exhibit. Contractor reserves the right to reject any security terms not identified in this SOW or the Contract

6.6. CalOptima as an independent duty to ensure the security and integrity of CalOptima Data, computers, networks and systems (which may include the use of encryption technology to protect CalOptima Data from unauthorized access). Additionally, CalOptima is solely responsible for: (a) Authorized Users' compliance with the Contract, (b) the accuracy, quality and lawful use of CalOptima Data and the means by which CalOptima acquired CalOptima Data, and (c) routine archiving of CalOptima Data.

6.7. Customer has an independent duty to manage its own change control processes. Should a change to this SOW be necessary, Customer shall request the change in writing. Agreed upon changes to this SOW shall be documented as set forth in Section 21 below

7. **CALOPTIMA'S RESPONSIBILITIES.** CalOptima will provide the following to Contractor

7.1. CalOptima resources shall be made available for the Service planning sessions, scheduled meetings, configuration, and concurrent training.

7.2. CalOptima shall assign a Project Manager, who has the necessary authority and will be available to manage both the receipt of Implementation Services and timely performance of CalOptima obligations and tasks to complete the Implementation Services in accordance with the Project Plan and this SOW.

7.3. Upon Contractor request, CalOptima shall provide information and data on its operations, activities, and existing systems in order to assure that CalOptima is able to configure settings and options in the Software for optimal performance within Subscriber's workflow.

7.4. CalOptima shall be responsible for providing test claims to be utilized for acceptance testing and shall provide prompt notice to the Contractor Project Manager of any questions, concerns, or issues identified in acceptance testing of the Subscription Service. These issues may be reported via email, or through any issue tracking system identified in the Project Plan.

8. **TERM:** The term of this SOW shall commence on June 1, 2022 and shall continue until December 31, 2022, unless earlier terminated in accordance with the Contract. In the event of early termination, CalOptima shall pay Contractor for all work performed prior to termination. Any extension of the term will be subject to mutual written agreement between the Parties

9. **PROJECT MANAGERS**

9.1. Contractor Project Manager to manage Ancillary Services under this SOW will be assigned by Contractor. Contractor may, at its discretion, substitute an equally qualified Contractor staff person for the Contractor Project Manager named above.

9.2. CalOptima Project Manager to manage Subscriber's implementation of the Ancillary Services and Software, and receipt of Ancillary Services, will be assigned by Subscriber.

10. **FEE AND PAYMENT TERMS**

10.1. CalOptima shall pay the One-Time Implementation Fees set forth on Exhibit B of the Contract, upon the completion each milestone as set forth in Section 16. Should CalOptima require additional hours and a change of scope, a mutually agreed upon amendment to this SOW will be executed between the Parties (as described in Section 24).

10.2. Should the implementation SOW need to be extended past December 31 2022, due to a change of scope or due to a CalOptima Issue, a mutually agreed upon Change Order will be executed, between the Parties (as described in Section 24), including a monthly fee of fifteen thousand dollars ($15,000.00) until the implementation is complete.

10.3. Reasonable expenses, including travel, lodging, and taxes are not included in the above fees and are payable in addition to the above fee. Estimated expenses for this engagement are 10%. Should CalOptima request Contractor personnel to perform any of the Ancillary Services onsite, CalOptima shall also be responsible for travel and per diem expenses for any travel by Contractor staff to CalOptima offices. All travel by Contractor staff requires prior approval from CalOptima in accordance with the Contract.

11. **CHANGE ORDER PROCEDURES**

11.1. Requirement to modify SOW. Pursuant to the Contract, Section 18 all modifications, changes and additions to the obligations of either party to any SOW shall require a written change order (a "Change Order"), signed by the Parties. Either party may initiate a Change Order by submitting a written request for a Change Order to the other party along with an explanation of reasons as to why such Change Order is desirable or necessary. Upon agreement by the parties to the terms of any Change Order, the Change Order shall be executed by authorized representatives of each party.

11.2. Change Order Contents. All Change Orders must contain:

11.2.1. a description of any additional work to be performed and/or changes to the performance required of either party; and

11.2.2. a statement of the impact of the work or changes on the Ancillary Services schedule, or other requirements of this Contract or a SOW.

11.2.3. a statement of any and/or pricing that will be modified as a result of the amendment.

The Burgess Group LLC	CalOptima
By: DocuSigned by: Ryan Mooney 2A62EC65EE1F4BB...	By: DocuSigned by: Nancy Huang D22E3B87032946F...
Print Name: Ryan Mooney	Print Name: Nancy Huang
Title: EVP, GM Burgess	Title: CFO, CalOptima
Date: 7/8/2022	Date: 08/09/2022

By:	By: DocuSigned by: Michael Hunn EDDDDCC19C894FB...
Print Name:	Print Name: Michael Hunn
Title:	Title: CEO
Date:	Date: 08/09/2022

Exhibit B

PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

B. Fees/Rates, as defined below, are acknowledged to include CONTRACTOR's base labor rates, overhead and profit. CONTRACTOR shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as CONTRACTOR has documented, to CalOptima's satisfaction, that CONTRACTOR has fully completed all work required under this Contract and CONTRACTOR's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of CONTRACTOR's work under this Contract.

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 22-10967; specify the number of hours worked; the specific dates the hours were worked; the description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Statement of Work, will be billed based upon completion of the milestones as set forth in the schedule(s) in Exhibit B-1, which is attached hereto and incorporated herein by reference. These fees are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

Table 1

Description	**Year 1**	**Year 2**	**Year 3**
One-Time Implementation Fees: Medicare Content and APR-DRG	$100,000	N/A	N/A
Medi-Cal Anesthesia	$25,000	N/A	N/A
Medi-Cal Long-Term Care	$25,000	N/A	N/A
Annual Subscription Fees: Subscription Fee (Including Medicare Content) *Includes up to 200,000 transactions	$450,000	$450,000	$450,000
Medi-Cal APR-DRG *Includes up to 100,000 transactions	$210,000	$210,000	$210,000
3M APR-DRG Royalty Fee	$112,209	$112,209	$112,209
Authorized Users	Includes 120 users. Add'l users will be assessed at $200 per user		
Total Annual Fees	$922,209	$772,209	$772,209

Table 2

Description	Year 1	Year 2	Year 3
Optional Modules: Medi-Cal Anesthesia *Includes up to 50,000 transactions	$125,000	$125,000	$125,000
Medi-Cal Long-Term Care *Includes up to 250,000 transactions	$200,000	$200,000	$200,000

E. One-Time Implementation Fees:

1. **Medicare Content and APR-DRG**. CONTRACTOR may invoice a one-time implementation and set-up cost in the amount of **One Hundred Thousand ($100,000.00)** as soon as the Contract has been executed. The Parties shall be mutually accountable for ensuring the completion of and implementation listed above in Exhibit A.

2. **Medi-Cal Anesthesia**. CONTRACTOR may invoice a one-time implementation and set-up cost in the amount of **Twenty-Five Thousand ($25,000.00)** as soon as the Contract has been executed. The Parties shall be mutually accountable for ensuring the completion of and implementation listed above in Exhibit A.

3. **Medi-Cal Long-Term Care**. CONTRACTOR may invoice a one-time implementation and set-up cost in the amount of **Twenty-Five Thousand ($25,000.00)** as soon as the Contract has been executed. The Parties shall be mutually accountable for ensuring the completion of and implementation listed above in Exhibit A.

