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

MARCH 2, 2023
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Clayton Corwin, Acting Chair	Vacant
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_4wa0qppISFmj025LNbSvGA and Join the Meeting.

Webinar ID: 896 1639 7747
Passcode: 201302-- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. Chief Executive Officer Report

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

CONSENT CALENDAR
2. Minutes
   a. Approve Minutes of the February 2, 2023 Regular Meeting of the CalOptima Health Board of Directors

3. Approve CalOptima Health Policy GG. 1213 Community Health Worker Services Policy

4. Approve New CalOptima Health Grievance and Appeals Resolution Services Policy MA.9015p

5. Authorize Proposed Budget Allocation Changes in the CalOptima Health's Fiscal Year (FY) 2022-23 Operating Budget for Cultural & Linguistic Expenses

6. Approve CalOptima Health Position on Proposed Legislation

7. Receive and File:
   a. January 2023 Financial Summary
   b. Compliance Report
   c. Federal and State Legislative Advocates Reports
   d. CalOptima Health Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS
8. Election of Officers to the CalOptima Health Board of Directors

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

10. Authorize Insurance Policy Procurements and Renewals for Policy Year 2023-24

11. Authorize Implementation of a Contract with Varis LLC and Amendment to the Contract with Cotiviti, Inc.

12. Approve Actions Related to the Procurement of a Modern Customer Contact Center Solution

13. Approve Actions Related to the Procurement for the Member Mobile App

14. Approve Actions Related to the Procurement of a Privileged Access Management Solution

15. Authorize the Chief Executive Officer to Execute a Contract Amendment with Delphix Corp. to Procure and Implement a Data Masking Solution in Support of CalOptima Health's Digital Transformation Strategy

ADVISORY COMMITTEE UPDATES

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

CLOSED SESSION

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

CS-2. CONFERENCE WITH LEGAL COUNSEL – STRATEGY ON EXISTING LITIGATION Pursuant to Government Code Section 54956.9(d)(1)

CS-3. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code Section 54956.9(d)(2):1 case

CS-4. CONFERENCE WITH LEGAL COUNSEL – PROACTIVE LITIGATION Pursuant to Government Code Section 54956.9(d)(4): 1 case

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

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_4wa0qppISFmj025LNbSvGA

To **Join** from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join.
https://us06web.zoom.us/s/89616397747?pwd=dlk2aUxzSjZSQlpRSmhWRnBTSWpsZz09

Passcode: **201302**

Or One tap mobile:
+16694449171,,89616397747#,,,,*201302# US
+17193594580,,89616397747#,,,,*201302# US

Or join by phone:
Dial(for higher quality, dial a number based on your current location):
US: +1 669 444 9171 or +1 719 359 4580 or +1 720 707 2699 or +1 253 205 0468 or +1 253 215 8782 or +1 346 248 7799 or +1 312 626 6799 or +1 360 209 5623 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

Webinar ID: 896 1639 7747
Passcode: 201302
International numbers available: **https://us06web.zoom.us/u/kyhqxFHsl**

MEMORANDUM

DATE: February 23, 2023

TO: CalOptima Health Board of Directors

FROM: Michael Hunn, Chief Executive Officer

SUBJECT: CEO Report — March 2, 2023, Board of Directors Meeting

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

a. CalOptima Focused on Informing Members About Upcoming Medi-Cal Redetermination

The Medi-Cal redetermination process will resume on April 1 (with the first disenrollments on July 1). Starting in April, the County of Orange Social Services Agency (SSA) will do an ex parte review to automatically renew members using available data, such as state wage databases, to confirm ongoing eligibility. If confirmed, members will receive notices informing them about their renewal, and they will not need to take any action. To help our members keep their coverage if the ex parte process doesn't renew them and they receive a renewal form, we have created a comprehensive communications plan to inform and educate the community over the 14 months of redetermination. We have also created an online toolkit of resources that our providers, community-based organizations and other trusted messengers can use to share information with members about the redetermination process. CalOptima Health is seeking their help to amplify two messages: First, members need to notify SSA if their contact information has changed over the past three years, and second, they need to complete the renewal process to keep their Medi-Cal.

b. State Joint Legislative Audit Recommendations – Pending

The California State Auditor (CSA) is wrapping up its audit of CalOptima Health as approved by the Joint Legislative Audit Committee (JLAC) back in June of 2022. The auditors are finalizing document reviews and interviews with staff and an exit conference is expected the week of March 6. A draft audit report will be provided to CalOptima Health, and staff will have five business days to review the draft report and prepare a written response. A special CalOptima Health Board meeting will convene a closed session to review the draft audit recommendations and any responses to the auditors. The final report is then expected to be released publicly in April.

c. Annual Medi-Cal Audit Set to Begin February 27

CalOptima Health has completed preparations for the Department of Health Care Services (DHCS) routine, annual medical audit, which will be underway starting February 27. 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.). As in previous years, the

Medi-Cal Regulatory Affairs & Compliance department coordinated CalOptima Health's participation in the audit, which will continue through March 10.

d. Medical Directors Represent a Broad Array of Specialties

Under the leadership of Chief Medical Officer Richard Pitts, D.O., Ph.D., and Deputy Chief Medical Officer Zeinab Dabbah, M.D., J.D., CalOptima Health's Medical Directors offer medical expertise in a broad array of specialties. Please see below for a list of the Medical Directors and their specialties/areas of responsibility:

Richard Pitts, D.O., Ph.D.	Chief Medical Officer	Emergency Medicine, Preventive Medicine and Occupational Medicine
Zeinab Dabbah, M.D., J.D.	Deputy Chief Medical Officer	Internal Medicine
Said Elshihabi, M.D., FAANS	Medical Director, Cranial & Spine Surgery	Neurosurgery and Spine Surgery
Donna Frisch, M.D.	Medical Director, PACE	Internal Medicine
Dajee Himmet, M.D., FACS	Medical Director, Medical Management	Cardio-Thoracic Surgery
Shilpa Jindani, M.D.	Medical Director, Population Health & Equity	Family Practice
Richard R. Lopez, M.D., FACS	Medical Director, Transplant & Medical Director, Credentialing	Surgery/Transplant
Nguyen Luu-Trong, M.D., FAAFP	Medical Director, Medical Management	Family Practice
Thanh-Tam Nguyen, M.D., FAAP	Medical Director, Whole Child Model	Medicine/Pediatrics
Tanu S. Pandey, M.D., MPH, FACP	Medical Director, Appeals and Grievance	Internal Medicine and Preventive Medicine
Donald Sharps, M.D., DLFAPA	Medical Director, Behavioral Health Integration	Psychiatry
Mohini Sinha, M.D.	Medical Director, Quality	Pediatrics

e. California Association of Housing Authorities' Presentation

Kelly Bruno-Nelson, Executive Director of Medi-Cal/CalAIM, presented at the California Association of Housing Authorities (CAHA) annual conference in Sacramento on January 26. She spoke about the intersection of housing and health and how CalOptima Health is partnering with our four local Housing Authorities to increase housing opportunities in Orange County. CAHA is a statewide association representing more than 75 housing authorities throughout the state of California.

f. National Health and Nutrition Examination Survey Hosts Media Event

Chief Medical Officer Richard Pitts, D.O., Ph.D., and I attended the National Health and Nutrition Examination Survey (NHANES) media event earlier this month. Speakers at the open house event included Dr. Pitts; Board of Supervisors Chairman Don Wagner and Supervisors Vicente Sarmiento, Doug Chaffee and Katrina Foley; Tony Nguyen, M.D., NHANES Chief Medical Officer; and Regina Chinsio-Kwong, M.D., County Health Officer. KFI AM Los Angeles ran a clip of Dr. Pitts being interviewed at the event.

g. CalOptima Health Welcomes New Executive Director, Medicare Programs

Javier Sanchez has joined CalOptima Health as the new Executive Director, Medicare Programs. He will oversee Medicare programs, including OneCare, PACE and future programs for seniors. Previously, he held executive roles at CalOptima Health from 2008–16, leading our contracted health networks and launching our direct network, now known as CalOptima Health Community Network. Javier went on to serve in executive roles for CHOC Health Alliance, providing strategic and operational direction for the physician/hospital organization, and for Kaiser Foundation Health Plan, leading Medi-Cal contracting efforts across California. Most recently, he was a vice president at Innovative Integrated Health Community Plans and the CEO of a new Medicare Advantage plan he launched in the California Central Valley.

h. CalOptima Health Board Appointments Pending Board of Supervisors Action

Following the resignation of Supervisor Andrew Do from the CalOptima Health Board of Directors, the Orange County Board of Supervisors (BOS) is expected to finalize the appointment of Supervisor Vicente Sarmiento at its meeting on February 28. Since Supervisor Sarmiento already occupies our Board's alternate seat, he will immediately fill the regular seat regardless of the formal appointment date. At the same meeting, the BOS will also appoint a new alternate, who has not yet been determined. Relatedly, the Orange County Health Care Agency continues its recruitment effort for our designated legal/accounting seat formerly held by Scott Schoeffel, but there is currently no expected timeline for the BOS to appoint a candidate.

i. Security Enhancements Installed at CalOptima Health's Building

As part of CalOptima Health's security enhancements at the 505 building, we have installed a new security camera monitoring system and emergency blue light stations throughout the property. There are six stations located in the main parking lot and one station located at the entrance facing The Outlets at Orange.

Fast Facts
March 2023

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

Membership Data* (as of January 31, 2023)

Total CalOptima Health Membership

973,571

Program	Members
Medi-Cal	955,824
OneCare Connect	26
OneCare (HMO D-SNP)	17,293
Program of All-Inclusive Care for the Elderly (PACE)	428

*Based on unaudited financial report and includes prior period adjustment

Operating Budget (for seven months ended January 31, 2023)

	YTD Actual	YTD Budget	Difference
Revenues	$2,300,826,825	$2,343,665,979	($42,839,155)
Medical Expenses	$2,137,607,072	$2,203,561,870	$65,954,798
Administrative Expenses	$104,345,874	$123,561,019	$19,215,145
Operating Margin	$58,873,879	$16,543,090	$42,330,789
Medical Loss Ratio (MLR)	92.9%	94.0%	(1.1%)
Administrative Loss Ratio (ALR)	4.5%	5.3%	0.7%

Reserve Summary (as of January 31, 2023)

	Amount (in millions)
Board Designated Reserves	$573.8*
Capital Assets (Net of depreciation)	$67.4
Resources Committed by the Board	$448.1
Resources Unallocated/Unassigned	$409.9*
Total Net Assets	$1,499.2

**Total of Board designated reserves and unallocated resources can support approximately 100 days of CalOptima Health's current operations.*

Total Annual Budgeted Revenue **$4 Billion**

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

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CalOptima Health Fast Facts

March 2023

Personnel Summary (as of February 10, 2023, pay period)

	Filled	Open	Vacancy %
Staff	1,331.4	154.0	10.97%
Manager	103.0	7.0	6.36%
Director	53.0	14.0	20.90%
Executive Director	11.0	1.0	8.33%
Chief	8.0	2.0	20.00%
Total FTE Count	1,506.4	181.0	10.73%

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

Provider Network Data (as of January 31, 2023)

	Number of Providers
Primary Care Providers	1,293
Specialists	8,160
Pharmacies	565
Acute and Rehab Hospitals	45
Community Health Centers	34
Long-Term Care Facilities	98

Treatment Authorizations (as of December 31, 2023)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	14.02 hours
Prior Authorization – Urgent	72 hours	16.13 hours
Prior Authorization – Routine	5 days	1.69 days

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

Member Demographics (as of January 31, 2023)

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%

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MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

February 2, 2023

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on February 2, 2023, 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 2:04 p.m., and Director Blair Contratto led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chairman; Clayton Corwin, Vice Chair; Isabel Becerra; Supervisor Doug Chaffee; Blair Contratto; José Mayorga M.D.; Nancy Shivers; Trieu Tran, M.D.

(All Board Members participated in person except Supervisor Chaffee and Director Shivers, who participated remotely)

Members Absent: Clayton Chau, M.D. (non-voting)

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

The Clerk noted for the record that staff is pulling Closed Session Item CS-1, from the agenda.

PRESENTATIONS/INTRODUCTIONS

Chairman Do introduced Connor Medina, Government Affairs Manager at Orange County Business Council (OCBC), noting that he will be providing brief remarks to congratulate CalOptima Health for receiving its 2022 Public-Private Partnership Award in recognition of its partnership with the Orange County Health Care Agency, Mind OC, and several private organizations that worked together to create the Be Well OC Orange Campus.

Mr. Connor noted that OCBC had given the award at their 12th Annual *Turning Red Tape in Red Carpet Awards* event in November 2022, but noted that he would like to formally present the award to the CalOptima Health Board and the CalOptima Health leadership team. The Board and Michael Hunn, Chief Executive Officer, also thanked Marshall Moncrief, Chief Executive Officer, Mind OC, for the work that went into establishing the Be Well OC Orange Campus.

Mr. Hunn and Chairman Do also presented Marshall Moncrief with a surprise recognition plaque from the Association for Community Affiliated Plans (ACAP). CalOptima Health had nominated Mr. Moncrief for ACAP's 11th Annual Leadership and Advocacy Award. Mr. Hunn announced that Mr. Moncrief received an honorable mention in ACAP's national award, which includes 74 plans, noting that even an honorable mention is a big deal.

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Mr. Moncrief thanked the Board and CalOptima Health, noting that he is honored to accept this award not only for Be Well OC, but also of all the many leaders and organizations that made Be Well OC possible.

Chairman Do provided comments regarding persevering in the face of opposition to have the strength to start the Be Well OC Campus. He thanked everyone who helped to make Be Well OC the first of its kind in Orange County and a valuable resource for Orange County and its residents in need of behavioral and mental health services.

Mr. Hunn also thanked the Board for its support in leading CalOptima Health into the future with its mission, "To serve member health with excellence and dignity, respecting the value and needs of each person," and its 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." Mr. Hunn presented each Board member with the CalOptima Health mission and vision framed and signed by the executive team to show their commitment to the mission and vision and their sincere thanks to the Board.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Mr. Hunn reviewed the Fast Facts as of December 2022 and noted that CalOptima Health currently serves 944,975 individuals, with a $4 billion dollar budget, which is 90% state funded and 10% federally funded. He noted that CalOptima Health receives no funding from the County of Orange.

For the current fiscal year, CalOptima Health spends 93.3% of every dollar on medical care, and 4.5% is the overhead cost to administer the program. Mr. Hunn noted that for a plan the size of CalOptima Health, the overhead is the lowest in the state.

CalOptima Health's Board-designated reserves are $568 million; its capital assets are $67 million; its resources committed by the Board are $451 million; and its resources that are unallocated and unassigned are $382 million. Mr. Hunn noted that CalOptima Health's total net assets are currently $1.4 billion.

Mr. Hunn also reviewed the CalOptima Health personnel data and noted there are 1,514 employees with a vacancy rate of about 10%, stating that this is CalOptima Health's lowest vacancy rate in some time.

Mr. Hunn reviewed the provider data, noting that CalOptima Health has over 10,000 providers, 1,475 primary care providers, and 9,292 specialists; 565 pharmacies; 44 acute and rehab hospitals; 34 community health centers; and 98 long term care facilities.

Mr. Hunn reported that CalOptima Health is directly responsible for care for 200,000 members and delegates the care of about 750,000 individuals to its medical groups and physician groups.

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, this month the average approval is within 17 hours; the state-mandated response is 72 hours. For urgent prior authorizations, the average approval is within 16 hours;

the state-mandated response is 72 hours. And for routine prior authorizations the average approval is 1.7 days; the state-mandated response is 5 days. Mr. Hunn noted that about a year ago he was reporting to the Board that CalOptima Health had a backlog of treatment authorizations that exceeded 15,000. Once that backlog was cleared, CalOptima Health has not had another backlog. He thanked Kelly Giardina, Dr. Pitts, and their teams for their hard work to achieve these results.

Mr. Hunn also updated the Board on recent California Advancing and Innovating Medi-Cal (CalAIM) activities, noting that on January 1, 2023, CalOptima Health launched five additional community supports, which now completes its offering of all 14 services that are part of CalAIM.

Mr. Hunn announced that CalOptima Health has added three new medical directors: Dr. Donna Frisch, as the medical director at CalOptima Health PACE center; Dr. Said Elshihabi, a board-certified neurosurgeon, who is leading the development of CalOptima Health's value-based neurosurgery and spine program; and Dr. Tanu Pandey, who is responsible for health areas including transgender health, appeals and grievances and quality.

Mr. Hunn also provided updates on Medi-Cal redetermination with the ending of the public health emergency (PHE), which will also cause a reduction in CalFresh funding for many CalOptima Health members. He noted that staff is working closely with the Social Services Agency to assist in help individuals navigate these upcoming changes.

Regarding Homeless Health Services, Mr. Hunn reported on a new program, the Housing and Homelessness Incentive Program (HHIP), which allows CalOptima Health to earn incentive funds for making investments and progress in addressing homelessness. On December 16, 2022, 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 its investment plan. This includes key deliverables in the multi-year effort. CalOptima Health will combine this funding with other committed dollars to make strategic investment throughout Orange County to mitigate the homelessness crisis. The remaining deliverables include two reports on the progress made toward HHIP's goals, with the potential to earn an addition $71 million.