F. Annual Fees: **S**ubscription Fee, Medi-Cal APR-DRG Fee and Medi-Cal Anesthesia Fee Annual Fees. On the first Start Date and annually thereafter, CONTRACTOR shall invoice the amounts listed below.

1. **Subscription Fee**. On the first Start Date and annually thereafter, CONTRACTOR shall invoice, and CalOptima shall pay the annual Subscription Fee of **Four Hundred Fifty Thousand Dollars ($450,000.00)**, which is inclusive of 200,000 Medicare Transactions annually.

2. **Medicare Transaction Fees**. On the first Start Date and annually thereafter, CONTRACTOR shall invoice, and CalOptima shall pay the following Transaction Fees as set forth below.

   a. $0.00 per Transaction on the first 200,000 Transactions, thereafter
   b. $2.00 per each Facility Transaction; and
   c. $0.50 per each Professional Transaction.

3. **Medi-Cal APR-DRG Fee**. On the first Start Date and annually thereafter, CONTRACTOR shall invoice, and CalOptima shall pay the Medi-Cal APR-DRG Fee of **Two Hundred Ten Thousand Dollars ($210,000.00)**, which is inclusive of one hundred thousand (100,000) Transactions annually. In the event that CalOptima exhausts the allotted one hundred (100,000) Transactions within any given annual period, CalOptima shall pay Two Dollars ($2.00) per each Transaction thereafter.

4. **Medi-Cal Professional fee for Anesthesia Claims**. On the first Start Date and annually thereafter, CONTRACTOR shall invoice, and CalOptima shall pay the Medi-Cal Anesthesia Fee of **One Hundred Twenty-Five Thousand Dollars ($125,000.00)**, which is inclusive of fifty thousand (50,000) Transactions annually. In the event that CalOptima exhausts the allotted 50,000 Transactions within any given annual period, CalOptima shall pay $0.50 per each Transaction thereafter.

5. **Medi-Cal Long Term Care**. On the first Start Date and annually thereafter, CONTRACTOR shall invoice, and CalOptima shall pay the Medi-Cal Long Term Care Fee of **Two Hundred Thousand Dollars ($200,000.00)**, which is inclusive of two hundred and fifty thousand (250,000) Transactions annually. In the event that CalOptima exhausts the allotted 250,000. In the event that CalOptima exhausts the allotted 250,000 included Transactions within any given annual period, CalOptima shall pay $1.00 per Transaction thereafter

G. Additional Authorized Users. CalOptima may increase the number of Authorized Users, over the number of included Authorized Users set forth in Exhibit A, Section 6, upon prior written notice to CONTRACTOR, pursuant to Addendum 1, Section 2.4(a), and payment of the Additional Authorized User Fee of $200.00 for each additional Authorized User for each annual period (or part thereof) during the Term, payable at the time each additional Authorized User is added, and annually thereafter.

H. Third-Party Fees:

1. **3M Royalty Fee**. In addition to the Annual Fees set forth in Section F above, CONTRACTOR shall invoice quarterly and CalOptima agrees to pay the 3M Royalty Fee which will be calculated based on the total number of Covered Lives, as determined from either CalOptima's reported Covered Lives or AIS'S Directory of the Health Plans and the rates set forth in the table below. If CalOptima fails to report the number of Covered Lives CONTRACTOR will calculate the applicable royalty fee based on the information available in AIS's Directory of Health Plans or CalOptima's last highest reported Covered Lives. CONTRACTOR reserves the right to adjust these terms once annually. CONTRACTOR will communicate these fees, and if a new fee is not provided, the fees below will be applicable to the relevant calendar year.

Table 2: Annual 3M Royalty License Fee

Covered Lives	GPCS California Inpatient Pricer Table, Per Authorized Site, Per Product, Per Year	All State Specific APRDRG Grouper and Reimbursement Per Authorized Site Per Product Per Year
0 – 14,999	$3,899.00	$11,881.00
15,000 – 34,999	4,874.00	14,851.00
35,000 – 64,999	6,093.00	18,563.00
65,000 – 99,999	7,616.00	23,204.00
100,000 – 249,999	8,264.00	35,038.00
250,000 – 499,999	8,910.00	61,317.00
500,000 – 999,999	9,555.00	112,209.00
1,000,000 – 1,999,999	10,205.00	209,832.00
2,000,000 – 2,999,999	10,846.00	339,927.00
3,000,000 – 3,999,999	11,493.00	435,107.00
4,000,000 – 4,999,999	12,140.00	526,016.00
5,000,000 – 7,499,999	12,785.00	652,611.00
7,500,000 – 9,999,999	13,432.00	812,139.00
10,000,000 – 14,999,999	14,075.00	1,044,176.00
15,000,000 – 19,999,999	14,724.00	1,160,199.00
20,000,000 – 24,999,999	15,365.00	1,450,248.00
25,000,000 – 29,999,999	16,014.00	1,740,297.00
30,000,000 – 49,999,999	16,654.00	2,001,341.00
50,000,000 – 69,999,999	17,321.00	2,281,528.00
70,000,000 – 89,999,999	18,013.00	2,578,129.00
90,000,000 – 109,999,999	18,734.00	2,810,160.00
110,000,000 – 149,999,999	19,484.00	3,063,073.00
150,000,000 – 199,999,999	20,262.00	3,338,752.00

Covered Lives	GPCS California Inpatient Pricer Table, Per Authorized Site, Per Product, Per Year	All State Specific APRDRG Grouper and Reimbursement Per Authorized Site Per Product Per Year
200,000,000 – 299,999,999	21,073.00	3,605,850.00
300,000,000 – 499,999,999	21,918.00	3,858,259.00
50,000,000 – 1,000,000,000	22,793.00	4,089,757.00

2. **American Medical Association (AMA) CPT Annual Fee.** CalOptima agrees to pay the AMA CPT Fees annually, which will be calculated at $0.005 **Per Member Per Year** (PMPY) based on the number of members reported as determined from either CalOptima's reported Members o available in AIS'S Directory of the Health Plans. If CalOptima fails to report the number of Members CONTRACTOR will calculate the applicable royalty fee based on the information available in AIS's Directory of Health Plans or CalOptima's last highest reported Members. CONTRACTOR reserves the right to adjust the AMA CPT Fee once annually. CONTRACTOR will communicate these fees, and if a new fee is not provided, the fee herein will be applicable to the relevant subscription period.

I. CONTRACTOR shall also invoice CalOptima on a monthly basis for approved travel-related expenses. All expenses charged to CalOptima under this Contract shall be consistent with Exhibit C, CalOptima's Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging, and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client. CONTRACTOR shall obtain CalOptima's written approval, which shall not be unreasonably withheld or delayed, before incurring any expenses. CalOptima shall not pay CONTRACTOR for time spent traveling.

J. Upon CONTRACTOR's request, CalOptima shall report to CONTRACTOR the highest number of Members for the monthly period by the 5th day of each calendar month. If CalOptima fails to report the number of Members, CONTRACTOR will, at its option, calculate the number of Members based on (i) the last reported highest number of Members available in the AIS's Directory of Health Plans, or (ii) the last highest CalOptima reported number and add a late fee of one percent (1%) of the annual Subscription Fee. Any individual Member shall only be counted once even if such Member had multiple enrollments during the applicable month. Following the first anniversary of Start Date and each ensuing anniversary thereafter, an invoice will be presented to CalOptima after a reconciliation between the invoices paid and recalculated invoices based upon an actual count of Members reported by CalOptima.

Exhibit B-1

[Not Applicable to Contract]

Exhibit C

CalOptima Travel Policy

CalOptima
A Public Agency
Better. Together.

Policy #:	GA.5004	
Title:	**Travel Policy**	
Department:	Finance	
Section:	Purchasing	
CEO Approval:		Michael Schrader MS
Effective Date:	8/1/12	Revised: 9/6/12, 3/1/13
Board Approval: 9/6/12		

I. PURPOSE

To establish a process for reasonable and equitable reimbursement of approved travel and other related expenses incurred by CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants while traveling on authorized CalOptima Business.

II. POLICY

A. For the purpose of this policy, Individual shall mean, unless otherwise specified, all persons authorized to submit an Expense Report, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima employees, and; individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses, in accordance with CalOptima rules and regulations.

B. CalOptima shall provide an expense reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel expenses and miscellaneous expenses incurred by authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal regulations.

C. CalOptima shall reimburse employees for reasonable expenses incurred while traveling on CalOptima business. All travel must be for the benefit of CalOptima, and must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible.

1. Travel Expenses shall include the following items:

   a. Transportation: including commercial carriers, rental vehicles, and mileage for use of personal vehicle;

   b. Lodging;

   c. Meals;

   d. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

   e. Insurance for rental vehicles;

   f. Parking fees and tolls fees (i.e., toll roads and necessary parking);

g. Miscellaneous expenses including:

i. Authorized local and long-distance telephone calls;

ii. Baggage fees;

iii. Internet or Wi-Fi charges;

iv. Facsimiles;

v. Expenses in connection with the preparation of authorized company reports or correspondence;

vi. Taxi or public transit fares, required to conduct business; and

vii. Other unforeseen or unusual expenses that are properly justified and substantiated.

D. Board Member/Standing Committee Member Travel

1. CalOptima shall allow Board members and Standing Committee members reasonable and necessary Travel Expenses and miscellaneous expenses incurred when participating in activities as a member of their respective Board or Committee. Eligible Travel Expenses shall be governed by this policy.

a. The CEO or the Chairperson of the CalOptima Board of Directors, or his or her designee, shall review and approve all Board member and Standing Committee member non-local travel.

b. CalOptima shall limit Board member and Standing Committee member travel to the following purposes:

i. CalOptima business-related activities;

ii. Requests to represent CalOptima as a speaker at an approved meeting, seminar or conference; and

iii. Other travel deemed necessary by the CalOptima Board of Directors.

E. Travel Approval

1. Budgeted Travel: All budgeted Travel and miscellaneous expenses for CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants shall be pre-approved by the appropriate level of CalOptima Management or Board Chair, prior to travel expenses being incurred, according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

2. Non-Budgeted Travel: Non-Budgeted Travel and miscellaneous expenses for authorized Individuals shall be pre-approved by the CEO, or his or her designee, prior to Travel Expenses being incurred.

F. Conferences and Seminars

1. Attendance at any given conference and/or seminar shall be:

   a. Limited to the number of Individuals deemed appropriate by the CEO for that particular conference or seminar, and

   b. Approved by Human Resources.

2. Payment of Fees

   a. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and seminar fees at the time the Travel and Training Authorization form is prepared, and submit necessary registration information to the Purchasing Department.

   b. In the event an Individual must personally pay for conference or seminar registration fees, the Individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

G. Meal Expenses

1. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

2. CalOptima shall reimburse authorized Individuals the actual cost of Travel Meals, excluding alcoholic beverages, in an amount not to exceed forty-five dollars ($45.00) per day, excluding taxes and gratuity.

   a. CalOptima shall reimburse employees and Board members for meals that exceed the forty-five dollars ($45.00) per day under the following conditions:

      i. The authorized Individual shall submit a valid receipt for such meals with a brief explanation of the expenditure. Individual meals shall be subject to the above limitations;

ii. The authorized Individual elects to pay for the meals of individuals with whom authorized CalOptima Business was conducted; or

iii. Extraordinary circumstances may cause it to be impractical or unfeasible for the authorized Individual to stay within the established meal rates, and the authorized Individual shall submit receipts for such meals with a brief explanation of the extraordinary expenditure.

iv. Expense reports containing extraordinary meal expenditures shall require approval of the CEO, or his or her designee.

b. CalOptima may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses, as stipulated in this policy. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board and Committee member meal reimbursement rate.

3. CalOptima shall reimburse for Business Meals at actual reasonable and necessary expenses for refreshments or meals, excluding alcoholic beverages, provided in conjunction with on-site or off-site meetings (e.g., in-house developed formal training sessions, conferences, seminars, workshops, staff meetings, and board and commission meetings) which extend over normal breaks or meal periods. An Expense Report for Business Meals must include receipt, names of those in attendance, and the business topic.

H. Lodging Expenses

1. CalOptima shall reimburse the cost of a single room at an Approved Lodging Facility for Non-Local Travel.

2. Adequate lodging expenses will be allowed. Price is an issue in selecting "adequate lodging". Prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged; booking through online travel Websites, as opposed to directly with the lodging facility, might provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

3. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. If such rates are not available, a hotel's discounted government rate shall be allowed. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) Website; www.gsa.gov.

4. CalOptima may reimburse additional lodging expenses for Non-Local Travel if:

a. It results in offsetting lower airfare; and

b. The cost of returning to home or office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

5. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima may approve Local Travel lodging expenses if:

a. It is not practical or feasible for the authorized Individual to return home due to extremely poor weather conditions; or

b. Less than eight (8) hours will elapse from the time business is concluded on one (1) day and the time business is scheduled to reconvene on the following calendar day; or

c. It is not practical or feasible for the authorized Individual to return home due to an extended commute.

6. Once approved, the Individual or his or her designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima travel services provider or another method approved by CalOptima's Purchasing Department.

7. The Individual shall be responsible for necessary cancellation of travel and lodging reservations, in accordance with the respective rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any cancellations.

I. Cash advances

1. Under normal circumstances, CalOptima shall not issue cash advances for Travel Expenses.

2. The Executive Management team shall approve cash advances for anticipated authorized travel.

3. CalOptima may authorize cash advances on a limited basis if the traveling Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized Travel Expenses, as defined in this policy.

4. When authorized, cash advances shall be based on an estimate of reasonable Travel Expenses, including travel, meals, lodging and miscellaneous expenses.

5. Individuals receiving cash advances shall complete an Expense Report within five (5) business days of the Individual's return to home or place of work, whichever occurs first. The Individual shall account for all expenses incurred while traveling on authorized CalOptima Business, and shall indicate any cash amounts due back to CalOptima, in the event the cash advance was greater than actual authorized expenses, or cash amounts due the Individual, in the event actual authorized expenses exceed the amount of the cash advance.

J. Transportation

1. The mode of transportation shall be based on the distance of the final destination from the Individual's home or primary workplace, business schedule, and the cost effectiveness of the various modes of transportation.

2. Cost of arrangements for personal travel in conjunction with a business travel itinerary will be at the authorized Individual's expense. The Individual shall document the incremental travel costs assessed to CalOptima, in accordance with this policy.