Kelly Bruno-Nelson, Executive Director, CalAIM, noted that CalOptima Health is excited about the opportunity to earn up to $85 million dollars to help those who are unhoused in the community.

Mr. Hunn reported that DHCS will be performing a routine medical audit at the end of February. John Tanner, Chief Compliance Officer, provided a brief update on the upcoming routine medical audit, which will begin on February 27 and will continue through March 1, 2023. CalOptima Health is meeting the submission deadlines and submitted requested documents in preparation for the audit to regulators.

Director Contratto recognized Deanne Thompson, Executive Director, Marketing & Communications, noting that she received the CalOptima Health Community Report and was really impressed. She asked how many people received the Community Report. Ms. Thompson responded that the Community Report was sent to approximately 1,500 members of the community.

Vice Chair Corwin noted that it has been almost a year since CalOptima Health launched CalAIM and asked if staff had an idea of the penetration for its membership of the various programs. Ms. Bruno-Nelson responded that CalOptima Health started off with homeless health initiatives in January and since

then added other initiatives. She noted that according to the data, CalOptima Health has served nearly 10,000 individuals with housing navigation, housing support and tenancy. She also noted that CalOptima Health has seen a great deal of penetration with the medical tailored meals, which launched in July and about 4,000 individuals utilize those services.

PUBLIC COMMENTS

There were no requests for public comment.

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. 23-0202-01, 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. 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 Community Outreach and Program Summary

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 8-0-0)***

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REPORTS/DISCUSSION ITEMS

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

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors: 1.) Authorized 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.) Authorized 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.) Authorized 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 (Motion carried 8-0-0)***

12. Approve Actions Related to the Homeless Health Initiatives

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.

The Clerk noted for the record that staff had corrections to this action and read the amended action below.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Authorized 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; 2.) Authorized 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.) Authorized 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; and 4.) Authorized 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. (Motion carried 6-0-0; Directors Becerra and Mayorga recused)

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
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.

Vice Chair Corwin asked if the funding is for marketing. Yunkyung Kim, Chief Operating Officer, responded that this would be for marketing, for education, and also for direct services and direct assistance with applications for redetermination.

Mr. Hunn added that with the upcoming redetermination process approximately half of CalOptima Health members could lose eligibility.

Supervisor Chaffee noted the importance of ensuring that members can navigate the redetermination process, with the risk of so many individuals losing their insurance and made an amended motion of up to $6 million dollars, instead of the original motion of up to $3 million dollars.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized 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.) Authorized 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.) Authorized the Chief Executive Officer (CEO) to execute agreements as necessary to implement proposed activities. (Motion carried 6-0-0; Directors Becerra and Mayorga recused)***

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

Action: ***On motion of Director Shivers, seconded and carried, the Board of Directors: 1.) Authorized 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.) Authorized unbudgeted expenditures and appropriate funds in an amount up to $250,000 from existing reserves for the contract with Harder+Company. (Motion carried 8-0-0)***

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

Action: ***On motion of Director Tran, seconded and carried, the Board of Directors Approved 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. (Motion carried 8-0-0)***

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

Vice Chair Corwin noted that this action indicated that it was unbudgeted and asked if this was part of the previous allocation for Digital Transformation. Nancy Huang, Chief Financial Officer, responded that CalOptima Health's fiscal year 2022-23 budget allocated about $11 million in Operating expenses and $34 million in Capital expenses. A total of $45 million out of the $100 million was budgeted for Digital Transformation Strategy Year One. This new project utilizes funds from the remaining balance of the $100 million Digital Transformation allocation to fund the project in this fiscal year.

Action: ***On motion of Supervisor Chaffee seconded and carried, the Board of Directors: 1.) Approved 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.) Authorized 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.) Authorized 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. (Motion carried 8-0-0)***

ADVISORY COMMITTEE UPDATES

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

Christine Tolbert, Chair, Member Advisory Committee (MAC) provided an update on the recent activities of the Joint Meeting of the MAC and Provider Advisory Committee. She noted that recruitment is underway for 21 seats altogether. Ms. Tolbert thanked the Board for adding stipends for the member seats on the committees and for extending the term limits.

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
This item was pulled from the agenda at the top of the meeting.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS
Director Mayorga commented that today's meeting is a testament to Better, Together, and recognized the efforts that have led to the earlier celebrations.

Director Becerra commended Mr. Hunn and staff for the movement toward increasing access to health and better outcomes.

Before adjourning the meeting, Chairman Do announced that today is his last meeting on the CalOptima Health Board. He is resigning his seat and will make a recommendation to the Board of Supervisors to appoint Supervisor Vincente Sarmiento to the CalOptima Health Board. Chairman Do noted that eight years ago when he was appointed to the Board of Directors, serving as Supervisor of the First District, the First District had the largest number of CalOptima Health members. He noted that now, with the newly drawn districts, Supervisor Sarmiento, who serves the Second District, serves the largest share of CalOptima Health members. Chairman Do noted that this wraps up eight very productive years of his life and will look back at the changes that he and the Board made with pride.

ADJOURNMENT
Hearing no further business, Chairman Do adjourned the meeting at 3:17 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: March 2, 2023

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CalOptima Health Board Action Agenda Referral

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

Consent Calendar
3. Approve New CalOptima Health Policy GG.1213: Community Health Worker Services

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

Recommended Action
Approve new CalOptima Health Policy GG.1213: Community Health Worker Services, in accordance with regulatory requirements.

Background
The Department of Health Care Services (DHCS) added Community Health Workers (CHW) services as a Medi-Cal benefit starting on July 1, 2022. CHWs are also known as promotores, community health advocates, or community health representatives. CHWs are front-line health workers who are trusted community members with lived expertise and/or have an exceptionally close understanding of the community served. CHWs help address chronic conditions, preventive health care needs, and health-related social needs within their communities.

Discussion
CalOptima Health establishes new policies and procedures to implement federal and state laws, programs regulations, contracts, and business practices. Additionally, CalOptima Health staff performs annual policy reviews to add or update internal policies and procedures to ensure compliance with applicable requirements. In September 2022, DHCS released All-Plan Letter (APL) 22-016: Community Health Worker Services Benefit with guidance for the delivery of CHW services.

The purpose of the new policy is to ensure the processes and procedures for CalOptima Health CHW services comply with DHCS APL 22-016. This policy describes the provisions of CHW services and benefit eligibility criteria. This policy also defines CHW qualifications and supervising provider and billing requirements.

Fiscal Impact
The CalOptima Health Fiscal Year (FY) 2022-23 Operating Budget assumed forecasted Medi-Cal revenue for the CHW benefit would be sufficient to cover costs through June 30, 2023. The recommended action to approve CalOptima Health Policy GG.1213 is operational in nature and has no additional fiscal impact beyond what has been incorporated in the FY 2022-23 Operating Budget.

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Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, staff recommends that the CalOptima Health Board of Directors approve and adopt CalOptima Health Policy GG.1213: Community Health Worker Services for Medi-Cal Members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Policy GG.1213: Community Health Worker Services for Medi-Cal Members

/s/ Michael Hunn *02/23/2023*
Authorized Signature **Date**

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Policy:	GG.1213
Title:	**Community Health Worker Services**
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

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1 **I. PURPOSE**
2
3 This Policy describes the eligibility criteria for CalOptima Health Community Health Worker (CHW)
4 services and identifies the qualifications for becoming a CHW provider and provision of CalOptima
5 Health CHW as a benefit.
6
7 **II. POLICY**
8
9 A. CHW services are preventive health services delivered by a CHW to prevent disease, disability, and
10 other health conditions or their progression; to prolong life; and to promote physical and mental
11 health.
12
13 B. CHW services may assist with a variety of concerns impacting CalOptima Health and Health
14 Network Members, including but not limited to, the control and prevention of chronic conditions or
15 infectious diseases, behavioral health conditions, and need for preventive services.
16
17 C. CHW services can help Members receive appropriate services related to perinatal care, preventive
18 care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health,
19 aging, injury, and domestic violence and other violence prevention services.
20
21 D. CHWs may include individuals known by a variety of job titles, such as promotors, community
22 health representatives, navigators and other non-licensed public health workers, including violence
23 prevention professionals, with the qualifications specified in this policy.
24
25 E. CalOptima Health and a Health Network must not require prior authorization for CHW services as
26 preventive services for the first twelve (12) units.
27
28 F. CalOptima Health and Health Networks shall ensure contracted Supervising Providers employing
29 CHWs meet the Provider requirements and qualification requirements as stated below.
30
31 G. CalOptima Health and a Health Network shall monitor organizations employing CHWs to ensure
32 compliance with the requirements listed below regarding CHW Supervising Providers,
33 documentation, plan of care, Provider enrollment, billing, and access to services.
34

H. CHWs and Members receiving CHW services, as applicable, shall be entitled to Grievance and Appeals procedures.

III. PROCEDURE

A. CHW Provider Requirement and Qualifications

1. Required CHW qualifications:

a. CHWs must have lived experience that aligns with and provides a connection between the CHW, and the Member or population being served.

b. Supervising Providers must maintain evidence of this experience.

c. CHWs must demonstrate, and Supervising Provider must maintain evidence of, minimum qualifications through one of the following pathways, as determined by the Supervising Provider.

i. Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates:

a) CHW Certificate: A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and Social Determinants of Health (SDOH), as determined by the Supervising Provider. Certificate programs must also include field experience as a requirement.

i) A CHW Certificate allows a CHW to provide all covered CHW services described in this policy, including violence prevention services.

b) Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training form the Urban Peace Institute.

i) A VPP Certificate allows a CHW to provide CHW violence prevention services only.

ii) A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.

ii. Work Experience Pathway: CHWs must provide proof of the following demonstrating qualifications:

a) At least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years.

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b) Demonstrated skills and practical training in the areas described above, as determined and validated by the Supervising Provider.

c) A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Member.

2. CHWs must complete a minimum of six hours of additional relevant training annually and the Supervising Provider must maintain evidence of this training.

B. Supervising Provider

1. The Supervising Provider ensures that CHWs meet the qualifications listed below, oversees CHWs and the services delivered to CalOptima Health Members, and submits claims for services provided by CHWs.

2. The Supervising Provider must be a licensed Provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO).

3. Supervising Providers must provide Direct Or Indirect Oversight to CHWs.

4. CalOptima Health and Health Networks must ensure that Supervising Providers or their Subcontractors contracting with or employing CHWs to provide covered CHW services to CalOptima Health and Health Networks' Members, verify that CHWs have adequate supervision and training.

5. A written care plan must be written by one or more individual licensed Providers, which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider.

6. Supervising Providers do not need to be the same entity as the Provider who made the referral for CHW services.

7. Supervising Providers do not need to be physically present at the location when CHWs provide services to Members.

8. Management and day-to-day supervision of CHWs as employees may be delegated as determined by the Supervising Provider.

9. Supervising Provider is responsible for ensuring the provision of CHW services complies with all applicable requirements.

C. Eligibility Criteria

1. CHW services require a written recommendation submitted to CalOptima Health by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.

a. Other licensed practitioners who can recommend CHW services within their scope of practice include physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers,

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licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

2. Licensed Providers must ensure that a Member meets eligibility criteria before recommending CHW services.

3. CHW services are considered medically necessary for Members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services.

4. The recommending Provider must determine whether a Member meets eligibility criteria for CHW services based on the presence of one or more of the following:

   a. Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.

   b. Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.

   c. Any stressful life event presented via the Adverse Childhood Events (ACE) screening.

   d. Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.

   e. Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity.

   f. One or more visits to a hospital emergency department (ED) within the previous six months.

   g. One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.

   h. One or more stays at a detox facility within the previous year.

   i. Two or more missed medical appointments within the previous six months.

   j. Member expressed need for support in health system navigation or resource coordination services.

   k. Need for recommended preventive services, including updated immunizations, annual dental visit, and well childcare visits for children.

5. CHW violence prevention services are available to Members who meet any of the following circumstances as determined by a licensed practitioner:

   a. The Member has been violently injured as a result of community violence.

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b. The Member is at significant risk of experiencing violent injury as a result of community violence.

c. The Member has experienced chronic exposure to community violence.

6. CHW violence prevention services are specific to community violence (e.g., gang violence), and CHW services can be provided to Members for interpersonal/domestic violence through other pathways with training/experience specific to those needs.

D. CalOptima Health and a Health Network must also use data driven approaches to determine and understand priority populations eligible for CHW services, including but not limited to, using past and current Member utilization/Encounters, frequent hospital admissions or ED visits, demographic and SDOH data, referrals from the community (including Provider referrals), and needs assessments, etc.

1. CalOptima Health and a Health Network will use available data sources to help identify Members who meet the eligibility criteria for CHW services and attempt outreach to qualifying Members and their Providers to encourage utilization of CHW services.

E. Documentation

1. CHWs are required to document the dates and time/duration of services provided to Members.

2. Documentation must be accessible to the Supervising Provider upon their request.

F. Plan of Care

1. For Members who need multiple ongoing CHW services or continued CHW services after 12 units of services as defined in the Medi-Cal Provider Manual, a written care plan must be written by one or more individual licensed Providers, which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider.

2. The Provider ordering the plan of care does not need to be the same Provider who initially recommended CHW services or the Supervising Provider for CHW services.

3. CHWs may participate in the development of the plan of care and may take a lead role in drafting the plan of care if done in collaboration with the Member's care team.

4. The plan of care may not exceed a period of one year.

5. Plan of care must:

a. Specify the condition that the service is being ordered for and be relevant to the condition;

b. Include a list of other health care professionals providing treatment for the condition or barrier;

c. Contain written objectives that specifically address the recipient's condition or barrier affecting their health;

d. List the specific services required for meeting the written objectives; and

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e. Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the plan's objectives.

6. A licensed Provider must review the Member's plan of care at least every six months from the effective date of the initial plan of care.

7. The licensed Provider must determine if progress is being made toward the written objective and whether services are still medically necessary.

G. Covered CHW Services including Violence Prevention Services

1. CHW services can be provided as individual or group sessions and can be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings. There are no service location limits.

2. Services include Health Education, Health Navigation, Screening and Assessment, and Individual Support or Advocacy.

3. Services may be provided to a parent or legal guardian of a Member under age 21 for the direct benefit of the Member, in accordance with a recommendation from a licensed Provider.

   a. A service for the direct benefit of the Member must be billed under the member's Medi-Cal ID.

4. CHWs may render street medicine and bill CalOptima Health or a Health Network for appropriate and applicable services within their scope of service.

5. Covered CHW services do not include any service that requires a license. The following services are non-covered CHW services:

   a. Clinical case management/care management that requires a license;

   b. Childcare;

   c. Chore services, including shopping and cooking meals;

   d. Companion services;

   e. Employment services;

   f. Helping a Member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care;

   g. Delivery of medication, medical equipment, or medical supply;

   h. Personal Care services/homemaker services;

   i. Respite care;

   j. Services that duplicate another covered Medi-Cal service already being provided to a Member;

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k. Socialization;

l. Coordinating and assisting with transportation;

m. Services provided to individuals not enrolled in Medi-Cal, except as noted above; and

n. Services that require a license.

6. Although CHWs may provide CHW services to Members with mental health and/or substance use disorders, CHW services do not include Peer Support Services as covered under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs.

   a. CHW services are distinct and separate from Peer Support Services.

H. Provider Enrollment

1. All Network Providers, including those that will operate as Supervising Providers, are required to enroll as Medi-Cal Providers if there is a state-level enrollment pathway for them to do so.

2. Providers must be vetted by CalOptima Health and Health Networks in order to participate as Supervising Providers, as described below.

   a. CalOptima Health and Health Networks must create and implement their own processes to ensure Supervising Providers, with a state-level Medi-Cal enrollment pathway, follow the standard process for enrolling through the DHCS' Provider Enrollment Division.

   b. To include a Supervising Provider in their Networks when there is no state-level Medi-Cal enrollment pathway, the CalOptima Health will vet the qualifications of the Provider or Provider organization to ensure they can meet the standards and capabilities required to be a Supervising Provider, and CalOptima Health will create and implement its own processes to do this.

3. CalOptima Health and Health Networks will ensure that Providers and Subcontractors that serve as CHW Supervising Providers are certifying that their CHWs have the appropriate training, qualifications, and supervision.

4. CalOptima Health and Health Networks will consider, at minimum, the following CHW Supervising Provider characteristics:

   a. The ability to receive referrals from licensed practitioners for CHW benefits;

   b. Validating Supervising Providers are appropriately assessing CHWs have sufficient experience to provide services;

   c. Ensuring Supervising Providers have the ability to submit claims or Encounters to CalOptima Health using standardized protocols;

   d. Ensuring Supervising Providers have business licensing that meet industry standards;

   e. Have the capability to comply with all reporting and oversight requirements;

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f. Have monitoring processes for fraud, waste, and/or abuse of CHW services;

g. Are able to process for monitoring recent history of criminal activity of Supervising Providers; and

h. Are able to process for monitoring history of liability claims against the Supervising Provider.

I. Billing

1. CHW services must be reimbursed through a CHW Supervising Provider in accordance with its Provider contract, unless reimbursed directly through CalOptima Health and/or Health Networks if the CHW is a Medi-Cal enrolled Provider.

2. Since CHW services are a preventive service, CalOptima Health and Health Networks must not require prior authorization for CHW services; however, quantity limits can be applied based on goals detailed in the plan of care.

3. CalOptima Health and Health Networks must not establish unreasonable or arbitrary barriers for accessing coverage.

4. Claims for CHW services must be submitted by the Supervising Provider with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.

5. CalOptima Health and Health Networks and all Subcontractors and Network Providers must not double bill for activities that are duplicative to services reimbursed through other benefits such as Enhanced Care Management (ECM), which is inclusive of the services within the CHW benefit.

6. CalOptima Health and Health Networks must ensure that Providers do not bill for CHW services and ECM for the same Member for the same time period.

7. Tribal clinics may bill CalOptima Health for CHW services at the Fee-for-Service rates using the CPT codes as outlined in the Provider Manual.

J. Access Requirements

1. CalOptima Health and Health Networks must ensure and monitor sufficient Provider Networks within their service areas, including for CHW services.

2. CalOptima Health is responsible for ensuring that Health Networks, Subcontractors and Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters, and that these requirements will be communicated to all Health Networks, Subcontractors and Providers.

IV. ATTACHMENT(S)

Not Applicable

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V. **REFERENCE(S)**

A. CalOptima Health Provider Manual
B. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-016: Community Health Worker Services Benefit
C. California State Plan Amendment (SPA) 22-0001
D. Title 42 Code of Federal Regulations (CFR) Section 440.130(c)

VI. **REGULATORY AGENCY APPROVAL(S)**

Date	Regulatory Agency	Response
12/02/2022	Department of Health Care Services (DHCS)	Pre-Approved as Submitted

VII. **BOARD ACTION(S)**

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

VIII. **REVISION HISTORY**

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	GG.1213	Community Health Worker Services	Medi-Cal

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1 **IX. GLOSSARY**
2

Term	Definition
Appeal	A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
California Medicaid State Plan	A comprehensive description of California's State Medicaid Program, based upon the requirements of Title XIX of the Social Security Act, that serves as a contractual agreement between the State of California and the federal Centers for Medicare and Medicaid Services.
CalOptima Health Community Supports	Community Supports that CalOptima Health has received approval from the Department of Health Care Services (DHCS) to provide.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and CalOptima Health Community Supports (as provided under the California Advancing and Innovating Medi-Cal initiative) for Members meeting eligibility criteria, or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
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.
Direct Oversight	This includes, but is not limited to, guiding CHWs in providing services, participating in the development of a plan of care, and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements.
Encounter	Any unit of Covered Services provided to a member by a Health Network regardless of reimbursement methodology.

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Term	Definition
Grievance	An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision.
Health Education	Promoting a Member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics. Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a Member's health or ability to self-manage their health conditions.
Health Navigation	Providing information, training, referrals, or support to assist Members to access health care, understand the health care delivery system, or engage in their own care. This includes connecting Members to community resources necessary to promote health; address barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs. Under Health Navigation, CHWs can also: i. Serve as a cultural liaison or assist a licensed health care Provider to participate in the development of a plan of care, as part of a health care team; ii. Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or iii. Help a Member enroll or maintain enrollment in government or other assistance programs that are related to improving their health if such navigation services are provided pursuant to a plan of care.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Indirect Oversight	This includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements.
Individual Support or Advocacy	Assisting a Member in preventing the onset or exacerbation of a health condition or preventing injury or violence. This includes peer support as well if not duplicative of other covered benefits.

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Term	Definition
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.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Screening and Assessment	Providing screening and assessment services that do not require a license and assisting a Member with connecting to appropriate services to improve their health.
Social Determinants of Health (SDOH)	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. Social Determinants of Health can be grouped into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Social Determinants of Health have a major impact on people's health, well-being, and quality of life. Examples of SDOH include safe housing, transportation, and neighborhoods, racism, discrimination, and violence, education, job opportunities, and income, access to nutritious foods and physical activity opportunities, polluted air and water, and language and literacy skills.
Subcontractor	An individual or entity who has a Subcontract with CalOptima Health that relates directly or indirectly to the performance of CalOptima Health's obligations under contract with DHCS.
Supervising Provider	The organization employing or otherwise overseeing the CHW, with which CalOptima Health contracts. The Supervising Provider ensures that CHWs meet required qualifications, oversee CHWs and the services delivered to CalOptima Health Members, and submit claims for services provided by CHWs. The Supervising Provider must be a licensed Provider, a hospital, an outpatient clinic, a Local Health Jurisdiction (LHJ), or a Community-Based Organization (CBO).

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

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

Consent Calendar
4. Approve New CalOptima Health Grievance and Appeals Resolution Services Policy MA.9015p

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Action
Approve Grievance and Appeals Resolution Services Policy MA.9015p: Standard Integrated Appeals.

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

Policy MA.9015p: Standard Integrated Appeals is a new policy that accommodates requirements from the Centers for Medicare & Medicaid Services' (CMS) Addendum to the Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeal Guidance for Applicable Integrated Plans (AIPs) and the CalAIM Dual Eligible Special Needs Plans Policy Guide, Contract Year 2023. This policy (a) merges applicable language and requirements from policies MA.9003: Standard Pre-Service Appeal and MA.9005: Payment Appeal that remain unchanged for appeals related to services prior to the transition of OneCare Connect to OneCare, CalOptima Health's AIP; and (b) incorporates new and distinct requirements, which apply to AIPs.

Policy MA.9015p: Standard Integrated Appeals Process and Procedures describes CalOptima Health's process, role, and responsibilities to address Part C appeals and describes the procedures regarding OneCare members specific to a standard process for integrated appeals involving Medi-Cal and Medicare covered services and benefits, consistent with CMS and Department of Health Care Services requirements.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health's Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation
CalOptima Health staff recommends that the Board of Directors approve and adopt the presented policy and procedure to ensure continued compliance of its operations with applicable state and federal laws and regulations.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. MA.9015p Standard Integrated Appeals
2. Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans
3. CalAIM Dual Eligible Special Needs Plans. Policy Guide, Contract Year 2023

/s/ Michael Hunn *02/23/2023*
Authorized Signature **Date**

Policy:	MA.9015p
Title:	**Standard Integrated Appeals**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2023
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

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1 **I. PURPOSE**
2
3 This policy addresses Part C Appeals and describes the procedures specific to a standard process for
4 Integrated Appeals involving Medi-Cal and Medicare Covered Services and benefits, consistent with the
5 Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS)
6 requirements.
7
8 **II. POLICY**
9
10 A. CalOptima Health shall establish and maintain a process that addresses the receipt, handling, and
11 disposition of a Part C Integrated Appeal (hereinafter, Appeal) involving Medi-Cal and/or Medicare
12 Covered Services and benefits, in accordance with applicable statutes, regulations, contractual
13 requirements, and the terms and conditions of this policy.
14
15 B. Grievance and Appeals Resolution Services (GARS) staff shall accept, track, and report all Appeals.
16
17 C. Subject to the provisions of this policy, an Appealing Party has the right to request an Appeal of:
18
19 1. A Pre-Service Organization Determination; or
20
21 2. An Organization Determination regarding payment for services rendered to an Enrollee.
22
23 a. If a Provider files an appeal regarding payment for services rendered on behalf of an
24 Enrollee, the Provider may not charge a fee to the Member for doing so.
25
26 D. A Member shall have the right to an attorney, or other representation, in the Appeal process.
27
28 E. Subject to the provisions of this policy, CalOptima Health shall process an Appeal within thirty (30)
29 calendar days, after receipt of the Appeal.
30
31 F. Subject to the provisions of this policy, CalOptima Health shall process an Appeal involving Part B
32 drugs within seven (7) calendar days after receipt of such Appeal type.
33
34 1. Part B drug cases do not apply to Appeals regarding payment for services already rendered to an
35 Enrollee.

2. Part B drug timeframes cannot be extended.

G. If an Appeal involves multiple issues, CalOptima Health shall process each issue separately and simultaneously under the appropriate process.

H. The processing timeframe for a standard Appeal shall begin when CalOptima Health, any unit within CalOptima Health, or a delegated entity (including those not responsible for processing the request) receives an Appeal request.

I. If the Appealing Party believes that CalOptima Health's thirty (30) calendar day Appeal process for Appeals of a Pre-Service Organization Determination may seriously jeopardize the Enrollee's life, health, or ability to regain maximum function, the Enrollee, the Enrollee's Authorized Representative, or physician may request an expedited Appeal, in accordance with CalOptima Health Policy MA.9004: Expedited Pre-Service Appeal.

J. All CalOptima Health departments shall respond promptly, within designated timeframes, to any inquiry related to an Appeal.

K. CalOptima Health shall ensure that there is no discrimination against an Enrollee on the grounds that such Enrollee filed an Appeal, in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination.

L. CalOptima Health shall ensure that Enrollees have equal access to, and can fully participate in, the Appeal process by providing assistance to Enrollees with limited English proficiency (LEP), vision disorders, or other communicative impairments and ensuring such Enrollees have the same level of access to CalOptima Health representatives and information regarding Appeals as Enrollees who are proficient in English, in accordance with CalOptima Health Policy MA.4002: Cultural and Linguistic Services, as follows:

1. Translation of forms and responses;

2. Interpretation services;

3. Telephone relay systems; and

4. Other reasonable accommodations, as appropriate.

M. CalOptima Health shall provide all parties to an Appeal with reasonable opportunity to present evidence, or allegations of fact or law, related to the issue in dispute, in person, or in writing (e.g., by telephone, fax, or hand delivered to CalOptima Health's physical location). CalOptima Health shall take all evidence into account when making its decision.

1. CalOptima Health shall inform the party of their right to request a fourteen (14) day extension if the party feels they will need additional time to submit such evidence.

N. Upon an Enrollee's request for a copy of the contents of the case file, at any point during the Appeals process, CalOptima Health shall:

1. Provide an Enrollee with a copy of the contents of the Enrollee's case file, including, but not limited to, a copy of supporting Medical Records, any new or additional evidence considered, relied upon, or generated, and other pertinent documents, records, or information used in

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connection with the Appeal and to support CalOptima Health's decision. Where an Enrollee has an alternate format preference, the case file contents must be provided in that format.

a. Make every reasonable effort to accommodate an Enrollee's request for case file material (e.g., allowing the enrollee or authorized representative to obtain the material at CalOptima Health's location or mailing the material to any address specified by the Enrollee or Authorized Representative) and provide such material in advance of making the Appeal decision.

b. Abide by all applicable federal and state laws regarding confidentiality and disclosure for mental health records, medical records, or other health information (Under Title 45 Code of Federal Regulations (C.F.R.) 164 Subpart E, regarding the privacy of individual identifiable health information).

c. CalOptima Health shall provide records at no cost.

O. CalOptima Health shall notify Enrollees about any changes to its Appeals procedures thirty (30) days in advance of the effective date of change.

P. CalOptima Health shall notify an Enrollee of the Appeal process:

1. Upon initial enrollment, and annually thereafter;

2. In the OneCare Evidence of Coverage (EOC) and periodic Enrollee newsletters;

3. In all notices of adverse Organization Determination;

4. Upon involuntary disenrollment; and

5. Upon the Enrollee's request.

Q. Non-contracted Provider Appeal requests related to claim disputes shall be processed in accordance with CalOptima Health Policy MA.9009: Non-Contract Provider Payment Appeals.

R. Any potential quality of care issues shall be referred to the Quality Improvement (QI) Department in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

S. Continuation of Benefits While Pending an Appeal

1. An Enrollee or an Enrollee's Authorized Representative or treating Provider, may request that the Enrollee continue to receive the previously authorized service or item while the Appeal is pending if:

a. The request for continuation was submitted by the later of the following: within ten (10) calendar days after CalOptima Health send the notice of its integrated Organization Determination, or the intended effective date of the integrated Organization Determination;

b. The Appeal was timely submitted;

c. The services meet the continuation of coverage standards;

d. The Appeal involves the termination, suspension, or reduction of previously authorized services; and

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d. The period covering the initial authorization has not yet expired.

2. If the Provider requests that the benefits continue while the Appeal is pending, pursuant to Title 42 C.F.R. §422.632 and consistent with state law or other applicable laws, the Provider must obtain the written consent of the Enrollee to request the Appeal on behalf of the Enrollee.

   a. If the Provider does not provide the Enrollee's written consent to continue benefits at the time the request is made, but the Appeal is otherwise valid, CalOptima Health should begin processing the Appeal.

   b. The consent must state that the Enrollee has given the Provider permission to request that the service or item continue while the Appeal is pending.

   c. CalOptima Health shall not provide continuation of benefits unless it receives the Enrollee's written consent (delivered either via the Provider or directly from the Enrollee or their Authorized Representative requesting continuation of benefits).

   d. Such request must be received in accordance with the timeframes outlined in Section II.S.1. of this policy.

3. If the request to continue the service or items meets the requirements listed in Section II.S.1. of this Policy, CalOptima Health must continue to provide the service or item, at the previously authorized level until:

   a. The Enrollee withdraws the request for the Appeal,

   b. CalOptima Health issues an Appeal determination that is unfavorable to the Enrollee,

   c. For Medi-Cal Covered Services and items only:

      i. The Enrollee fails to file a request for a State Fair Hearing and continuation of benefits, within ten (10) calendar days after CalOptima Health sends the notice of the Appeal;

      ii. The Enrollee withdraws the Appeal or request for a State Fair Hearing; or

      iii. A State Fair Hearing Officer issues a hearing decision adverse to the Enrollee.

4. If CalOptima Health or the State Fair Hearing entity issues a decision that is adverse to the Enrollee, CalOptima Health or the State agency may not pursue recovery for costs of services furnished CalOptima Health while the Integrated Appeal was pending if the services were furnished solely under the requirements of Title 42 C.F.R. §422.632.

5. If, after the Appeal decision is final, an Enrollee requests that Medi-Cal Covered Services continue until a State Fair Hearing decision is made, state rules on recovery costs, in accordance with the requirements of Title 42 C.F.R. §438.420(d), apply for costs incurred for items and services provided the Enrollee after the date that the Appeal decision was made.

III. PROCEDURE

A. Parties to a Standard Appeal

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5. An Enrollee, an individual appointed by the Enrollee (e.g., relative, friend, advocate, attorney), or any person authorized under State law acting as the Enrollee's Authorized Representative may file an Appeal. If an Authorized Representative files an Appeal, he or she shall submit documentation of such appointment, as follows:

   a. Appropriate legal documents, or authority, supporting such appointment, or another form that meets state and Medicare requirements (as applicable to the Covered Service or benefit); or

   b. Appointment of Representative Form or equivalent written notice (i.e., Representative Form) signed by both the Enrollee and the Enrollee's Authorized Representative, except if an attorney acts as the Enrollee's Authorized Representative. If an attorney acts as the Authorized Representative, the Authorized Representative may submit a Request for Appointment of Representative Form, or equivalent written notice, signed by the Enrollee only.

   c. For cases only involving a Medi-Cal covered benefit, CalOptima Health may accept a written authorization from an Enrollee that complies with state Medi-Cal requirements (even if such authorization does not contain every element described under Section 20.2 of the CMS Grievance and Appeals Guidance).

6. A court acting in accordance with state or other applicable laws can authorize an individual to act on behalf of the Enrollee in filing an Appeal.

   a. Authorized Representatives could include, but is not limited to a court appointed guardian, individual with durable power of attorney, a health care proxy, a person designated under a health care consent statute, executor of an estate.

   b. The Authorized Representative shall produce and submit appropriate legal papers supporting his or her appointment under state law (a Representative Form is not required).

3. A Non-Contracted Provider, on his, her, or its own behalf, may file an Appeal for a denied claim, in accordance with CalOptima Policy MA.9009: Non-Contracted Provider Payment Appeals, if such Non-Contracted Provider:

   a. Furnished a Covered Service to a Member; and

   b. Completes a Waiver of Liability (WOL) statement that states that the Non-Contracted Provider shall not bill the Member for the Covered Service, regardless of the outcome of the Appeal.

4. A Provider who is providing treatment to the Enrollee may file an Appeal on behalf of the Enrollee. The Provider must give the Enrollee notice of filing the Appeal.

   a. A Provider who is providing treatment to the Member may, upon providing notice to the Member, file a standard Appeal on behalf of the Member, but may not file an expedited Appeal related to a payment request on behalf of the Member, in accordance with this policy.

   b. If the Enrollee's records indicate that he or she has not previously visited the requesting Provider, CalOptima Health shall undertake reasonable efforts to confirm that the Enrollee has received the appropriate notification of the Appeal request.

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c. A Provider shall not charge an Enrollee to act as the Enrollee's Authorized Representative.