3. The Individual shall make transportation arrangements as far in advance as possible using the most economical carrier, and the most economical departure point, within the selected mode of transportation. A Saturday night stay may be required to obtain the lowest possible rate, and may be authorized if the savings will reasonably offset the additional cost of meals, automobile rental and lodging.

   a. Flight arrangements made through CalOptima's travel services provider shall be reviewed by CalOptima's Purchasing Department, and submitted directly to Accounts Payable for payment.

   b. Flight arrangements not made through the CalOptima travel services provider shall be submitted by the Individual on an Expense Report.

   c. Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance by the CEO. An Individual shall pay any increase in transportation fares based on indirect or interrupted direct travel routes. Any resulting excess travel time shall not be considered work time, but shall be charged to the appropriate type of leave.

   d. Additional expenses shall not be the responsibility of the Individual if, through no fault or control of the Individual, it is necessary to travel an indirect route, or an interrupted direct route. In such cases, additional time shall be considered work time, and shall not be charged to any type of leave.

   e. Whenever available, all Individuals shall travel via "Coach Class," or similar reduced fare accommodations. "Business Class" reservations shall not be used except in the event that "Coach Class" or similar reduced fare accommodations are unavailable, and departure time is critical to the nature of the reason for travel. Under no circumstances shall "First Class" travel be reserved.

   f. Individuals requesting travel reservations shall not insist on any certain commercial carrier if using the specified carrier will result in a fare which is higher than the lowest available fare.

   g. Any deviation from lowest available rate for commercial carriers shall be at the Individual's expense.

4. The Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective carrier rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established carrier rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any such cancellations.

5. Use of Privately-Owned Vehicles

   a. An authorized Individual may use a privately-owned vehicle for travel if such use is more economical than the lowest-priced direct commercial carrier fare plus rental car expenses. The Individual must be licensed, and shall carry liability insurance as required by the State of California, at the Individual's sole expense.

b. CalOptima shall reimburse the use of privately-owned vehicles solely based on actual mileage at the Internal Revenue Service (IRS) Standard Mileage Rate. Total mileage reimbursed should consider the Individual's daily commute.

c. CalOptima shall not reimburse costs for fuel, automobile repairs, or other automobile expense items.

d. If more than one authorized Individual is traveling for CalOptima Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

e. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

f. CalOptima shall compensate property damages to an Individual's automobile incurred without fault or cause on the part of the Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the Individual's insurance policy, whichever is the lesser amount, for each accident.

6. Rental Automobiles

a. An Individual may rent automobile when such rental is considered to be more advantageous to CalOptima than other means of transportation.

b. Advance reservations shall be made whenever possible. Reservations for employees, Board and Committee members shall be made in the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

c. The vehicle rental agreement for the authorized Individual shall reference the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

d. Rental automobile approved classes are as follows:

i. Economy Class: An Individual shall select an economy class vehicle whenever four (4) or fewer individuals, including the driver, will be passengers in the rental automobile at any one time.

ii. Mid-size Class: An Individual may select a mid-size class vehicle in the event more than four (4) individuals will be riding in the rental automobile at any one (1) time, or in the event an economy class vehicle is not available, and the nature of the travel requires immediate departure.

iii. Luxury Class: Under no circumstances shall an Individual select a luxury class vehicle.

7. Other Modes of Transportation

a. Taxi Fares: CalOptima shall reimburse taxi fares when public transportation is not practical or available. Examples include travel between hotel and place of business, and from one business to another.

III. PROCEDURE

A. Travel and Training Authorization Form

1. Shall be accessed and completed on-line by all Individuals or their designee using CalOptima's Intranet system (or similar system in place at the time request is made), and shall include all actual or estimated expense amounts related to the request; and

2. Shall be routed for approval systemically based on the Individual's level, cost center, and whether they are a CalOptima employee according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

3. Shall also be routed systemically to the Human Resources Department in order to track the Individual's training.

4. Shall also be routed systemically to the Finance Department for confirmation that requested expenses are budgeted, and that enough budget remains to cover requested expenses.

5. Requestors shall receive an automatic e-mail after submitting their request, notifying them of the approval status, and providing a link to the electronic form to track approval progress.

6. The Purchasing Department shall review, authorize for appropriate approvals, and notify the requestors that they may begin making travel commitments.

B. Travel and Training Arrangements

1. Authorizations that include event registration fees shall be pre-paid and processed by CalOptima's Purchasing Department, where possible. CalOptima's Purchasing Department shall verify with the requestor that the registration has not been processed before proceeding with registration of the Individual for the event.

2. The requestor, or his or her designee, shall make air travel arrangements through CalOptima's travel services provider, where possible. Arrangements should be made as far in advance as possible to minimize costs. Exceptions to using CalOptima's travel services provider are subject to approval by CalOptima's Purchasing Department.

3. All other arrangements shall be made with the Individual's personal credit card, either through CalOptima's travel services provider, another approved method, or directly with the establishment(s), subject to CalOptima's Purchasing Department approval.

C. Expense Reimbursement using Expense Report

1. Individuals or designees shall prepare and submit request claims for reimbursement of Travel Expenses on a CalOptima Expense Report. The report shall be completed by the Individual or designee, including all details, and shall be routed with a copy of the previously-approved Travel and Training Authorization Form for appropriate Expense Report approval signatures, if applicable, as follows:

Individual	**Approver**
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee*
CEO	Board Chairperson or designee*
Board Member/Standing Committee Member	Board Chairperson, CEO or designee*

*Designee authorization is not valid when self approval would result.

2. Receipts

   a. For any expenses in excess of twenty-five dollars ($25.00), the Individual shall include an original credit card receipt, if available, or other computer-generated or hand-written receipt, in the event a credit card receipt is unavailable. CalOptima contractors authorized to receive reimbursement for expenses shall submit receipts for all expenses, regardless of the dollar amount of the expenditure.

   b. Small receipts, such as credit card, gas and airline receipts, shall be attached to an 8 ½ by 11 inch sheet of paper. Hotel receipts and other larger receipts may be submitted as is.

   c. In the absence of credit card receipts, or other proof of actual expenditure, CalOptima shall reimburse lodging expenses only if marked "paid" by the management of the lodging facility.

   d. In most instances, airfare for CalOptima employees and Board members shall be prepaid by CalOptima. CalOptima contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not prepaid for any reason, shall submit passenger receipts for reimbursement consideration.

   e. If receipts cannot be obtained or have been lost, a statement to that effect shall be made on the Expense Report, along with an appropriate explanation. In the absence of a satisfactory explanation, CalOptima shall not allow the amount.

3. Completed and approved Expense Reports and supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel.

4. No reimbursement shall be made for Expense Reports submitted beyond six (6) months after completion of travel.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

2. Code expenses to appropriate department and general ledger account numbers; and

3. Process payment for reimbursement.

E. The Purchasing Department shall:

1. Provide travel reports to the CEO, Executive Management, and Department Directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of individuals per event, and may be required to distinguish between budgeted and non-budgeted travel.

2. Review details of statements/invoices received from the CalOptima travel services provider for accuracy and reasonableness;

3. Attach appropriate copies of completed Travel and Training Authorization Forms related to travel service provider invoice line items, and submit to Accounts Payable for payment.