5. Any other Provider or entity (other than CalOptima) determined to have an appealable interest.

B. Request for an Appeal (Level 1 Appeal)

1. Timely Filing Requirements: An Appealing Party may request an Appeal verbally, by telephone, in-person with the Customer Service Department, or in writing to CalOptima Health within sixty (60) calendar days from the date of the receipt of notice of an initial adverse Organization Determination, or an Explanation of Benefits (EOB).

a. CalOptima Health may accept a request for an Appeal filed after the sixty (60) calendar day limit, if the Appealing Party submits a written request for an extension of the timeframe for good cause.

i. In its request for an extension, the Appealing Party must include a written statement explaining why the request for Appeal was not filed on time.

ii. If the request for an extension submitted does not include an explanation as to why the request for Appeal was not filed on time, CalOptima Health may attempt to obtain information supporting good cause for the late filing.

iii. In making its determination, CalOptima Health should consider the circumstance that kept the party from making the request on time and whether any organization actions may have misled the party.

iv. CalOptima Health shall ensure that there is no discrimination against an Enrollee in the determination of good cause justification when an Appeal request is outside the sixty (60) calendar day limit, in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination.

v. Instances where good cause may exist include, but are not limited to:

a) The Appealing Party either not personally receiving the notice for the adverse initial determination or receiving it late;

b) The Appealing Party was seriously ill which prevented a timely Appeal;

c) Death or serious illness in the Appealing Party's immediate family;

d) An accident causing important records to be destroyed;

e) Difficulty in locating and/or receiving necessary documents within the established time limits;

f) Incomplete or incorrect information regarding the Appeal process;

g) The Appealing Party's lack of capacity to understand the Appeal filing timeframe;

h) The Appealing Party sent the request to an incorrect address, in good faith, within the established time limit;

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i) The delay resulted from additional time required to produce Enrollee documents in an accessible format pursuant to CalOptima Health Policy MA.4002: Cultural and Linguistic Services; or

j) The delay resulted from the Appealing Party having sought and received help from an auxiliary resource (such as a state Health Insurance Assistance Program or a senior center), on account of his or her disability, in order to be able to file the Appeal.

b. If CalOptima Health denies the Appealing Party's request for good cause extension, CalOptima Health must dismiss such request in accordance with Section III.D.5. of this Policy and the Appealing Party may file a Grievance in accordance with CalOptima Health Policy MA.9002: Enrollee Grievance Process.

2. An Appeal request shall be considered received on the date and time:

   a. When any department within CalOptima Health initially stamps a document received by regular mail;

   b. A delivery service (that has the ability to track when a shipment is delivered) delivers the document to CalOptima Health (or its designee);

   c. A faxed document is successfully transmitted to CalOptima Health, as indicated on the fax transmission report;

   d. A verbal request is made by telephone with Customer Service;

   e. A message is left on CalOptima Health's voicemail system (if a voicemail system is utilized to accept the Appeal request or supporting statements after normal business hours); or

   f. An Appeal request is received through CalOptima Health's website.

3. Withdrawal of an Appeal Request: An Appealing Party may withdraw the request at any time before CalOptima Health renders a decision by notifying CalOptima Health of such withdrawal verbally or in writing.

   a. If the request to withdraw is filed with CalOptima Health as appropriate, CalOptima Health shall dismiss the Appeal request in accordance with Section III.D.5. of this Policy.

   b. The request to withdraw the Appeal must be filed by the Appealing Party who initially requested the Appeal.

   c. If that party withdraws the Appeal request verbally, CalOptima Health shall:

      i. Clearly document the date and reason why the Appealing Party chose not to proceed with the Appeal.

      ii. Mail all parties a written confirmation of the withdrawal within three (3) calendar days from the date of the verbal request using the Notice of Dismissal of Appeal Request as detailed in Section III.D.5.h. of this Policy.

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d. If the withdrawal request is received after CalOptima Health has forwarded the case file to the Independent Review Entity (IRE), then CalOptima Health must forward the withdrawal request to the IRE for processing.

4. Any unit within CalOptima Health or a delegated entity not responsible for processing Appeals that incorrectly receives an Appeal request, shall submit such request to the CalOptima Health Grievance and Appeals Resolution Services email inbox: grievancemailbox@caloptima.org, as expeditiously as possible for requests submitted in writing, or transfer to the CalOptima Health Customer Service Department for verbal requests.

5. An Appealing Party may request an expedited Appeal for Appeals of a Pre-Service Organization Determination, in accordance with CalOptima Health Policy MA.9004: Expedited Pre-Service Appeal.

C. Standard Appeal Timeframe (Level 1 Appeal)

1. Subject to the provisions of this Policy, CalOptima Health shall make an Appeal determination, as expeditiously as the Enrollee's case requires, based on the Enrollee's health status, but not later than thirty (30) calendar days upon receipt of a request for an Appeal for items and services. Part B drug timeframes cannot be extended, and a decision will be rendered within seven (7) calendar days of receipt.

2. CalOptima Health may extend the timeframe for an Appeal determination for items and services up to fourteen (14) calendar days upon the Enrollee's request (except for Part B drugs); or if CalOptima Health needs additional information to make a determination and there is a reasonable likelihood that receipt of such information would lead to approval of the request if received, and such extension is justified and in the Enrollee's interest due to the need for additional medical evidence from a non-contracted Provider that may change CalOptima Health's decision to deny an item or service; or it is the Enrollee's best interest due to extraordinary, exigent, or other non-routine circumstances, such as a natural disaster. If CalOptima Health extends the timeframe for an Appeal determination, it shall notify the Enrollee as follows:

a. Verbal Notification: Notify the Appealing Party and all involved parties of the decision to extend the timeframe for an Appeal determination, verbally, no later than one (1) business day from such decision; and

b. Written Notification: Notify the Enrollee of the decision, in writing, no later than two (2) calendar days of the verbal notice and include:

i. The reason for the extension; and

ii. The Enrollee's right to file an expedited Grievance, in accordance with CalOptima Health Policy MA.9002: Enrollee Grievance Process, if he or she disagrees with CalOptima Health's decision to extend the timeframe.

D. Standard Appeal Processing (Level 1 Appeal)

1. Upon receipt of a request for Appeal, GARS staff shall:

a. Date stamp, and code the request with the appropriate categorization in the database; and

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b. Prepare a case file that contains the original request for Appeal, notice of CalOptima Health's or the Health Network's adverse Organization Determination, and all other correspondence.

2. If after a standard Appeal request is initiated and a Provider indicates that the Enrollee's health requires an expedited decision, the Provider may request to change the review priority (i.e., from standard to expedited).

   a. CalOptima Health shall begin the applicable expedited review period at the time CalOptima Health receives the Provider's request to expedite the decision.

   b. Change of review priority does not allow for extra review time.

   c. If the remaining standard review period is less than the applicable expedited review period, the original standard deadline shall still apply.

3. If an Enrollee makes a verbal Appeal, GARS staff shall request confirmation of such Appeal as follows:

   a. GARS staff shall confirm with the party receiving the verbal Appeal that he or she verified with the Appealing Party the facts and basis of the request for Appeal. The validated verbal acknowledgment shall be documented in the CalOptima Health database.

   b. GARS staff shall send an acknowledgement letter for verbal Appeal requests to the Enrollee to confirm the facts and basis of the Appeal to ensure the request is properly and accurately noted and addressed by CalOptima Health. Notice should advise the Enrollee to contact CalOptima Health if the acknowledgement letter does not correctly capture the Enrollee's request.

4. GARS staff shall verify that the request meets criteria for processing as an Appeal:

   a. GARS staff shall verify that the requestor is an Enrollee, the Enrollee's Authorized Representative, treating physician acting on behalf of the Enrollee, or staff of physician's office acting on said physician's behalf or working under the direction of the physician. If the requestor is not one of these parties, GARS staff shall make the following attempts to secure the missing documentation:

      i. Written Attempt: If CalOptima Health does not receive documentation of the requestor's status as the Enrollee's Authorized Representative, GARS staff shall request, in writing, that the requestor submit documentation of the requestor's status as the Enrollee's Authorized Representative. Included with the request, staff shall send an Appointment of Representative Form, and an Authorization for Use and Disclosure of Protected Health Information Form to avoid delays for an Appeal determination.

      ii. Verbal Attempt: If CalOptima Health does not receive documentation of the requestor's status as the Enrollee's Authorized Representative, GARS staff shall make and document at least two (2) telephone calls to the requestor in an attempt to obtain documentation.

      iii. If CalOptima Health does not receive documentation (i.e., any type of Representative Form) of the requestor's status as the Enrollee's Authorized Representative within thirty (30) calendar days after CalOptima Health's receipt of the Appeal, CalOptima

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1 Health shall dismiss the Appeal as detailed in Section III.D.5. of this Policy due to lack
2 of the required documentation to process the request.
3
4 b. GARS staff shall verify whether:
5
6 i. CalOptima Health or a Health Network denied a service.
7
8 a) If CalOptima Health or a Health Network did not deny a service, GARS staff shall
9 contact the Appealing Party to determine the purpose of the request for Appeal.
10
11 ii. CalOptima Health or a Health Network denied a claim for payment.
12
13 a) If CalOptima Health or a Health Network did not process the claim, GARS staff
14 shall transmit the claim to the CalOptima Health Claims Department or the Health
15 Network for processing and shall notify the Appealing Party who requested the
16 Appeal, of CalOptima Health's claims processing and Organization Determination
17 process.
18
19 b) If CalOptima Health or a Health Network did not deny the claim, GARS staff shall
20 determine if the Member disputes a cost-sharing determination, or if the Provider
21 who requests an Appeal disputes the payment amount.
22
23 c. GARS staff shall review the notice of adverse Organization Determination to verify that
24 CalOptima Health received the request for Appeal within sixty (60) days after the date of
25 notice. If CalOptima Health received the request later than sixty (60) days after the date of
26 notice, GARS staff shall provide the over sixty (60) day letter to the Appealing Party,
27 indicating that the request does not meet criteria for Appeal unless the Appealing Party
28 provides good cause for an extension, in accordance with Section III.B.1.a.5). of this policy.
29
30 d. If CalOptima Health determines an Enrollee's Appeal was misclassified as a Grievance and
31 later discovers the error, CalOptima Health shall notify the Enrollee, in writing, of the
32 misclassified Appeal, and immediately process the reclassified Appeal through the Appeal
33 process in accordance with this Policy. CalOptima Health shall consider the date of receipt
34 of the original request as the date of receipt of the Appeal and not the date the
35 misclassification was discovered.
36
37 e. If GARS staff identifies a potential quality of care issue, he or she shall refer the issue to the
38 Quality Improvement (QI) Department, in accordance with quality of care Grievance
39 procedures within CalOptima Health Policy MA.9002: Enrollee Grievance Process.
40
41 5. Dismissal of Appeal Request
42
43 a. CalOptima Health shall dismiss an Appeal request under any of the following
44 circumstances:
45
46 i. If an individual who requests an Appeal is not a proper party to the Appeal and a
47 properly executed Representative Form or required documentation has not been filed
48 (and there is no other documentation to show that the requestor is legally authorized to
49 act on the Enrollee's behalf) within thirty (30) calendar days.
50
51 ii. If the Appealing Party fails to file the Appeal within sixty (60) calendar days and does
52 not provide written request for an extension for good cause, and/or CalOptima Health

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denies the Appealing Party's request for good cause extension in accordance with Section III.B.1. of this Policy.

iii. If the Enrollee becomes deceased while the Appeal is pending, and the Enrollee's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the Appeal request.

iv. When the Appealing Party submits a timely written request to withdraw their request for an Appeal.

v. If CalOptima Health is unable to obtain the information necessary (e.g., receipt from Enrollee; Provider claim) to process an Appeal of an Organization Determination regarding payment for services rendered to an Enrollee (i.e., a payment request).

a) CalOptima Health shall send a written Notice of Dismissal of Appeal Request form to the Member or Member's Authorized Representative at their last known address at the conclusion of the applicable adjudication timeframe.

b) The dismissal is not considered an adverse determination; however, the dismissal notice must state the reason for the dismissal and explain the Member's right to request IRE review of the dismissal, which must be filed within sixty (60) calendar days from the date of receipt of CalOptima Health's written dismissal notice.

b. CalOptima Health's dismissal of an Appeal request shall be binding unless:

i. The Enrollee or other Appealing party requests review by the IRE or the dismissal is vacated by CalOptima Health under the applicable regulation.

ii. The Appeal is modified or reversed by CalOptima Health, as applicable, upon reconsideration or vacated.

iii. A party meets the amount in controversy threshold requirements necessary for the right to a review by an Administrative Law Judge (ALJ) or attorney adjudicator and the party files a proper request for review with the Office of Medicare Hearings and Appeals.

iv. A party submits a request to vacate a dismissal and the request contains sufficient evidence or other documentation that supports good cause for vacating.

a) If CalOptima Health makes a favorable good cause determination, it shall vacate its prior dismissal action and process the appeal within thirty (30) calendar days of vacating the dismissal.

b) CalOptima Health shall document the good cause determination in the case file.

c. If CalOptima Health does not find good cause to vacate a dismissal request, the dismissal shall remain in effect.

i. CalOptima Health shall notify the Enrollee, in writing (not Notice of Dismissal), explaining that good cause has not been established and the dismissal cannot be vacated.

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ii. CalOptima Health shall explain in clear language, why the information submitted with the request to vacate the dismissal does not establish good cause to vacate the dismissal action.

d. If CalOptima Health or the IRE establish good cause for vacating an issued dismissal of an Appeal within six (6) months of the date of the dismissal, the dismissal may be vacated.

e. If the IRE requests to review CalOptima Health's dismissal of an Appeal request by obtaining a case file, CalOptima Health GARS shall:

i. Assemble and forward the case to the IRE via mail or submit through the IRE Quality Independent Contractor (QIC) Appeals web portal within twenty-four (24) hours of receipt of the IRE's case file request.

f. If the IRE vacates the dismissal and remands the case to CalOptima Health for appeal processing:

i. CalOptima Health GARS shall document the appeal case with the notice and requested action ensuring processing of the appeal within thirty (30) calendar days of receipt of the IRE's remand order.

ii. The adjudication timeframe begins when any department within CalOptima Health receives the IRE's remand order vacating CalOptima Health's dismissal of appeal request.

iii. The IRE's decision regarding CalOptima Health's dismissal of an appeal request is binding and not subject to further review.

g. Dismissal Notice: If CalOptima Health dismisses an Appeal request, CalOptima Health shall mail or otherwise transmit a written notice of the dismissal to the appropriate parties at their last known address no later than thirty (30) calendar days using the Notice of Dismissal of Appeal Request. The notice shall state the following:

i. The reason for the dismissal.

ii. The right to request that CalOptima Health vacate the dismissal action; and

iii. The right to request review of the dismissal by the IRE and that such request must be filed with the IRE within sixty (60) calendar days from the date of CalOptima Health's dismissal notice.

6. GARS staff shall prepare the case file with appropriate information and documents that include, but are not limited to, the following:

a. The case file for all Appeals which shall include:

i. A copy of the Enrollee's eligibility status; and

ii. A copy of the Appealing Party's request for Appeal.

b. The case file for Appeals of a Pre-Service Organization Determination:

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1. If the Appeal involves non-coverage of a hospital or Skilled Nursing Facility (SNF) stay, the case file shall include:

    a) A copy of the Enrollee's Medical Records from the corresponding hospital, or SNF;

    b) A copy of utilization records related to admission and discharge; and

    c) A copy of a signed non-coverage letter to the Enrollee, or his or her Authorized Representative, or a copy of the certified mail receipt.

ii. If the Appeal involves non-coverage of home health care, the case file shall include:

    a) A copy of the Enrollee's home health records;

    b) A copy of the Enrollee's Medical Records from the Enrollee's physician; and

    c) A copy of the Enrollee's discharge notification.

iii. If the Appeal involves a pre-service denial or non-authorization, the case file shall include:

    a) A copy of all records considered at the time of denial;

    b) A copy of the notice of Organization Determination; and

    c) Any additional Medical Records mentioned by the Enrollee, or Provider.

iv. If the Appeal involves a Covered Service that does not meet criteria, the case file shall include:

    a) A copy of all records considered at the time of denial; and

    b) A copy of the notice of Organization Determination.

c. The case file for Appeals of an Organization Determination regarding payment for services rendered to an Enrollee:

    i. If the Appeal involves a denied hospital claim, including emergency room claims:

        a) A copy of the Enrollee's Medical Records;

        b) A copy of the notification of admission; and

        c) A copy of the notice of Organization Determination.

    ii. If the Appeal involves a denied ambulance claim:

        a) A copy of the transport record;

        b) A copy of the Enrollee's Medical Records relating to the ambulance trip, including records from the triage or medical departments, as applicable; and

        c) A copy of the notice of Organization Determination.

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iii. If the Appeal involves co-payment charges or co-payment reimbursement:

a) A copy of the Enrollee's Medical Records from the corresponding hospital, emergency room, or Provider office;

b) A copy of utilization records if the Enrollee was admitted;

c) A copy of the notification of emergency room visit or admission; and

d) A copy of the notice of Organization Determination.

7. GARS staff shall request necessary Medical Records using an Authorization for Use and Disclosure of Protected Health Information Form, an Appeal Information Request Form or Medical Records Request Form.

   a. GARS staff may request an Enrollee's Medical Records from any Provider by submitting an Authorization for Use and Disclosure of Protected Health Information Form to such Provider by facsimile labeled with "MEMBER SIGNATURE ON FILE," which shall suffice to obtain records for an Enrollee.

   b. If a Provider fails to respond to a request for an Enrollee's Medical Records within five (5) calendar days after such request, GARS staff shall notify the Provider Relations Department. If the Provider Relations Department is unable to obtain the Enrollee's Medical Records within five (5) calendar days, the GARS staff shall present the Appeal to the Medical Director without such Medical Records.

   c. If CalOptima Health cannot obtain all relevant documentation, it shall make a decision based on the material available.

8. Upon verification that the request meets criteria for processing as an Appeal, GARS staff shall send an Acknowledgment Letter, an Authorization for Use and Disclosure of Protected Health Information, and a self-addressed stamped envelope to the Appealing Party who submitted the request for Appeal within five (5) business days after CalOptima Health receives such request.

E. Standard Appeal Determination (Level 1 Appeal)

1. CalOptima Health shall designate an individual, who was neither involved in any previous levels of review or decision-making nor a subordinate of any such individual making the initial Organization Determination, to review a request for Appeal.

   a. If CalOptima Health based the original denial on a lack of Medical Necessity, a physician or other appropriate health care professional with clinical expertise in the field of medicine that is appropriate for the requested service shall review the request for Appeal. The reviewing physician shall possess the appropriate level of training and expertise, in treating the Enrollee's condition or disease and knowledge of Medicare and Medi-Cal coverage criteria to evaluate the necessity of the service, but need not have the same specialty, or subspecialty, as the treating physician.

   b. If the request for Appeal involves emergency services, CalOptima Health shall apply the prudent layperson standard when making the Appeal determination.

2. GARS staff shall present the Appeal to the designated reviewer for decision.

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3. GARS staff shall document the decision and the rationale for the decision in CalOptima Health's database.

4. Favorable Decisions

   a. If, upon Appeal, CalOptima Health completely reverses its adverse Organization Determination, for a benefit not furnished while the Appeal was pending, GARS staff shall conduct the following:

      i. Verbal Notification: Notify the Appealing Party and all involved parties of the decision, verbally, no later than one (1) business day from the decision date; and

      ii. Written Notification: Notify the Enrollee of the decision, in writing, no later than two (2) calendar days of the verbal notice and no later than (30) thirty calendar days.

      iii. Effectuation.

         a) Standard Appeals.

            i) Appeals of Pre-Service Organization Determinations: Coordinate with CalOptima Health's Utilization Management (UM) Department or the Enrollee's Health Network to authorize or provide the disputed service.

            ii) Appeals of an Organization Determination regarding payment for services rendered to an Enrollee: Notify the Claims Department, or the Health Network, of the decision to pay the appeals claim, in accordance with the Provider's contract or the Medicare Fee for Service rates for Providers.

               1) Verify that payment has been made through the claims system, or that authorization has been issued

               2) The payment does not need to be in the hands of the requestor to be considered effectuated; authorization of the payment is sufficient.

            iii) Ensure that CalOptima Health or the Health Network authorized or provides the disputed service or adjusts the claim payment as expeditiously as the Enrollee's health condition requires, but

               1) No later than the earlier of seventy-two (72) hours from the Integrated Appeal decision date (i.e., CalOptima Health's decision); or receipt of the notice of a decision (i.e., for a State Fair Hearing decision); or

               2) No later than thirty (30) calendar days after CalOptima Health's receipt of the request for Appeal.

         b) Standard Part B Drug Appeals: No later than the earlier of seven (7) calendar days after the date CalOptima Health receives the request for the Appeal.

      iv. Notify the Enrollee's requesting Provider of CalOptima Health's decision.

      v. Ensure that the Enrollee's case file includes documentation of the authorization or provision; and

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vi. Note the Appeal as “closed” in the Appeals database.

5. Partially Favorable, Adverse, or Untimely Decisions

a. Partially Favorable or Adverse Decisions: If, upon Appeal, CalOptima Health affirms, in whole or in part, the adverse Organization Determination, CalOptima Health GARS shall take the following actions:

i. Verbal Notification: Notify the Appealing Party of CalOptima Health’s decision, verbally, within one (1) business day after CalOptima Health makes the Appeal determination, but not later than thirty (30) calendar days after receipt of the request for Appeal; and

ii. Written Notification: Notify the Appealing Party, in writing, within two (2) calendar days of the verbal notice and no later than thirty (30) calendar days. GARS will notify the Enrollee upon forwarding the case to the IRE of the following by using the model Appeal Decision Letter:

a) Notice shall explain the resolution of and basis for the Appeal

b) Include the date it was completed; and

c) Additional information outlined in the following Section III.E.5.c. of this policy.

b. Untimely Decisions: If CalOptima Health fails to provide an Appealing Party with an Appeal determination within the timeframes specified in Sections III.C. Of this policy:

i. Such failure shall constitute an adverse Organization Determination; and

ii. CalOptima Health shall send a notice to the Enrollee using the Appeal Decision Letter, providing the information outlined in the following Section III.E.5.c. of this policy.

c. Partially Favorable, Adverse, and Untimely Decisions:

i. CalOptima Health shall identify, where appropriate, whether the benefit(s) at issue are covered by Medicare or Medi-Cal or potentially both.

ii. CalOptima Health shall send a notice (i.e., using the Appeal Decision Letter) to the Enrollee that is written in plain language and available in a language and format that is accessible to the Enrollee. The Notice shall explain the following:

a) The next level of both the Medi-Cal and Medicare Appeals process,

b) The steps the Enrollee needs to take to make the next level Appeal under each program.

i) Medicare Appeal cases: CalOptima Health shall auto forward the case to the IRE the complete case file of the Appeal request to the IRE, no later than thirty (30) calendar days after receiving the request for Appeal, in accordance with Section III.E.6. of this Policy (Enrollee does not need to take any action).

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ii) Medi-Cal Appeal cases: The Enrollee may choose to file for a State Fair Hearing or, if applicable, a Medi-Cal external medical review (in accordance with 42 CFR § 438.402I(1)(i)(B)).

c) Provide information on how the Enrollee can obtain assistance in pursuing the next level of Appeal under each program, and

d) Next level Appeal rights for both Medicare and Medi-Cal Covered Services and benefits.

i) Medicare covered benefits:

1) Notice must include that CalOptima Health has forwarded the case to the IRE;

2) Advise the Enrollee of his or her rights to submit additional evidence that may be pertinent to the Enrollee's case;

3) Direct the Enrollee to submit such evidence to the IRE; and

4) Include information regarding how the Enrollee may contact the IRE.

ii) Medi-Cal covered benefits:

1) Notice must include information that Enrollee can have the benefits continue while the Appeal is pending with a State Fair Hearing; and

2) How the Enrollee should make such request (if applicable);

iii) Medicare and Medi-Cal covered benefits:

1) The notice to the Enrollee shall advise that the case has been forwarded to the IRE; and

2) The Enrollee shall be informed of the right to a State Fair Hearing under there Medi-Cal Appeal rights

6. GARS staff shall mail or submit through the IRE QIC Appeals web portal, a copy of the case file to the IRE, following receipt of CalOptima Health's Appeal determination as follows:

a. Standard Appeal: As expeditiously as the Enrollee's health condition requires, or no later than thirty (30) calendar days after receipt of the request for Appeal; or

b. Part B Drug Appeals: Within twenty-four (24) hours of CalOptima Health's Appeal determination.

c. If GARS staff is unable to upload the case files (standard Appeal or standard Part B Drug Appeal) through the IRE QIC Appeals Portal, GARS staff shall submit such case files to the IRE by overnight mail/next day delivery, within twenty-four (24) hours after the decision is rendered.

d. The following should be included in the case file forwarded to the IRE:

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i. Appeal Case File Cover Sheet;

ii. Reconsideration Background Date Form (not required if submitting via IRE web portal);

iii. Case Narrative;

iv. Copy of the initial Adverse Organization Determination Request and Notice;

v. Copy of the Appeal Request and Notice;

vi. Copy of information used to make Appeal decision, including supporting documentation (e.g., medical records, or evidence submitted by the Enrollee, provider, and/or prescriber);

vii. Representation documentation for representative Appeals;

viii. A complete copy of the relevant EOC on a universal digital storage devise (e.g., USB flash drive) (if file is not submitted via IRE web portal); and

ix. Dismissal Case File Data Form.

7. Within ten (10) business days of CalOptima Health's case file submission of a standard Appeal to the IRE, the GARS Manager, or his or her designee, shall review such case file to determine if CalOptima Health received an IRE Acknowledgment Letter to Member. If CalOptima Health did not receive such a letter, GARS staff shall send a letter to the IRE requesting acknowledgment of receipt of the case file, using the CalOptima Health Letter to IRE for acknowledgement of receipt upon identifying no receipt of the IRE Acknowledgement Letter from the IRE.

F. State Fair Hearing (Level 2 Appeal of Medi-Cal Covered Services)

1. For cases involving Medi-Cal Covered Services, the appropriate Appealing Parties have the right to access the State Fair Hearing process in accordance with CalOptima Health Policy HH.1108: State Hearing Process and Procedures.

2. If a State Fair Hearing Officer reverses CalOptima Health's integrated Appeal decision to deny, limit, or delay a Medi-Cal Covered Service or benefit that was not furnished while the Appeal was pending:

a. Effectuation: CalOptima Health GARS must coordinate with the appropriate CalOptima departments or the Enrollee's Health Network to either authorize or provide the disputed item or service or adjust the claim payment promptly and as expeditiously as the Enrollee's health condition required, but no later than seventy-two (72) hours from the date it receives notice to reverse the determination.

G. IRE Determination (Level 2 Appeal of Medicare Covered Services)

1. The IRE will make a decision on an Appeal as quickly as the Enrollee's health requires, but no later than its CMS contracted timeframe.

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2. The IRE may request additional information from CalOptima Health within a specified timeframe, using the IRE Request for Additional Information Form. Upon receipt of such request, GARS staff shall make every effort to provide the requested information within the specified timeframe using the Request for Information Response Cover Sheet and Request for Information Response Letter to IRE.

3. If the IRE upholds CalOptima Health's adverse Organization Determination, it will notify CalOptima Health and the Enrollee of such decision, in writing. Upon receipt of such notice, GARS staff shall place the notice in the Enrollee's Appeal file and update the Appeal tracking system.

4. If the IRE reverses or partially reverses CalOptima Health's adverse Organization Determination, GARS staff shall conduct the following:

    a. Send a Notice of Compliance letter to the Enrollee;

    b. Notify the Enrollee's Provider of the IRE's decision;

    c. Effectuation: CalOptima Health GARS must coordinate with the appropriate CalOptima departments or the Enrollee's Health Network to either authorize or provide the disputed item or service or adjust the claim payment, promptly and as expeditiously as the Enrollee's health condition required:

        i. But not later than fourteen (14) calendar days after notice of such reversal from the IRE; or

        ii. Within seventy-two (72) hours after notice of such reversal from the IRE.

    d. Send a notice of compliance to the IRE using the Statement of Compliance Form within fourteen (14) calendar days after authorization, or provision of the disputed service; and

    e. Document all activities in the Appeal tracking system.

H. Administrative Law Judge (ALJ) Hearing

1. An Appealing Party has the right to a hearing before an ALJ if the projected value of the disputed service is within the threshold amount set by CMS.

2. An Appealing Party shall request an ALJ hearing by submitting, such request:

    a. In writing to CalOptima Health, or to the IRE; and

    b. Within sixty (60) calendar days after the notice from the IRE of its Appeal decision. The Appealing Party may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the Enrollee or the Enrollee's Authorized Representative cannot meet the timeframe, in accordance with Title 20 C.F.R. § 404.911.

3. If CalOptima Health receives a request for an ALJ hearing from an Appealing Party GARS staff shall forward the request to the IRE. The IRE will compile and forward the Enrollee's file to the ALJ.

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4. CalOptima Health shall not have the right to request an ALJ hearing but shall remain a party to the hearing.

5. If the ALJ reverses CalOptima Health's adverse Organization Determination, in whole or in part, CalOptima Health GARS shall:

   a. Effectuation: Coordinate with the appropriate CalOptima departments or the Enrollee's Health Network to either authorize or provide the disputed item or service or adjust the claim payment, as expeditiously as the Enrollee's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the ALJ reversing the determination, unless CalOptima Health requests Medicare Appeals Council (MAC) review of the ALJ decision, in accordance with Section III.I. of this policy. If CalOptima Health requests a MAC review of the ALJ decision, it may wait for the MAC's decision before it authorizes, or provides, the disputed service; and

   b. Inform the IRE, in writing, when it effectuates the decision.

I. Medicare Appeals Council (MAC) Review

1. Any party that is dissatisfied with the ALJ hearing decision, including CalOptima Health, may request a MAC review of the ALJ decision or dismissal.

2. A party requesting a MAC review shall submit such request:

   a. In writing, directly to the MAC; and

   b. Within sixty (60) calendar days after the date of receipt of the ALJ hearing decision, or dismissal. The MAC may grant an extension if the requesting party demonstrates good cause.

3. If CalOptima Health receives an Appealing Party's request for a MAC review, it shall forward a copy of the Enrollee's request for MAC review, the Enrollee's complete case file, and a cover letter to the MAC.

4. If CalOptima Health requests a MAC Review, it shall:

   a. Submit a written request to the MAC;

   b. Concurrently notify the Enrollee of CalOptima Health's request by sending the Enrollee a copy of the request and all information submitted to the MAC; and

   c. Notify the IRE of CalOptima Health's request.

5. The MAC may initiate a review on its own motion within sixty (60) calendar days after the date of an ALJ hearing decision, or dismissal. The MAC will notify all parties in writing of its decision to initiate such review.

6. If the MAC reverses CalOptima Health's adverse Organization Determination, in whole or in part, CalOptima Health shall:

   a. Effectuation: Coordinate with the appropriate CalOptima departments or the Enrollee's Health Network to either authorize or provide the disputed item or service or adjust the claim payment, as expeditiously as the Enrollee's health condition requires, but no later

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than sixty (60) calendar days after the date it receives notice from the MAC reversing the adverse Organization Determination; and

b. Inform the IRE, in writing, when it effectuates the decision.

J. Judicial Review

1. Any party, including CalOptima Health, may request a judicial review of an ALJ decision if:

a. The MAC denied the party's request for review; and

b. The amount in controversy meets the CMS designated amount for judicial review.

2. Any party, including CalOptima Health, may request a judicial review of a MAC decision if:

a. The MAC denied the party's request for review; or

b. It is the final decision of CMS; and

c. The amount in controversy meets the CMS designated amount for judicial reviews.

3. A party may not obtain judicial review unless the MAC has acted on the case.

4. In order to obtain judicial review, a party shall file a civil action in a district court of the United States, in accordance with Section 205(g) of the Social Security Act.

5. CalOptima Health shall notify all other parties to an Appeal prior to requesting judicial review.

6. If the judicial review reverses CalOptima Health's adverse Organization Determination, in whole or in part, CalOptima Health shall:

a. Effectuation: Coordinate with the appropriate CalOptima departments or the Enrollee's Health Network to either authorize or provide the disputed item or service or adjust the claim payment, as expeditiously as the Enrollee's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the judicial review reversing the Organization Determination; and

b. Inform the IRE, in writing, when it effectuates the decision.

K. Appeals Data

1. The Quality Improvement Committee (QIC) shall track, trend, and analyze Appeals data, taking into account information from other sources including, but not limited to, Grievances, Enrollee satisfaction survey results, and disenrollment forms.