4. Review details of statements/invoices received from credit card account used by Purchasing to arrange attendance at conferences, training, and other events, and to make authorized purchases.

5. Attach appropriate copies of completed Travel and Training Authorization Forms related to credit card invoice travel and training line items, and submit to Accounts Payable for payment.

IV. ATTACHMENTS

A. Electronic Travel and Training Authorization Form
B. CalOptima Expense Report
C. Cash Advance Form

V. REFERENCES

A. Internal Revenue Service Publication 463
B. California Government Code Section 53232.2
C. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994

VI. APPROVALS OR BOARD ACTION

9/6/12: CalOptima Regular Board Meeting

VII. REVISION HISTORY

A. 9/6/12: GA.5004: Travel Policy
B. 8/1/12: GA.5004: Travel Policy

VIII. KEYWORDS

Approved Lodging
CalOptima Business
Executive Management

Expense Report
Individual
Local Travel
Lodging
Meals
Miscellaneous Expenses
Non-Local Travel
Non-Reimbursable Expenses
Parking, Fees and Tolls
Registration Fees
Reimbursable Expenses
Transportation
Travel
Travel and Training Authorization Form
Travel Expenses

Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

As a condition of obtaining access to information concerning procedures or other data records utilized/maintained by the Department of Health Care Services and CalOptima, Burgess Group, LLC, including any and all individual employees and agents, agrees not to divulge any information obtained in the course of completion of this Contract to any unauthorized persons.

CONTRACTOR further agrees not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

CONTRACTOR further recognizes that unauthorized release of confidential information may be subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

DocuSigned by:

By: Ryan Mooney 2A62EC65EE1F4BB... Date: 7/8/2022

Print Name: Ryan Mooney

Title: EVP, GM Burgess

Exhibit E
Part 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that :

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

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Burgess	Ryan Mooney
Name of Contractor	Printed Name of Person Signing for Contractor
	DocuSigned by: Ryan Mooney 2A625C6DE51F4B5...
Contract/Grant Number	Signature of Person Signing for Contractor
7/8/2022	EVP, GM Burgess
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

Exhibit E

Part 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	☐a. bid/offer/application ☐b. initial award ☐c. post-award	☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	Congressional District, *if known*:
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*):	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):
(*attach Continuation Sheet(s) SF-LLLA, if necessary*)	
11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____
12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value_____	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

DocuSigned by:
Signature: Ryan Mooney
2A62EC65EE1F4BB...
Print Name: Ryan Mooney
Title: EVP, GM Burgess
Telephone No.:
Date: 7/8/2022

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Standard Form-LLL

Rev. 07/2014 **Contract No. 22-10967**

Back to Item

Back to Agenda

Exhibit E

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

Exhibit F

Not applicable for this Contract

Exhibit G

ADDENDUM 1
MEDICARE ADVANTAGE PROGRAM

To the extent that any of CalOptima's activities or responsibilities under its contract with CMS are delegated by CalOptima to CONTRACTOR, or as required by CMS and/or applicable Medicare laws, the following additional terms and conditions apply to the provision of goods or services to be utilized, directly or indirectly, by or for the Medicare Advantage Program. These terms and conditions are additive to those contained in the main Contract, and apply to the extent applicable to the services provided by CONTRACTOR. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

A. In addition to compliance with the provisions of Section 8 in the Contract, CONTRACTOR expressly warrants that CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

B. For any medical records or other health and enrollment information CONTRACTOR maintains with respect to Medicare enrollees, CONTRACTOR shall establish procedures to:

1. Abide by all Federal and State laws regarding confidentiality and disclosure of medical records and other health and enrollment information. CONTRACTOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify: (a) the purpose or purposes the information will be used within CONTRACTOR's organization; and (b) to whom and for what purpose CONTRACTOR will disclose the information.

2. Ensure that the medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

3. Maintain the records and information in an accurate and timely manner.

4. Ensure timely access by enrollees to the records and information that pertain to them.

C. CONTRACTOR shall comply with the reporting requirements provided in Title 42 of the Code of Federal Regulations, Section 422.516 as well as the encounter data submission requirements of 42 CFR Section 422.257.

D. For all contracts in the amount of $100,000 or more, in addition to the Equal Opportunity provisions included in the Contract, CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with 41 CFR 60-300.5(a) and 41 CFR 60-741.5(a) as follows:

1. **THIS CONTRACTOR AND SUBCONTRACTOR SHALL ABIDE BY THE REQUIREMENTS OF 41 CFR 60-300.5(a). THIS REGULATION PROHIBITS DISCRIMINATION AGAINST QUALIFIED PROTECTED VETERANS, AND REQUIRES AFFIRMATIVE ACTION BY COVERED PRIME CONTRACTORS AND SUBCONTRACTORS TO EMPLOY AND ADVANCE IN EMPLOYMENT QUALIFIED PROTECTED VETERANS. (**41 CFR 60-300.5(d).)

2. **THIS CONTRACTOR AND SUBCONTRACTOR SHALL ABIDE BY THE REQUIREMENTS OF 41 CFR 60-741.5(a). THIS REGULATION PROHIBITS DISCRIMINATION AGAINST QUALIFIED INDIVIDUALS ON THE BASIS OF DISABILITY, AND REQUIRES AFFIRMATIVE ACTION BY COVERED PRIME CONTRACTORS AND SUBCONTRACTORS TO EMPLOY AND ADVANCE IN EMPLOYMENT QUALIFIED INDIVIDUALS WITH DISABILITIES. (**41 CFR 60-741.5(d).)

E. In addition to the termination provisions of Section 16 of this Contract, CONTRACTOR agrees and acknowledges that CalOptima may terminate the Contract if CMS or CalOptima determines that CONTRACTOR has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay CONTRACTOR its allowable costs incurred to the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima for matters pertaining to this Contract.

F. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its contract with CMS, CONTRACTOR shall comply with all such requirements at the direction of CalOptima.

G. CalOptima shall review, approve, and audit on an ongoing basis, the credentialing of medical professionals, if any, associated with CONTRACTOR and CONTRACTOR's performance of this Contract.

H. Notwithstanding the delegation by CalOptima to CONTRACTOR for the selection of providers, contractors, or subcontractors, CalOptima expressly retains the right to approve, suspend, or terminate any such arrangement.

I. Notwithstanding the written delegation by CalOptima to CONTRACTOR of any other activities under this Contract, CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its contract with CMS, and expressly retains the right to approve, suspend, or terminate any such arrangement with CONTRACTOR. With all such delegated activities, CalOptima shall monitor CONTRACTOR's performance on an ongoing basis to ensure compliance with all applicable CalOptima and CMS requirements.

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Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and Contractor must complete the Offshore Subcontracting Attestation.

Which CalOptima program(s) does this form pertain to? Select all that apply.	☒ OneCare Connect ☒ PACE ☒ OneCare ☒ Medi-Cal

Please check one of the following:

☒ Our Organization does not offshore any protected health information.
Please skip to Part V below

☐ Our Organization does offshore protected health information.
Please complete Offshore Subcontractor Attestation (Part I through Part V) below

Part I — Offshore Subcontractor Information

Attestation	Response
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima	☐ Yes ☐ No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)

Question	Response
1. Describe the PHI that will be provided to the offshore subcontractor	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

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Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐ Yes ☐ No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with CalOptima's contract with the offshore subcontractor.	☐ Yes ☐ No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐ Yes ☐ No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	☐ Yes ☐ No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐ Yes ☐ No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐ Yes ☐ No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐ Yes ☐ No*

***Explanation required for all "no" responses to Part III and Part IV above:**

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person: Ryan Mooney	Title: EVP, GM Burgess
Email: rmooney@healthedge.com	Phone #: 612-298-4023
Signature: DocuSigned by: Ryan Mooney 2A62EC65EE1F4BB...	Date: 7/28/2022

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

Exhibit I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: The Burgess Group L.L.C.