2. The QIC shall present aggregate information to the CalOptima Health Board of Directors with recommendations for interventions, as appropriate.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

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A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Policy HH.1104: Complaints of Discrimination.
C. CalOptima Health Policy HH.1108: State Hearing Process and Procedures
D. CalOptima Health Policy MA.4002: Cultural and Linguistic Services
E. CalOptima Health Policy MA.9002: Enrollee Grievance Process
F. CalOptima Health Policy MA.9004: Expedited Integrated Appeals
G. CalOptima Health Policy MA.9009: Non-Contracted Provider Payment Disputes
H. Health Plan Management System (HPMS) Notice September 10, 2013, Change in Part C Reconsideration Dismissal Procedures
I. MAXIMUS Appendix: Reconsideration Case Forms and Instructions
J. MAXIMUS Federal Medicare Health Plan Reconsideration Process Manual
K. Medicare Managed Care Manual, Chapter 13, Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs)
L. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
M. Addendum to the Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans
N. Reason Codes
O. Social Security Act, §205(g)
P. Title 20, Code of Federal Regulations (C.F.R.), §404.911
Q. Title 42, Code of Federal Regulations (C.F.R.), §422.113(b)(1)(i), § 422.2267(e)(31), §422.560, §422.632, §422.633, §438.420(d), et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

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

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2023	MA.9015	Standard Integrated Appeals	OneCare

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1 **IX. GLOSSARY**
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Term	Definition
Appealing Party	For purposes of this Policy, a Member, a Member's Authorized Representative, treating physician acting on behalf of the Member, or staff of physician's office acting on said physician's behalf or working under the direction of the physician.
Authorized Representative	An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity. Form CMS-1696 may not be used to appoint an authorized representative for the purposes of enrollment and disenrollment. This form is solely for use in the claims adjudication or claim appeals process, and does not provide broad legal authority to make another individual's healthcare decisions. The Authorized Representative will have all of the rights and responsibilities or an enrollee or other party, as applicable.
Covered Services	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Dismissal	Includes a decision not to review a request for an integrated grievance, integrated appeal, or integrated organization determination because it is considered invalid or does not otherwise meet the requirements for a request for integrated grievance, integrated appeal, or integrated organization determination. Subject to the guidance in this Addendum (see, for example, Section 20.2.a and Section 50.9.1.a), wherever the Part C & D Guidance refers to a "Dismissal," the statements and guidance apply equally to integrated grievances, integrated appeals, and integrated organization determinations for applicable integrated plans.
Effectuation	Authorization or provision of a benefit that a plan has approved, payment of a claim or compliance with a complete or partial reversal of a plan's original adverse determination.
Enrollee	For purposes of this policy, the term "Enrollee" will be applied both synonymously and/or in lieu of the term "Member" to reflect regulatory and/or contractual language of the Centers for Medicare and Medicaid Services (CMS). An eligible individual who has elected a Medicare Advantage, Prescription Drug, or cost plan or health care prepayment plan (HCPP).
Independent Review Entity (IRE)	For purposes of this policy, an independent entity contracted by the Centers for Medicare & Medicaid Services (CMS) to review adverse level 1 Appeal decisions made by the plan. Under Part C, an IRE can review plan dismissals

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Term	Definition
Integrated Appeal	The procedures that deal with, or result from, adverse integrated organization determinations by an applicable integrated plan on the benefits both under Part C and under state Medicaid rules the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service. See 42 CFR § 422.561. Integrated appeals do not include appeals related to Part D benefits.
Integrated Grievance	A dispute or complaint that would be defined and covered, for grievances filed by an enrollee in non-applicable integrated plans, under § 422.564 or §§ 438.400 through 438.416 of this chapter. Integrated grievances do not include appeals procedures and QIO complaints, as described in § 422.564(b) and (c). An integrated grievance made by an enrollee in an applicable integrated plan is subject to the integrated grievance procedures in §§ 422.629 and 422.630. Integrated grievances do not include grievances related to Part D benefits.
Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury.
Member	A beneficiary enrolled in a CalOptima Health program.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, or other person or institution who furnishes Covered Services.

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Term	Definition
Organization Determination	Any determination made by CalOptima Health with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3. CalOptima Health's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by CalOptima Health; 4. Reduction or premature discontinuation of a previously authorized service; or CalOptima Health's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Pre-Service	Review of any case or service that requires approval by OneCare or a Health Network, in whole or in part, in advance of the Member obtaining medical care or services. Pre-authorization and precertification are pre-service decisions.
Quality Improvement Committee	CalOptima Health committee that is responsible for the Quality Improvement (QI) process.
Reconsideration	For purposes of this policy, under Part C, the first level in the appeals process which involves a review of an adverse organization determination by CalOptima Health, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, CalOptima Health or CMS. Under Part D, the second level in the appeals process which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the enrollee submits or the IRE obtains. As used in this guidance, the term may refer to the first level in the Part C appeals process in which CalOptima Health reviews an adverse Part C organization determination or the second level of appeal in both the Part C and Part D appeals process in which an independent review entity reviews an adverse plan decision.
Redetermination	For purposes of this policy, first level in the Part D appeal process in which CalOptima Health reviews an adverse Part D coverage determination, including the findings upon which the decision was based, and any other evidence submitted or obtained.

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Term	Definition
Representative	For purposes of this policy, under Part C, as defined in §422.561, an individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in a grievance, organization determination, or appeal. Under Part D §423.560 *defines "representative" as* an individual either appointed by an enrollee or authorized under state or other applicable law to act on behalf of the enrollee in filing a grievance, obtaining a coverage determination, or in dealing with any of the levels of the appeals process. For both Part C & Part D*, unless otherwise provided in the applicable law,* the representative will have all of the rights and responsibilities of an enrollee or other party, as applicable.
Representative Form	For purposes of this Policy, a term used to collectively refer to an Appointment of Representative Form and/or equivalent written notice.
Withdrawal	A voluntary verbal or written request to rescind or cancel a pending grievance, initial determination, or appeal request submitted by the same party.

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Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans
Updated August 2022

10.a – Introduction

This Addendum to the Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Part C & D Guidance)[1] provides guidance on the integrated grievances and appeals provisions set forth at 42 CFR §§ 422.629-634, which apply to applicable integrated plans as defined in 42 CFR 422.561, covering Medicare Part C and Medicaid benefits through the integrated grievances, integrated organization determinations, and integrated reconsiderations process. Important notes about this Addendum:

- Except as noted in this Addendum, all guidance in the Part C & D Guidance applies to applicable integrated plans.
    - Where the Part C & D Guidance refers to an MA plan or plan, it also applies to applicable integrated plans;
    - Where the Part C & D Guidance refers to an organization determination, initial determination, or coverage request, it also applies to integrated organization determinations; and
    - Where the Part C & D Guidance refers to a reconsideration or Level 1 Appeal, it also applies to integrated reconsiderations and integrated appeals.
    - Where the guidance applies to Part C, it also applies to all integrated reconsiderations, including those related to Medicaid coverage.
- This guidance Addendum does not apply to or address Medicare Part D procedures. Applicable integrated plans must follow all Part D requirements in 42 CFR Part 423, including the appeal requirements for Part D benefits.
- This Addendum contains an additional section not included in the Part C & D Guidance, Section 50.13, which provides guidance to applicable integrated plans on continuing benefits while an integrated appeal is pending. Section 50.13 applies to all integrated appeals in accordance with 42 CFR § 422.632.
- Pursuant to 42 CFR § 422.629(c), a State may, at its discretion, implement standards for timeframes or notice requirements that are more protective for the enrollee than required by the Addendum and the regulations for applicable integrated plans at 42 CFR §§ 422.630 through 422.634. For example, a state may require applicable integrated plans to issue integrated reconsideration determinations faster than the requirements at 42 CFR § 422.633. The applicable integrated plan's contract with the state under 42 CFR § 422.107 must include any standards that differ.
- Organization of this Addendum:
    - Section numbers in this Addendum correspond to section numbers in the Part C & D Guidance.

[1] The Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance can be found here: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf

- Guidance included in this Addendum supplements the Part C & D Guidance by noting, in corresponding sections, where requirements for applicable integrated plans differ from requirements from other MA plans due to differences in governing regulations, or by clarifying a requirement or process.
- Significant operational differences in processes compared to the Part C & D guidance are noted by an asterisk (*) throughout the Addendum.

10.1.a – Glossary

In this Addendum, the following terminology is used to substitute for analogous Medicare Part C terms:

Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Terminology	Addendum Terminology
Medicare Advantage (MA) plan, Medicare Advantage Organization (MAO), Medicare cost plan or health care prepayment plan (HCCP)	Applicable Integrated Plan
Request for Organization Determination or Initial Determination	Request for Integrated Organization Determination
Organization Determination or Initial Determination	Integrated Organization Determination, or Level 1 Appeal
Reconsideration	Integrated Reconsideration or Integrated Appeal

Definitions in the Part C & D Guidance apply to applicable integrated plans, except for the following definitions that are modified, as indicated below, for applicable integrated plans. As used in the Part C & D Guidance and in this Addendum, the following terms should be read as follows in connection with applicable integrated plans:

Integrated Appeal: The procedures that deal with, or result from, adverse integrated organization determinations by an applicable integrated plan on the benefits both under Part C and under state Medicaid rules the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service. See 42 CFR § 422.561. Integrated appeals do not include appeals related to Part D benefits.

Integrated appeals cover procedures that would otherwise be defined and covered, for non-applicable integrated plans, as an appeal defined in §422.561 or the procedures required for appeals in accordance with §§438.400 through 438.424 of this chapter. Such procedures include integrated reconsiderations. Subject to the guidance in this Addendum,

wherever the Part C & D Guidance refers to an "Appeal," the statements and guidance apply equally to integrated appeals for applicable integrated plans.

Dismissal: Dismissal includes a decision not to review a request for an integrated grievance, integrated appeal, or integrated organization determination because it is considered invalid or does not otherwise meet the requirements for a request for integrated grievance, integrated appeal, or integrated organization determination. Subject to the guidance in this Addendum (see, for example, Section 20.2.a and Section 50.9.1.a), wherever the Part C & D Guidance refers to a "Dismissal," the statements and guidance apply equally to integrated grievances, integrated appeals, and integrated organization determinations for applicable integrated plans.

Integrated Grievance: A dispute or complaint that would be defined and covered, for grievances filed by an enrollee in non-applicable integrated plans, under § 422.564 or §§ 438.400 through 438.416 of this chapter. Integrated grievances do not include appeals procedures and QIO complaints, as described in § 422.564(b) and (c). An integrated grievance made by an enrollee in an applicable integrated plan is subject to the integrated grievance procedures in §§ 422.629 and 422.630. Integrated grievances do not include grievances related to Part D benefits. Subject to the guidance in this Addendum, wherever the Part C & D Guidance refers to a "Grievance," the statements and guidance apply equally to integrated grievances for applicable integrated plans.

Integrated Reconsideration: A reconsideration that would otherwise be defined and covered, for a non-applicable integrated plan, as a reconsideration under § 422.580 and appeal under § 438.400(b) of this chapter. An integrated reconsideration is made by an applicable integrated plan and is subject to the integrated reconsideration procedures in §§ 422.629 and 422.632 through 422.634. Integrated reconsiderations do not include redeterminations related to Part D benefits. Subject to the guidance in this Addendum, wherever the Part C & D Guidance refers to a "Reconsideration," the statements and guidance apply equally to integrated reconsiderations for applicable integrated plans.

10.4.a – General Responsibilities of the Plan

The guidance in all subsections of Section 10.4 applies, in addition to the following requirements for applicable integrated plans:

(1) Provide the enrollee a reasonable opportunity to present, in person and in writing, evidence and testimony and make legal and factual arguments for integrated grievances, and integrated reconsiderations. The applicable integrated plan must inform the enrollee of the limited time available for presenting evidence sufficiently in advance of the resolution timeframe for integrated appeals as specified in this section if the case is being considered under an expedited timeframe for the integrated grievance or integrated reconsideration. See 42 C.F.R. § 422.629(d). The applicable integrated plan must also provide the enrollee information on how evidence and testimony should be presented.

(2) Provide an enrollee reasonable assistance in completing forms and taking other procedural steps related to integrated grievances and integrated appeals (note that this requirement is in addition to the requirements related to assisting enrollees in §422.562(a)(5)). See 42 C.F.R. § 422.629(e).

(3) Send to the enrollee written acknowledgement of integrated grievances and integrated reconsiderations upon receiving the request. See 42 C.F.R. § 422.629(g). Applicable integrated plans must comply with additional or revised timeframes for sending the acknowledgment, as specified in the state Medicaid contracts if the revised or additional timeframe is more protective of the enrollee

(4) Ensure that no punitive action is taken against a provider that requests an integrated organization determination or integrated reconsideration, or supports an enrollee's request for these actions. See 42 C.F.R. § 422.629(i).

(5) Ensure that individuals making decisions on integrated appeals and grievances take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse integrated organization determination. See 42 C.F.R. § 422.629(k)(1).

(6) The applicable integrated plan must maintain records of integrated grievances and integrated appeals. Each applicable integrated plan that is a Medicaid managed care organization must review the Medicaid-related information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record of each integrated grievance or integrated appeal must contain, at a minimum:

   i. A general description of the reason for the integrated appeal or integrated grievance.
   ii. The date of receipt.
   iii. The date of each review or, if applicable, review meeting.
   iv. Resolution at each level of the integrated appeal or integrated grievance, if applicable.
   v. Date of resolution at each level, if applicable.
   vi. Name of the enrollee for whom the integrated appeal or integrated grievance was filed.
   vii. Date the applicable integrated plan notified the enrollee of the resolution.

   See 42 C.F.R. § 422.629(h).

10.5.3.a – When Notification is Considered Delivered by the Plan

The guidance in Section 10.5.3 applies, except that applicable integrated plans must give written notice within *2* calendar days, after providing prompt oral notice, in the following

circumstances:

(1) The applicable integrated plan extends the timeframe for resolving a grievance (per 42 CFR § 422.631(e)(2)(ii)). See also Section 30.2.1.a– Notification Requirements for Integrated Grievance, below.

(2) The applicable integrated plan denies the enrollee's request to expedite an integrated reconsideration (per 42 CFR § 422.633(e)(4)). See also Section 50.2.2.a – How to Process Requests for Expedited Level 1 Integrated Appeals, below.

(3) The applicable integrated plan extends the timeframe for resolving an integrated reconsideration (per 42 CFR § 422.633(f)(3)(ii). See also Section 50.10.1.a- Part C Notification Requirements, below.

10.6.a – Outreach for Additional Information to Support Coverage Decisions

The guidance in Section 10.6 applies, except that the regulatory references for applicable integrated plans are different:

(1) For the content of the written denial notices: 42 CFR § 422.631(d) (for integrated organization determination notices) and § 422.633(f)) (for integrated reconsiderations).

(2) For the timing for requests to providers for additional information to make an expedited decision: 42 CFR § 422.631(d)(2)(iv)(C) (expedited integrated organization determinations) and § 422.633(e)(5) (for expedited integrated reconsiderations).

20.2.a – Appointment of Representative (AOR) Form or Equivalent Written Notice

The guidance in Section 20.2 applies to applicable integrated plans, except that for cases involving only a Medicaid-covered benefit, an applicable integrated plan may accept a written authorization from an enrollee that complies with state Medicaid requirements, even if such an authorization does not contain every element described under Section 20.2.

30.a – Integrated Grievances

The guidance in Section 30 applies to integrated grievances, except that:

(1) The regulatory references for the requirements for integrated grievances are 42 CFR §§ 422.629 and 422.630, for applicable integrated plans.

(2) Individuals making decisions on integrated grievances must be individuals who:

a. Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; and
b. If deciding any of the following, have the appropriate clinical expertise, including as defined by the state, in treating the enrollee's condition or disease:
    i. An integrated grievance regarding denial of expedited resolution of an integrated appeal.
    ii. An integrated grievance that involves clinical issues.

30.1.a– Classification between Integrated Grievances, Inquiries, Coverage Requests, and Integrated Appeals

The guidance in Section 30.1 applies to applicable integrated plans and the distinctions between integrated grievances and integrated appeals.
In addition to the examples listed in Section 30.1, additional examples of inquiries, integrated grievances, coverage requests, and integrated appeals relevant for applicable integrated plans include:

- Integrated grievances may include expressing dissatisfaction with the service of a personal care aide.
- Requests for an integrated organization determination (Coverage Requests) may include an enrollee stating that they would like additional service hours from a personal care aide.

30.1.1.a – Inquiries Related to Non-Part D and Excluded Drugs (Part D Only)

The guidance in Section 30.1.1 applies, with the following additional guidance for applicable integrated plans:
* When a Part D plan sponsor receives an inquiry (that is, a question that is not a request for a coverage determination) about a drug that is not a covered Part D drug or is an excluded drug, an applicable integrated plan should also check if the drug is covered by the enrollee's Medicaid benefit. If the drug is not a Part D drug or is an excluded drug and not covered by Medicaid, the plan should explain to the requestor the information listed in the bullet points of Section 30.1.1, as well as provide any additional information appropriate under state Medicaid policy. If the drug is not a Part D drug or is an excluded drug but is covered by Medicaid, the applicable integrated plans should explain the limits of Part D coverage and: 1) furnish the Medicaid benefit if covered by its Medicaid contract with the State; or 2) assist the enrollee in obtaining Medicaid coverage for the drug if the applicable integrated plan does not cover the Medicaid-covered drug (for example, if Medicaid drugs are carved out of the applicable integrated plan's benefit package). Applicable integrated plans can refer to 42 CFR 422.562(a)(5) for examples of assistance that it may provide.

30.2.a– Procedures for Handling an Integrated Grievance

* The guidance in Section 30.2 applies for processing an integrated grievance, except that an enrollee can file an integrated grievance *at any time*. In addition, the regulatory reference for integrated grievances for applicable integrated plans is at 42 CFR § 422.630(b).

30.2.1.a– Notification Requirements for Integrated Grievance

* The guidance in Section 30.2.1 applies for notification requirements for integrated grievances, except that where an applicable integrated plan extends the timeframe for resolving a grievance, while it may initially provide verbal notification of its decision it must send written confirmation of its decision within *2* calendar days of the verbal notification in accordance with 42 CFR § 422.630(e)(2)(ii).

30.3.1.a– Procedures for Handling a Quality of Care Integrated Grievance

The guidance in Section 30.3.1.1 applies except:

(1) * Integrated grievances may be filed at any time per 42 CFR § 422.630(b).
(2) * The regulatory reference for the 30-day timeframe for responding to a grievance and the authority for applicable integrated plans to extend the timeframe for responding to a grievance by an additional 14 days is at 42 CFR §§ 422.630(e).
(3) The regulatory reference for the requirement to cooperate with the Quality Improvement Organization (QIO) is at 42 CFR § 422.*630*(e)(1)(iii).