Business Entity Type: LLC
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: 1701 Duke Street, 3rd Floor

City: Alexandria State: VA Zip: 22314

Business Phone: 800.637.2004 Email: : Legal@healthedge.com

President: Steve Krupa Contact Person: Meredith Smith

Person(s) Signing Contract & Title: : Ryan Mooney, EVP & General Manager, Source

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
HealthEdge Software, Inc.	100%

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

DocuSigned by:
Ryan Mooney
2A62EC65EE1F4BB...
Authorized Signature

7/14/2022
Date

Ryan Mooney
Name and Title EVP, GM Burgess

Exhibit J

Not applicable for this Contract

Exhibit K

Not applicable for this Contract

Exhibit L

Not applicable for this Contract

EXHIBIT M
EXHIBIT M-1
THIRD PARTY CONTENT LICENSE TERMS
CPT LICENSE TERMS

CPT License Terms.

A. Grant of Rights Restrictions.

1. The Software incorporates content that is licensed from the American Medical Association ("AMA") under the CPT License, consisting of content from the Current Procedural Terminology ("CPT") data files, a coding work of nomenclature and codes for reporting of healthcare services ("Editorial Content"), and the license granted with respect thereto pursuant to this Agreement is a nontransferable, nonexclusive license for the sole purpose of internal use of Subscriber within the Territory defined in the CPT License (Argentina, Australia, Bahamas, Belgium, Bermuda, Brazil, Canada, Cayman Islands, Chile, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, India, Israel, Italy, Jamaica, Japan, Mexico, New Zealand, Norway, Panama, Portugal, Singapore, South Africa, Spain, Sweden, Thailand, Turkey, United Arab Emirates, United Kingdom, United States and its territories, and Venezuela).

2. Subscriber is prohibited from publishing, distributing via the Internet or other public computer-based information system, creating derivative works (including translating), transferring, selling, leasing, licensing, or otherwise making available to any unauthorized party, the Software, or a copy or portion of the Software.

3. The provision of updated Editorial Content in the Software by Burgess to Subscriber shall be subject to and in accordance with the continuation of the CPT License.

4. Subscriber shall ensure that all Authorized Users comply with the terms of the CPT License and this Agreement. For purposes of this Section 8.1, except where the context provides otherwise, the term "Subscriber" shall be deemed to include "Authorized Users".

5. Except as set forth in Section B below, the parties do not confer any rights or remedies upon any Person other than the parties to this Agreement and their respective successors and permitted assigns.

6. The parties hereby designate AMA as third-party beneficiaries of 4.3 of this Agreement having the right to enforce Section 10.

B. Notices.

1. CPT is copyrighted by the AMA, and CPT is a registered trademark of the AMA.

2. The following notice from Section 6.2.1 of the CPT License is hereby incorporated in this Agreement as follows: "U.S. Government Rights. This product includes CPT which is commercial technical data, which was developed exclusively at private expense by the AMA, 330 North Wabash Avenue, Chicago, Illinois 60611. The AMA does not agree to license CPT to the Federal Government based on the license in FAR 52.227-14 (Data Rights – General) and DFARS 252.227-7015 (Technical Data – Commercial Items) or any other license provision. The AMA reserves all rights to approve any license with any Federal agency

C. Back-Up Rights. All notices of proprietary rights, including trademarks and copyright notices, must appear on any copy of the Software which Burgess may authorize to be made for back up or archival purposes.

D. Warranty Limitations. Editorial Content as contained in the Software is provided "as is" without any liability to Burgess or the AMA, including without limitation, non-liability for consequential or special damages, or lost profits, for sequence, accuracy, or completeness of data, or that it will meet Subscriber's requirements. The AMA's sole responsibility is to make available to Burgess replacement copies of the Editorial Content if the Editorial Content is not intact. The AMA disclaims any liability for any consequences due to use, misuse, or interpretation of information contained or not contained in the Editorial Content.

EXHIBIT M
EXHIBIT M-2
3M License Terms

1. The Software incorporates content that is licensed from 3M, consisting of the following software: (i) Grouper Plus System APR/DRG; (ii) GPS MD Reimbursement (APR); and (iii) GPS NY Reimbursement (APR) ("3M Software"). Subscriber's right to access and use the 3M Software is non-exclusive and non-assignable, and the 3M Software and Documents are solely for Subscriber's internal use and not for use on behalf of any other entity except as expressly authorized in this this Agreement. For purposes hereof, "3M Documents" means written reference, operations and/or users manuals and other documents, and all revisions thereto, which provide specifications for or instructions for the use of the 3M Software and which are furnished to Subscriber by 3M or Burgess.

2. Subscriber is prohibited from making any modifications to or derivatives of the 3M Software or Documents, including the removal of any copyright or other proprietary rights notices.

3. Subscriber is prohibited from disassembling or otherwise reverse engineering the 3M Software, except as may be specifically authorized by law.

4. Subscriber is prohibited from providing copies of the 3M Software or Documents to third parties, or making the 3M Software or Documents accessible to third parties.

5. Subscriber is prohibited from making copies of the 3M Software or Documents except for archival and backup copies authorized by the End User License Agreement.

6. Subscriber shall treat the 3M Software and Documents in a confidential manner and to use Subscriber's best efforts to prevent disclosure of the contents of the 3M Software and Documents to third parties.

7. Subscriber must ensure that anyone who has authorized access to the 3M Software and Documents complies with the provisions of this Agreement.

8. 3M does not represent or warrant that the operation of the 3M Software will be uninterrupted or error-free. In the event 3M is unable to remedy a failure of the 3M Software to perform in accordance with the 3M Documents, when properly operated in accordance with the 3M Documentation, Burgess's and 3M's sole liability to Subscriber shall be to refund of the most recent License Fee payment, if any, which Burgess has actually received from Subscriber affected by the condition 3M was unable to resolve. **IN THE EVENT THAT SUBSCRIBER MAKES, OR ALLOWS TO HAVE MADE, ANY CHANGE, MODIFICATION OR ENHANCEMENT TO THE 3M SOFTWARE NOT PERMITTED HEREUNDER, THEN THIS WARRANTY SHALL BE INVALIDATED AND SUBSCRIBER SHALL USE THE 3M SOFTWARE "AS IS", WITHOUT ANY WARRANTY, AND WITH ALL RISK OF USE.**

9. NEITHER 3M NOR ITS SUPPLIERS SHALL HAVE ANY LIABILITY UNDER ANY CIRCUMSTANCES FOR ANY INCIDENTAL, SPECIAL, INDIRECT, EXEMPLARY OR CONSEQUENTIAL DAMAGES OR ECONOMIC LOSS, BASED UPON BREACH OF WARRANTY, BREACH OF CONTRACT, NEGLIGENCE, STRICT LIABILITY IN TORT OR ANY OTHER LEGAL THEORY, EVEN IF 3M OR ITS SUPPLIERS HAVE BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES OR LOSS, INCLUDING, BUT NOT LIMITED TO, LOSS OF PROFITS, REVENUE, EQUIPMENT USE, DATA OR INFORMATION OF ANY KIND. NEITHER 3M NOR ITS SUPPLIERS SHALL HAVE ANY LIABILITY ARISING FROM ANY INTERRUPTION OR LOSS OF USE OF THE SOFTWARE, NOR FROM A PARTY'S INABILITY TO ACCESS INFORMATION.

Back-Up Rights. All notices of proprietary rights, including trademarks and copyright notices, must appear on any copy of the 3M Software which Burgess may authorize to be made for back up or archival purposes.

EXHIBIT N
MAINTENANCE AND SUPPORT; PERMITTED DOWNTIME

1. Definitions.

1.1 "Measurement Period" means, in relation to each Service Level, the time period specified less any Permitted Downtime.

1.2 "Initial Notification" is defined as receipt of CalOptima' request for Support.

1.3 "Service Level" means the required Uptime, Response Time or other performance associated with the Subscription Service.

1.4 "Service Credit" means the amount payable to CalOptima, by CONTRACTOR, in the event of Service Level Failure.

2. Maintenance and Support. CONTRACTOR shall provide the following Maintenance and Support for the Service.

2.1 Production Service Maintenance.

(a) Scheduled Maintenance ("Scheduled Maintenance") shall include the following:

(i) Technical updates to the production servers and ancillary components used to host the Software;

(ii) Extended downtime for clean-up and maintenance of systems as periodically required for voluminous data and claims, periodic infrastructure maintenance, and periodic updates to application software and content;

(iii) Periods of testing prior to scheduling updates to the Software;

(iv) Emergency maintenance to remedy unforeseen problems with the Subscription Service, and ancillary components used to host the Software;

(v) Software updates for Medicare and Medicaid rate and policy changes and corrections;

(vi) Software updates for new functionality for Software Components described in Section 3 of Exhibit A; and

(vii) Software patches designed to maintain functionality of the Subscription Service in accordance with the Documentation.

(b) CalOptima is solely responsible for monitoring, maintenance, support, availability and performance of CalOptima's computer and communications systems used to access and use the Subscription Service as described in Addendum 1, Section 2.4(i) of the Agreement, including CTMs, CalOptima networks, CalOptima Internet Service Provider ("ISP") and any other transport mechanism facilitating access by the CalOptima to the Subscription Service not covered by CONTRACTOR.

2.2 Support. CONTRACTOR shall provide support services based on the severity level definitions set forth below. Support is limited to (i) identifying potentially applicable data in the Software and rate calculation functions of the Software that are based on an interpretation of such data; (ii) support of the Subscription Service and infrastructure hosted by CONTRACTOR or its Hosting Provider, and excludes support service for all CalOptima hardware and third party software unless such support is contractually agreed to by CONTRACTOR in a SOW; and (iii) diagnosis of actual reproducible errors or malfunctions attributable to the Subscription Service hosted by CONTRACTOR or its Hosting Provider and the equipment utilized to run the Subscription Service and make it accessible to CalOptima, and excludes errors and malfunctions caused by or attributable to actions or inaction by CalOptima or any CalOptima third party, hardware or software not provided by CONTRACTOR or its Hosting Provider, or use of Software and Subscription Service other than as permitted by this Agreement. As used herein "Business Hours" are Monday – Friday 8:30AM to 5:30PM Eastern Time, excluding holidays. CalOptima will report all issues to the CONTRACTOR Help Desk and will use the following contact information for these types of notifications:

Phone: 1-800-637-2004
Email: support@CONTRACTORgroup.com

(a) Severity Level 1. Severity Level 1 is defined as a critical production issue that severely impacts CalOptima's use of the Subscription Service resulting in (i) the inability of CalOptima to perform production claims pricing within the application or (ii) when the entire application has terminated and attempts to restart have failed. CONTRACTOR shall respond to an Emergency Support within one (1) hour of receipt of CalOptima's request ("Initial Notification"). CONTRACTOR' initial response shall include an acknowledgement of the stated issue and any applicable requests for additional information for resolution scoping. The issue will then be submitted to the appropriate support team which will respond to CalOptima regarding initial incident status within two (2) hours thereafter and provide status updates every two (2) hours thereafter, during Business Hours. CONTRACTOR shall provide a timely diagnosis of the error or malfunction or provide a suitable workaround until a solution is available.

(b) Severity Level 2. Severity Level 2 is defined as an issue where use of the Subscription Service is severely impacted wherein one or more major functions of the Subscription Service severely impacts CalOptima's business operations and no procedural workaround exists. CONTRACTOR support resources will respond, during Business Hours, to Severity Level 2 issues for initial diagnosis and troubleshooting within two (2) hours. CONTRACTOR will provide status updates every four (4) hours thereafter. CONTRACTOR shall make all commercially reasonable efforts to provide an estimate of a permanent solution once the error or malfunction has been identified.

(c) Severity Level 3. CONTRACTOR will provide CalOptima with pricing and IT support services ("Standard Support") at no additional charge via telephone and email during Business Hours to respond to CalOptima's requests that relate to routine Subscription Service functionality and operation. CONTRACTOR will use reasonable efforts to respond within twenty-four (24) hours of receipt of CalOptima's request. CONTRACTOR will provide prompt notice to CalOptima stating a target time frame beyond twenty-four (24) hours for CalOptima's request for Standard Support service(s) that CONTRACTOR determines to require research and analysis for response. Notwithstanding the foregoing, in no event shall CONTRACTOR fail to respond within twenty-four (24) hours of receipt of CalOptima's request.

2.3 Exceptions to Support. Support service is limited to (i) support of the Subscription Service, and excludes support or maintenance for all hardware and third party software unless such support is contractually agreed to by CONTRACTOR under a separate Statement of Work executed by the Parties, and (ii) diagnosis of actual reproducible errors or malfunctions attributable to the Software hosted by CONTRACTOR or its Hosting Provider, and excludes the following:

(a) Errors and malfunctions caused by or attributable to actions or inaction by CalOptima or any third party.

(b) Hardware or software not provided by CONTRACTOR or its Hosting Provider.

(c) Use of the Software and Subscription Service other than as permitted by this Agreement.

(d) Bugs, errors or other problems in third party software.

(e) Negligent or willful conduct by CalOptima and/or Authorized Users in using the Subscription Service.

(f) Errors in content or format and viruses or other corruption in CalOptima Data.

2.4 Out of Scope Services. Standard Support services does not include response to CalOptima requests that relate to the CalOptima's infrastructure, computer, computer configuration, and/or telecommunications systems, including equipment, software, operating systems and other components, or CalOptima requests for non-standard support.

3. Permitted Downtime. The inability of CalOptima's Authorized Users to access and use the Subscription Service attributable to any of the following shall be deemed Permitted Downtime as described in Section 3.1 of the Agreement:

3.1 Periods of scheduled or emergency maintenance described in Section 2 of this Exhibit F.

3.2 Any Force Majeure Event.

3.3 Failure of the server or other computer hardware used to host the Software.

3.4 Bugs, errors or other problems in third party software.

3.5 Negligent or willful conduct by CalOptima and/or Authorized Users in using the Software or Subscription Service in a manner not authorized by this Agreement.