Applicable integrated plans that are D-SNPs must comply with 42 CFR §§ 422.562(a)(2)(ii) and (c) and 422.620 through 422.626 regarding QIO and Independent Review Entity (IRE) reviews of terminations of services furnished by providers of services and hospital discharges. For Medicaid-covered benefits, applicable integrated plans must also comply with any state Medicaid quality of care requirements.

40.1.a – Part C Integrated Organization Determinations

For applicable integrated plans, the guidance in Section 40.1 applies to integrated organization determinations, which include both Medicaid and Medicare Part C benefits. See definition of integrated organization determination at 42 CFR § 422.561.

40.6.a– Who May Request an Initial Determination.

The guidance in Section 40.6 applies with the following additional guidance for applicable integrated plans:

(1) Where an enrollee can make a request involving Medicare Part C, the enrollee may also make a request involving Medicaid coverage.
(2) The regulation controlling who is a party to an integrated appeal and who may request an integrated organization determination and integrated reconsideration is 42 CFR § 422.629(l).

40.8.a– How to Process Requests for Expedited Initial Determinations

The guidance in Section 40.8 applies with the following additional guidance for applicable integrated plans:

(1) Applicable integrated plans must use the same processes for Medicaid-related requests as used for Medicare-related requests. See 42 CFR § 438.402(a).
(2) * Payment requests are not treated differently than non-payment requests for expedited integrated determinations.
    a. Applicable integrated plans should apply the same process to assess a request to expedite a payment request as they do to assess requests to expedite non-payment cases. The standard for deciding whether to expedite a payment request is the same as for non-payment cases (e.g. the standard timeframe could seriously jeopardize the life or health or the enrollee, or their ability to regain maximum function, in accordance with 42 CFR 422.631(c)).[2] Decisions in payment cases:
        i. Must be provided as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date of the request, in accordance with 422.631(d)(2)(iv) (following the same timelines as are required for items and services in Section 40.8) unless an extension is taken.
        ii. May include an extension (in standard and expedited payment cases) that meet the criteria specified in 422.631(d)(2)(ii)).
    b. Note: providing notice of the decision does not mean the payment must be made to the enrollee within that timeframe; in accordance with 422.634(d), the payment must be authorized *or* provided within 72 hours, and thus authorizing the payment in the applicable integrated plan's system is sufficient action within 72 hours.
(3) In addition to the enrollee and the enrollee's representative, a physician or other provider on behalf of the enrollee may make the request for an expedited integrated determination. This information supplements the table with column headers "Who May Request an Expedited Determination" and "Plan Requirements," with respect to who may request an expedited integrated determination. See 42 CFR §§ 422.629(l)(2) and 422.631(c)(1).

[2] See 83 FR 54982 (November 1, 2018), page 55011, for a discussion of this policy, and the policy related to payment cases generally.

(4) * Instead of the information in the section titled "*Extension of Timeframe for Items and Services*" the applicable integrated plan may only extend the 72-hour timeframe for providing an expedited integrated organization determination for covered benefits by up to 14 additional days under the conditions listed in 42 CFR § 422.631(c)(2)(iii), specifically:

- The enrollee or provider requests the extension; or
- The applicable integrated plan can show that the extension is in the enrollee's interest; and
- There is a need for additional information and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.

(5) With respect to the guidance for obtaining information from non-contract providers (at the end of the Part C guidance in Section 40.8), if an applicable integrated plan needs information from a non-contract provider it should follow the same procedures as indicated in Section 40.8. However, the plan should refer to the regulatory requirements at 42 CFR § 422.631(d)(2)(iv)(C) rather than the requirements at § 422.572 for additional details.

40.9.a – Who Must Review an Initial Determination

The guidance in Section 40.9 applies with the following additional guidance for applicable integrated plans:

(1) An appropriate healthcare professional reviewing a partially or fully adverse decision based on medical necessity must have knowledge of the Medicare and Medicaid coverage criteria (in addition to sufficient medical and other expertise, and a current and unrestricted license to practice within the scope of his or her profession).

(2) For integrated organization determinations:

a. If the applicable integrated plan expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the integrated organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare and Medicaid coverage criteria, before the applicable integrated plan issues the integrated organization determination.

b. Any physician or other health care professional who reviews an integrated organization determination must have a current and unrestricted license to practice within the scope of his or her profession.

40.12.1.a– Medicaid and Medicare Part C Notification Requirements

The guidance in Section 40.12 applies to applicable integrated plans, except where it is superseded by guidance detailed below.

(1) With respect to the guidance in the section titled "Denials and Discontinuation/Reduction of Previously Authorized Ongoing Course of Treatment," for applicable integrated plans:

- For integrated organization determination denials, applicable integrated plans must use the approved integrated denial notice, rather than the standard Integrated Denial Notice when issuing written denial notices to enrollees. The standardized integrated denial notice for applicable integrated plans is the Applicable Integrated Plan Coverage Decision Letter (Form CMS-10716), also known as the Coverage Decision Letter.

- Timing of sending the Coverage Decision Letter:

  - * In cases where the Applicable Integrated Plan is reducing, suspending or terminating a previously approved service (except in circumstances where an exception is permitted under §§431.213 and 431.214), the plan must send the notice least 10 days before the date of action (that is, before the date on which a termination, suspension, or reduction becomes effective), consistent with 42 CFR § 422.631(d)(2)(i)(A);

  - The Applicable Integrated Plan must send the Coverage Decision Letter in all other cases within the timeframes specified in Section 40.10.

(2) * Special instructions for payment denials: For cases involving payment denials where there is no member liability, applicable integrated plans must send the enrollee a notice of the denial. The notice does not have to be the OMB approved Coverage Decision Letter; it could instead be an Explanation of Benefits (EOB) or other notice. The notice should include that there is no member liability.

(3) * With respect to the guidance in the section titled "Enrollee and Non-contract Provider Payment Requests," because state Medicaid policies differ regarding direct reimbursement of enrollees, applicable integrated plans should consult state policy as noted in this table (guidance for applicable integrated plans is added in italics):

Requestor	Payment Approval	Payment Denial
Enrollee or Representative	Receives payment, *in alignment with state policy where applicable for Medicaid benefits,* and EOB.	• The enrollee or representative receives an IDN or an EOB. • Document must include notice of integrated appeal rights.

(4) With respect to the guidance in the section titled "Denial of a Request for an Expedited Integrated Organization Determination," applicable integrated plans' notice of the denial of a request for an expedited integrated organization determination must comply with the requirements listed in Section 40.12.1 except that the plan should use a specialized integrated notice for notifying the enrollee of the denial. Plans are encouraged to use the model notice, Letter about Your Right to Make a Fast Complaint available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs.

50.1.a– Who May Request a Level 1 Integrated Appeal

The guidance in Section 50.1 applies to applicable integrated plans except that:

1. The Part C table with column headings "Type of Request" and "Who May Request an Appeal" does not apply to applicable integrated plans and the following guidance applies instead:

Type of Request	Who May Request An Appeal
Standard or Expedited Reconsideration for a pre-service or previously approved service or item	• An enrollee (42 CFR § 422.629(l)(1)(i)); • An enrollee's representative (42 CFR § 422.629(l)(1)(i)); • A provider who is providing treatment to the enrollee may file an appeal on behalf of the enrollee.[+] The provider must give the enrollee notice of filing the appeal. (42 CFR § 422.629(l)(1)(ii), and (l)(3)) ○ Note: If the provider requests that the enrollee continue to receive the previously approved service or item while the appeal is pending, see the additional information below.
Standard or Expedited Payment Reconsideration	• An enrollee (42 CFR § 422.629(l)(1)(i)); • An enrollee's representative (42 CFR § 422.629(l)(1)(i)); • The legal representative of a deceased enrollee's estate (42 CFR § 422.629(l)(1)(iii)); or • Non-contract provider (i.e. an assignee of the enrollee, that is, a physician or other provider who has furnished or intends to furnish a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service. See Section 50.1.1 for more detail on waiving the right to payment). *A provider may file a standard integrated reconsideration on behalf of the enrollee but may not file an expedited integrated reconsideration related to a payment request on behalf of the enrollee (42 CFR § 422.629(l) and 422.633(e)(1)(ii))*; • Any other provider or entity (other than the applicable integrated plan) determined to have an appealable interest in the proceeding (42 CFR § 422.629(l)(1)(i)).

[+]If the enrollee's records indicate that he or she has not previously visited the requesting provider, the applicable integrated plan should undertake reasonable efforts to confirm that the enrollee has received appropriate notification of the appeal.

2. If an individual is acting as a representative of the enrollee, the OMB-approved Form CMS-1696, Appointment of Representative (AOR), or another form that meets state and Medicare requirements, is acceptable. As noted in Section 20.2.a, for a case involving only a Medicaid-covered benefit, an applicable integrated plan may accept a written authorization from an enrollee that complies with state Medicaid requirements.

3. If the provider requests that the benefits continue while the integrated appeal is pending, pursuant to 42 CFR § 422.632 and consistent with State law, the provider must obtain the written consent of the enrollee to request the integrated appeal on behalf of the enrollee.

   a. If the provider does not provide the enrollee's written consent to continue benefits at the time that the request is made but the appeal is otherwise valid, the applicable integrated plan should begin processing the appeal.

   b. The consent must state that the enrollee has given the provider permission to request that the service or item continue while the appeal is pending. However, the applicable integrated plan should not provide continuation of benefits unless it receives the enrollee's written consent (delivered either via the provider or directly from the enrollee or their authorized representative requesting continuation of benefits).

   c. Such a request must be received within the timeframes specified in 42 CFR § 422.632(c) (or within the timeframe specified in the applicable integrated plan's contract with the state).

   See section 50.13 for more information on continuing benefits during the appeal.

50.2.1.a– Guidelines for Accepting Level 1 Integrated Appeal Requests

The guidance in Section 50.2.1 applies to applicable integrated plans, except:

1) * Applicable integrated plans must accept integrated appeals filed orally (in both standard and expedited cases). Note, although non-contracted providers may also file an appeal orally, they must provide additional written documentation such as a waiver of liability in order for the appeal to go forward (see 42 CFR § 422.629(l)(1)(ii)).
2) The regulation that controls integrated reconsiderations is 42 CFR § 422.633 instead of §§ 422.578 through 422.582.
3) * An applicable integrated plan must extend the 60-day timeframe for the filing of a request for integrated reconsideration when party filing the request shows good cause for an extension. The request for integrated reconsideration and to extend the timeframe must—

a. be in writing; and
b. state why the request for integrated reconsideration was not filed on time.
c. See Section 50.3 for more details on exceptions for late filing, including examples of acceptable good cause.

4) * Upon request, the applicable integrated plan must also provide the enrollee and his or her representative the enrollee's case file (including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated in connection with the integrated appeal of the integrated organization determination), free of charge and in advance of making the integrated reconsideration decision. 42 CFR § 422.633(c).
5) In addition, if the State has established an external medical review process, the requirements of § 438.402(c)(1)(i)(B) apply to each applicable integrated plan that is a Medicaid managed care organization. See 42 CFR 422.633(b).

50.2.2.a – How to Process Requests for Expedited Level 1 Integrated Appeals

The guidance in Section 50.2.2 applies to applicable integrated plans. The following additional provisions also apply to applicable integrated plans:

1) In the table with column headings "Who May Request an Expedited Level 1 Integrated Appeal" and "Plan Requirements," physicians and providers or appropriate health care professionals may make requests for integrated reconsiderations.
2) With respect to the section titled "Action Following Acceptance of a Request for Expedited Level 1 Integrated Appeal," in the Part C table with column headings titled "Reconsideration Decisions" and "Processing Requirements for Expedited Reconsiderations" applicable integrated plans must:
    - In addition to ensuring that the person or persons conducting the integrated reconsideration were not involved in the integrated organization determination, where the issue is the denial of coverage based on a lack of medical necessity the integrated reconsideration must be made by a physician or other appropriate health care professional with expertise in the enrollee's condition or disease and knowledge of Medicare and Medicaid coverage criteria, before the applicable integrated plan issues the integrated reconsideration determination. (As in the Part C & D Guidance, the physician need not be of the same specialty or subspecialty as a treating physician.)
    - * In contrast to the instructions to MA plans (which do not require MA plans to send notification of adverse decisions to enrollees), applicable integrated plans must send an Appeal Decision notice in *all* cases including in cases where the applicable integrated plan's decision is partially favorable or adverse to the enrollee. In accordance with the requirements in 42 CFR 422.633(f)(4), this

notice must inform enrollees of their relevant appeal rights under Medicaid, including steps to take and how to obtain assistance.

- Enrollees will also receive notification from the IRE if the case is auto forwarded to the IRE (i.e. in cases where an integrated appeal involving Medicare coverage issues is not decided in the enrollee's favor).
- Applicable integrated plans may choose to use the model Appeal Decision Letter, available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs to inform parties when a case has been forwarded to the IRE, or may develop its own notice that complies with the requirements of 422.633(f)(4).

3) In the section titled "Extension of Timeframe for Items and Services" the second and third bullets in the list are replaced to conform with 42 CFR § 422.633(f)(3) as follows:

   * The applicable integrated plan may only extend the 72-hour timeframe by up to 14 additional days if:

   - The enrollee requests the extension; or

   - The extension is justified and in the enrollee's interest; *and there is need for additional information and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.*

4) In the section titled "Action Following Denial of a Request for an Expedited Level 1 Appeal":

   - * If an applicable integrated plan denies a request to expedite a Level 1 Integrated Reconsideration it must send a written notice of enrollee's rights within *2* calendar days of the verbal notice of the denial to expedite the request, consistent with 42 CFR § 422.633(e)(4). As with other notice requirements, an applicable integrated plan may initially provide verbal notification of its decision to the enrollee but it must then deliver written confirmation of its decision within 2 calendar of the verbal notification in accordance with 42 CFR § 422.633(e)(4).
   - In providing notice of the denial of a request for an expedited level 1 integrated appeal, applicable integrated plans must follow the Part C guidance but are encouraged to use the Letter about Your Right to Make a Fast Complaint available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs. Applicable integrated plans should not use the Notice of Right to an Expedited Grievance for Part C.

50.5.2.a–Enrollee Request for Case File Content

The guidance in Section 50.5.2 applies to applicable integrated plans except that the applicable integrated plan may not charge the enrollee for copying and mailing the case file, consistent with 42 CFR § 422.633(c). The case file should include medical records,

other documents and records, and any new or additional evidence considered, relied upon, or generated by the applicable integrated plan (or at the direction of the applicable integrated plan) in connection with the appeal of the integrated organization determination.

50.6.a– Who Must Conduct a Level 1 Integrated Appeal

The guidance in Section 50.6 applies to applicable integrated plans except that individuals making an integrated reconsideration determination must be individuals who:

1) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; and
2) If the applicable integrated plan is deciding an integrated appeal of a denial that is based on lack of medical necessity (or any substantively equivalent term used to describe the concept of medical necessity), is a physician or other appropriate health care professional who has the appropriate clinical expertise, including any state-specific definition of "clinical expertise", in treating the enrollee's condition or disease, and knowledge of Medicare and Medicaid coverage criteria, before the applicable integrated plan issues the integrated reconsideration decision. As for MA plans, this does not require the physician to always have the same specialty training as the treating physician. For example, where there are few practitioners in a highly specialized field of medicine, a plan may not be able to hire a physician of the same specialty or sub-specialty to review adverse initial determinations.

50.7.1.a– Processing Timeframes

The guidance in Section 50.7.1 applies except as follows:

1) In the Parts C & D Level 1 Appeal Adjudication Timeframes table, for the "Type" columns with the headings "Type," "Part C," and "Part C with Extension," for standard integrated reconsiderations, payment cases must be adjudicated within *30* days, consistent with 42 CFR § 422.633(f)(1). This means that, with an extension, applicable integrated plans have a maximum of 44 days to adjudicate the case.
2) In the Parts C & D Level 1 Appeal Adjudication Timeframes table, for the "Type" columns with the headings "Type," "Part C," and "Part C with Extension," for expedited integrated reconsiderations, including post-service payment requests, must be adjudicated within *72 hours* days, consistent with 42 CFR § 422.633(f)(2) and (3). This means that, with an extension, applicable integrated plans have a maximum of 17 days to adjudicate the case. In the section titled "Extension of Timeframe," for standard pre-service and expedited integrated reconsiderations for items and services, including post-service payment requests (involving Medicare and Medicaid-covered services), consistent with 42 CFR § 422.633(f)(3), the applicable integrated plan may extend the timeframe by up to 14 calendar days only if:

- The extension is requested by the enrollee; or
- The extension is justified and in the enrollee's interest and there is a reasonable likelihood that receipt of such information would lead to approval of the request.