3.6 Security breaches involving CalOptima's systems, equipment or CTM, or use of compromised access credentials.

3.7 Restrictions in capacity or bandwidth or failure or interruption of access to the Subscription Service attributable to CalOptima's Internet service provider or other CTM used to access the Subscription Service.

3.8 Failure or interruption of CalOptima hardware, software, or network connection.

3.9 Errors in content or format and viruses or other corruption in CalOptima Data or otherwise introduced by CalOptima.

3.10 Increases in CalOptima use of the Subscription Service resulting from claim volumes which exceed CalOptima's normal usage of the Subscription Service which exceeds its normal average claim volume by twenty-five (25%) percent or more.

3.11 Mass or large-scale adjustments in CalOptima use of the Subscription Service resulting from retroactive fee schedule changes or other business changes directed by CalOptima.

3.12 Errors or malfunctions in CalOptima technologies or services, or third party software (other than software of CONTRACTOR or its Hosting Provider used to provide the Subscription Service), or delays or unavailability of services provided by third parties that impact system availability, including any downtime while waiting for issue resolution by such third parties.

4. Service Levels.

4.1 Uptime**.** The Subscription Service will have the availability set forth in Section 4.1.

4.2 Support Service Response Time & Severity Levels**.** CONTRACTOR shall respond to all support requests in accordance with the Service Levels set forth in *Table 2: Service Level for Support Services*. The severity level, assigned by CONTRACTOR at the time of communicating the support request, may be changed by mutual written consent during the process of resolving the error.

Table 2: Service Level for Support Services

Issue	**Required Service Level Response Time**
Severity Level 1	Provider shall acknowledge receipt of a Support Request and respond via email or phone within 60 minutes.
Severity Level 2	Provider shall acknowledge receipt of a Support Request and respond via email or phone within 2 hours.
Severity Level 3	Provider shall acknowledge receipt of a Support Request and respond via email or phone within 24 hours.

5. Service Credits.

5.1 If the Subscription Service does not achieve the Uptime (exclusive of Permitted Downtime) in any given calendar quarter, CONTRACTOR shall provide CalOptima with a Service Level Credit for such quarter equal to an amount determined in accordance with *Table 3: Service Credits*.

Table 3: Service Credits

Availability	Service Level Credit
Greater than or equal to 99.5%	None
Less than 99.5% but greater than or equal to 98%	1% of Subscription Fee
Less than 98% but greater than or equal to 97%	2% of Subscription Fee
Less than 97%	3% of Subscription Fee

5.2 The Service Credit shall not be available to CalOptima until six (6) months after implementation has concluded, and nor more than three (3) times per annual invoice cycle. Aside from the rights afforded to CalOptima in Section 8 of the Agreement, the Service Credit shall be the sole and exclusive liability of CONTRACTOR and its Hosting Provider and the sole and exclusive remedy of CalOptima for any outage or unavailability of the Software or Subscription Service. CalOptima agrees to notify CONTRACTOR immediately if CalOptima suspects the Subscription Service is unavailable due to a fault of CONTRACTOR or its Hosting Provider. CalOptima agrees to provide reasonable information as requested by CONTRACTOR for proper diagnosis/repair and for proper calculation of any Service Credit. To be eligible to claim a Service Credit, CalOptima's Primary Contact must submit a request through the CONTRACTOR customer support services department within five (5) business days of the claimed unavailability, which request must include the dates, times, service type, IP Address, contact information and full description of the unavailability. In the event that a CONTRACTOR representative requests the server logs that support the unavailability, CalOptima shall provide same within five (5) business days in order for CalOptima to be eligible for a Service Credit. CONTRACTOR will reconcile such information provided by CalOptima to CONTRACTOR records. Once CONTRACTOR confirms the unavailability and approves a request, the corresponding Service Credit will be applied to CalOptima's next billing statement. Failure to request a Service Credit within the time periods set forth above, or to provide the required documentation supporting the request, will make CalOptima ineligible for a Service Credit for that period of unavailability.

5.3 If CalOptima is currently in arrears of payment on annual or other fees in accordance with Section 7 of the Agreement CalOptima shall not be eligible for a Service Credit. Except as expressly set forth herein, any remedy CalOptima may receive pursuant to this Section 5 does not relieve CalOptima for, or allow a set-off against, any other payment obligations of CalOptima to CONTRACTOR under this Agreement.

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
The Burgess Group, L.L.C.	1701 Duke Street, 3rd Floor	Alexandria	VA	22314
HealthEdge Software	30 Corporate Drive, Suite 150	Burlington	MA	01803

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Board of Directors Meeting
February 2, 2023

Special Joint Meeting of the Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee Report to the Board

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On December 8, 2022, the Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC), Provider Advisory Committee (PAC) and the Whole-Child Model Family Advisory Committee (WCM FAC) held a special joint meeting to discuss topics of mutual interest. The committees received one public comment regarding non-emergency medical transportation.

Yunkyung Kim, Chief Operating Officer thanked all of the committee members for their service to CalOptima Health and discussed quality initiatives including a $240 million investment to CalOptima Health's quality programs. She noted that these investments were approved at the at the December Board meeting, noting that these are multi-year quality incentives that will begin in January 2023. Ms. Kim also discussed the implementation of a new annual wellness initiative for Medi-Cal members who are 45 years and older. Lastly, Ms. Kim reviewed the recent changes to the Board Advisory Committees, which included adding stipends for member seats on the MAC and updating the term limits from a two-year to three-year for members serving on the MAC.

Richard Pitts, D.O., Ph.D., Chief Medical Officer, discussed recently approved Board items and noted that in addition to the quality initiatives, the Board approved $50 million dollars to support comprehensive community cancer screening and support program for Medi-Cal members for a five-year period. He also discussed the Board's approval of a $10 million three-year program to enhance quality in skilled nursing facilities and strengthen the safety net across Orange County. Dr. Pitts also provided a COVID-19 update, noting that with the new variants we are seeing an increase in hospitalizations in Orange County.

Wael Younan, Chief Information Officer, presented the Digital Transformation Key Performance Indicators including plans to enhance CalOptima's technology to improve the member and provider portals.

Rachel Selleck, Executive Director, Government Affairs and Strategic Development, provided an update on the development of CalOptima Health's 2022-2025 Strategic Plan and reviewed the strategic priorities timeline with the committees. Ms. Selleck noted that once a final draft has been developed more information would be shared with the committees at future meetings.

Kelly Bruno-Nelson, Executive Director, Program Implementation, provided a verbal update on the Street Medicine Pilot Program, which was approved by the CalOptima Health Board of Directors at its December 1, 2022 meeting. Ms. Bruno-Nelson reviewed the step-by-step flow chart of how the program would be structured.

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Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health, presented on School Based Behavioral Health and provided an overview of the program including goals of this program and reviewed the projected timeline.

Leadership thanked the members of the OneCare Connect Member Advisory Committee (OCC MAC) for their years of dedication and service and shared that CalOptima Health will be hosting a luncheon in the near future to honor Committee members for their service. The luncheon will include all Committees and in addition to honoring the members of the OCC MAC, they will also honor past Committee members, whose term ended during COVID.

The members of the MAC, OCC MAC, PAC, and WCM FAC appreciate the opportunity to update the Board on their current activities.

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