50.7.2.a – Effect of Failure to Meet the Timeframe for Level 1 Integrated Appeals

The guidance in Section 50.7.2 applies to applicable integrated plans except that:

1) If the plan fails to provide the enrollee a level 1 integrated appeal decision the timeframes specified (in 42 CFR § 422.633(f)), the applicable integrated plan must send a notice to the enrollee which explains:

    - The next level of both the Medicaid and Medicare appeals process,
    - The steps the enrollee needs to take to make the next level appeal under each program. This includes that, for Medicare appeals, the enrollee will not need to take any action because the applicable integrated plan will auto forward the case to the IRE, and for Medicaid cases the enrollee may choose to file for a state fair hearing or, if applicable, a Medicaid external medical review (see 42 CFR § 438.402(c)(1)(i)(B)),
    - Provide information on how the enrollee can obtain assistance in pursuing the next level of appeal under each program, and,
    - For Medicaid-covered benefits, explain that the enrollee can have the benefits continue while the appeal is pending, if applicable, and how the enrollee should make such a request (see 422.633(f)(4)(ii)(B) and 42 CFR § 438.420(c)).

    Applicable integrated plans may choose to use the model Appeal Decision Letter available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs.

* The text box in Section 50.7.2 that provides guidance that Part C plans are not required to send a notice to enrollees upon forwarding a case to the Part C IRE does <u>not apply to applicable integrated plans</u>. Applicable integrated plans must send the enrollee notice of all integrated reconsideration decisions.

- The contents of the notice must comply with the requirements in 42 CFR § 422.633(f)(4), including providing relevant information on the next level of appeal rights for both Medicare and Medicaid.
    - If the case involves a Medicare-covered benefit the notice must include that the applicable integrated plan has forwarded the case to the IRE;
    - If it is a Medicaid-covered benefit the notice must include information on the steps the enrollee must take to continue the Medicaid-benefit appeal with a State fair hearing;

  - For cases involving a benefit that may be covered by both Medicare and Medicaid, the case should be forwarded to the IRE and the enrollee should also be informed of Medicaid appeal rights. The applicable integrated plan should identify, where appropriate, whether the benefit(s) at issue are covered by Medicare or Medicaid or potentially both.
- Applicable integrated plans may use the model Appeal Decision Letter for this notification, which provides model language for cases involving different types of services. The model is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs.

50.9.1.a- Dismissals (Part C and Medicaid only)

The guidance in Section 50.9 applies to applicable integrated plans, however:

1) In evaluating whether to dismiss an integrated reconsideration, in cases involving only a Medicaid-covered benefit where an individual requests an integrated reconsideration on behalf of an enrollee applicable integrated plans must comply with both state (Medicaid) and Medicare requirements, as described in Section 20.2.a above, i. For Medicare requirements, see Section 20.2.
2) Under the section titled "Notice for Dismissal of a Reconsideration," the written notice of the dismissal must also include information on the member's Medicaid rights, if the case involves Medicaid benefits. In such cases, applicable integrated plans using the model Notice of Dismissal of Appeal Request referenced in Section 50.9 should add any relevant state-specific Medicaid information to the Notice.

50.10.1.a- Part C Notification Requirements

The guidance in Section 50.10.1 applies to applicable integrated plans except that, in the section titled "Partially Favorable, Adverse, or Untimely Decisions," when applicable integrated plans send case files to the IRE they must adhere to the following additional notice requirements::

1) In contrast to the guidance and regulation to MA plans (which does not require MA plans to send notification of adverse decisions to enrollees when the matter is forwarded to the IRE), applicable integrated plans must send an Appeal Decision notice in all cases, including in cases where the applicable integrated plan's decision is partially favorable or adverse to the enrollee and, if the matter is about a Medicare benefit, the file will be forwarded to the IRE for review. In accordance with the requirements in 42 CFR 422.633(f)(4), this notice must:
   - Be written in plain language and available in a language and format that is

accessible to the enrollee.

i. Translating the notice, providing it in a large font format, or including a multi-language insert are examples of providing the notice in a format *that* may make it accessible to an enrollee.

ii. Applicable integrated plans should also be sure to comply with any applicable state Medicaid reading level requirements.

- Explain the resolution of and basis for the integrated reconsideration.
- Include the date it was completed.
- For integrated reconsiderations that are not resolved wholly in favor of the enrollee, the notice must also:
- * Explain the next level of both the Medicaid and Medicare appeals process;
- * As discussed in Section 50.7.2.a above, explain the steps the enrollee needs to take to make the next level appeal under each program including that:
    - If the case involves a Medicare-covered benefit the notice must include that the applicable integrated plan has forwarded the case to the IRE;
    - If it is a Medicaid-covered benefit the notice must include information on the steps the enrollee must take to continue the Medicaid-benefit appeal with a State fair hearing;
    - For cases involving a benefit that may be covered by both Medicare and Medicaid (an overlap service), the case should be forwarded to the IRE and the enrollee should also be informed of Medicaid appeal rights. The applicable integrated plan should identify, where appropriate, whether the benefit(s) at issue are covered by Medicare or Medicaid.
- * Provide information on how the enrollee can obtain assistance in pursuing the next level of appeal under each program, and,
- * For Medicaid-covered benefits, explain that the enrollee can have the benefits continue while the appeal is pending, if applicable, and how the enrollee should make such a request (applicable integrated plans may choose to use the model Appeal Decision Letter, available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs). (Benefits will not continue at this stage of the appeal for Medicare-covered services. Please see Section 50.13.a for more information on continuation of Medicaid-covered benefits while the appeal is pending.)

2) * As for other notification requirements (for example, a notification where the applicable integrated plan is taking an extension), the applicable integrated plan may initially provide verbal notification of its decision to the enrollee, however it must deliver written confirmation of its decision within *2* calendar days of the verbal notification, in accordance with 42 CFR 422.633(f)(3)(ii).

50.13.a – Continuing Benefits While An Integrated Reconsideration Is Pending

*** NOTE:** *Section 50.13 is a new guidance section, applicable only to applicable integrated plans*

This section applies to cases where an enrollee, or an enrollee's representative or provider, is appealing an applicable integrated plan's decision to reduce, terminate, or suspend a previously authorized Medicare Part C or Medicaid-covered service or item, in accordance with 42 CFR § 422.632.

1) The enrollee or an enrollee's representative or provider, may request that the enrollee continue to receive the previously authorized service or item at the previously authorized level while the integrated reconsideration is pending if:
    a. The request for continuation and the integrated reconsideration are both filed timely:
        i. For the service or item to continue, the enrollee must make the continuation request by the later of the following: within 10 calendar days after the applicable integrated plan sends the notice of its integrated organization determination ***or*** the intended effective date of the integrated organization determination.
        ii. As noted in Section 50.2.1 and 50.2.1a, enrollees must file integrated reconsiderations within 60 calendar days from the date of the notice of the initial determination. For requests received after the 60-day filing timeframe, please see §50.3 regarding good cause exceptions for late filing.
    b. The service or item was ordered by an authorized provider,
    c. The integrated appeal involves the termination, suspension or reduction of previously authorized services, and
    d. The period covering the initial authorization has not yet expired.

2) If the request to continue the service or items meets the above requirements, the applicable integrated plans must continue to provide the service or item, at the previously authorized level until:
    a. The enrollee withdraws the request for the integrated reconsideration;
    b. The applicable integrated plan issues an integrated reconsideration determination that is unfavorable to the enrollee;
    c. For Medicaid-covered services and items only:
        i. The enrollee fails to file a request for a State fair hearing and continuation of benefits, within 10 calendar days after the applicable integrated plan sends the notice of the integrated reconsideration;
        ii. The enrollee withdraws the appeal or request for a State fair hearing; or
        iii. A State fair hearing office issues a hearing decision adverse to the enrollee.

3) If the applicable integrated plan or the State fair hearing entity issues a decision that is

adverse to the enrollee, the applicable integrated plan or State agency may not pursue recovery for costs of services furnished by the applicable integrated plan while the integrated reconsideration was pending if the services were furnished solely under the requirements of 42 CFR 422.632.

4) If, after the integrated reconsideration decision is final, an enrollee requests that Medicaid services continue until a State fair hearing decision is made, state rules on recovery of costs, in accordance with the requirements of 42 CFR § 438.420(d), apply for costs incurred for items and services provided to the enrollee after the date that the integrated reconsideration decision was made.

Note: continuation of benefits rights under 42 CFR 422.632 are separate from and in addition to procedures discussed in Section 100 of the guidance regarding Provider Notices in Hospital, SNF, HHA, and CORF Settings.

90.a – Effectuation

In addition to the guidance in Section 90 (including the requirements listed in the table of Part C effectuations), the following requirements also apply for applicable integrated plans:

1. If an applicable integrated plan reverses its *own* integrated reconsideration to deny, limit, or delay a benefit that was not furnished while the integrated appeal was pending, the applicable integrated plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than:

- For a **standard** integrated reconsideration, *no later than the earlier of*:
    - 72 hours of making its decision (for an applicable integrated plan's decision) or receiving notice of the decision (for a State fair hearing decision) *or*,
        - *With the exception of a Part B drug, 30 calendar days after the date the applicable integrated plan receives the request for the integrated reconsideration (or no later than upon expiration of an extension described in § 422.633(f));*
        - *For a Part B drug, 7 calendar days after the date the applicable integrated plan receives the request for the integrated reconsideration.*
- For an **expedited** reconsideration, 72 hours of when the applicable integrated plan received the request for the integrated reconsideration. Note: 42 CFR § 422.634(d) only applies in lieu of 42 CFR § 422.618(a), but *not* in lieu of 42 CFR § 422.619. The requirements of 42 CFR § 422.619 apply to applicable integrated plans.

*2. If a **State fair hearing** officer reverses an applicable integrated plan's integrated reconsideration decision to deny, limit, or delay **a Medicaid benefit** that was not furnished while the integrated appeal was pending, the applicable integrated plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health*

condition requires but no later than 72 hours from the date it receives notice reversing the determination.

Note: in the case of a payment request, the payment does not need to be in the hands of the requester to be considered effectuated; authorization of the payment is sufficient.

3. If the Part C independent review entity, an administrative law judge or attorney adjudicator at the Office of Medicare Hearings and Appeals, or the Medicare Appeals Council reverses the integrated reconsideration to deny, limit, or delay services for a Medicare benefit, applicable integrated plans must follow Part C procedures described in Section 90 and required by 42 CFR §§ 422.618 and 422.619.

See 42 CFR § 422.634(d).

MICHELLE BAASS
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State of California—Health and Human Services Agency
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GAVIN NEWSOM
GOVERNOR

CalAIM Dual Eligible Special Needs Plans

Policy Guide

Contract Year 2023

January 2023

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Introduction

This California Advancing and Innovating Medi-Cal initiative (CalAIM) Dual Eligible Special Needs Plan (D-SNP) Policy Guide is intended to serve as a resource for D-SNPs in California, including both exclusively aligned enrollment (EAE) D-SNPs and non-EAE D-SNPs.

D-SNPs are Medicare Advantage (MA) plans that provide specialized care to beneficiaries dually eligible for Medicare and Medi-Cal, and offer care coordination and wrap-around services. Medicare Medi-Cal Plan, or MMP, is the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs). All D-SNPs in California must have executed contracts with the Department of Health Care Services (DHCS), the state Medicaid agency. These contracts, referred to as the State Medicaid Agency Contract (SMAC) or Medicare Improvements for Patients and Providers Act (MIPPA) contract, must meet a number of requirements, including Medicare-Medicaid integration requirements. DHCS developed two SMAC templates for 2023: the first for EAE-SNPs and the second for non-EAE D-SNPs. DHCS maintains the authority to contract or not to contract with D-SNPs.

As part of the CalAIM initiative, DHCS is leveraging the lessons and success of the Cal MediConnect (CMC) Financial Alignment Initiative to launch EAE D-SNPs, effective January 1, 2023, in the seven counties where the Coordinated Care Initiative (CCI) was implemented: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. EAE D-SNPs are D-SNPs where enrollment is limited to D-SNP members who are also enrolled in the affiliated Medi-Cal managed care plan.

This CalAIM D-SNP Policy Guide is intended to serve as a resource for all D-SNPs, beginning in Contract Year (CY) 2023, by providing additional details to supplement the 2023 SMAC. The Policy Guide provisions that apply to all D-SNPs, and those that apply only to EAE D-SNPs, are indicated at the beginning of each section. The provisions of this Policy Guide will be part of the DHCS SMAC requirements for 2023. Updates will be published as guidance is added.

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Summary of Updates and Key Changes

Date	Chapter/Section	Update/Change	Notes
1/3/2023	VIII. Integrated Appeals and Grievances Requirements for EAE D-SNPs	• Clarified integrated appeals and grievances noticing and definitions	
12/30/22	VI. Quality and Reporting Requirements	• Updated reporting requirements for clarity • Added Core 2.1 and Core 2.3 for EAE and non-EAE D-SNPs	
12/7/22	III. Network Guidance for EAE D-SNPs	• Initial Release	
12/7/22	VIII. Integrated Appeals and Grievances Requirements for EAE D-SNPs	• Initial Release	
11/14/22	All	• Formatting adjustments	
10/5/22	II. Information Sharing	• Initial Release	
8/19/22	IV. Enrollment and Disenrollment	• Initial Release	
8/1/22	VI. Quality and Reporting Requirements	• Initial Release	
8/19/22	VII. Integrated Materials	• Initial Release	
6/30/22	I. Care Coordination	• Specified language regarding training content for dementia care specialists	
6/30/22	Appendix A	• Revised formatting of LTSS questions for HRA	
6/9/22	I. Care Coordination	• Updated language regarding training content for dementia care specialists • Added language regarding ECM benefit for Duals	
6/9/22	V. Continuity of Care	• Initial Release	
12/30/21	I. Care Coordination	• Initial Release	

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I. Care Coordination Requirements

The purpose of this section is to provide state-specific care coordination requirements to health plans intending to operate EAE D-SNPs in California, beginning January 1, 2023. These requirements are specific to EAE D-SNPs, however non-EAE D-SNPs are welcome to adopt this approach.

The state requirements described in this section are in addition to all existing Medicare D-SNP Model of Care requirements outlined in 42 CFR §422.101(f) and Chapter 5 of the Medicare Managed Care Manual. They are similar to requirements included in the CMC three-way contract, and will be included in California's SMAC for EAE D-SNPs in 2023. DHCS intends to build on these requirements to continue to enhance integrated care for dually eligible beneficiaries in future years.

New EAE D-SNPs must reflect these state requirements in their Model of Care narratives for 2023, using the provided CalAIM EAE D-SNP components template (Appendix C). Existing D-SNPs, that will become EAE D-SNPs in 2023, which are not required to resubmit their Models of Care in February 2022 for CY 2023, should consider whether an off-cycle Model of Care update would be needed to accurately reflect their care coordination process as a result of implementing the state requirements. All EAE D-SNPs should submit their Models of Care to DHCS by 8pm Pacific Time on February 16, 2022, on a file and use basis. Should DHCS identify any concerns with a plan's Model of Care, the department will contact the plan for further information.

Risk Stratification

D-SNP risk stratification of enrollees must account for identified member needs covered by Medi-Cal. At a minimum, this process must include a review of:

- Any available utilization data, including Medicaid utilization data available through the aligned Medi-Cal managed care plan (including long-term care utilization) and utilization data from the member's CMC plan (for members transitioning from the CMC to the D-SNP in 2023);
- Any other relevant and available data from delivery systems outside of the managed care plans such as In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), other 1915(c) and home-and community-based waiver programs, behavioral health (both mental health and substance use disorder data, if available), and pharmacy data;
- The results of previously administered CMC or Medi-Cal Health Risk Assessments (HRAs), if available; and
- Any data and risk stratification available through the DHCS Population Health Management Platform (when it becomes available).

Additional technical guidance on how to access Medi-Cal data not otherwise available from the aligned Medi-Cal managed care plan will be forthcoming.

Health Risk Assessment (HRA)

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To the extent possible, while still meeting both Medicare and Medi-Cal requirements, the D-SNP should work with the aligned Medi-Cal managed care plan to create efficiencies in their respective HRA tools and processes to minimize the burden on members. Plans must make best efforts to create a single, unified HRA to meet the requirements for both the D-SNP and Medi-Cal managed care plans. Plans have flexibility in the design of their HRA tools as long as the content specified below is included. Plans should rely on Medicare timeframes for the completion of initial and annual HRAs. To the extent that Medi-Cal and Medicare guidance for HRAs conflict, plans should follow Medicare guidance.

D-SNPs must ensure their HRA identifies the following elements:

(1) Medi-Cal services the member currently accesses.
(2) Any Long-Term Services and Supports (LTSS) needs the member may have or potentially need, utilizing the LTSS questions provided in Appendix A or similar questions. If a plan intends to use a variation of the LTSS questions provided, the question must be reviewed and approved by DHCS. Plans may incorporate the questions into their HRA in any order.
(3) Populations that may need additional screening or services specific to that population, including dementia and Alzheimer's disease.

If a member identifies a caregiver, assessment of caregiver support needs should be included as part of the D-SNPs assessment process. HRAs must directly inform the development of member's Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT), per federal requirements.

Individualized Care Plans (ICPs) and Interdisciplinary Care Teams (ICTs)

Both the ICP and ICT meeting should include, to the extent possible, services and providers from the Medi-Cal managed care and carved-out delivery systems, as appropriate for the member and consistent with their preferences. Plans must encourage participation of both members and primary care providers in development of the ICP and ICT activities.

The ICP should be person-centered and informed by the member's HRA and past utilization of both Medicare and Medi-Cal services. One ICP should be used to meet both Medicare and Medi-Cal ICP requirements. To the extent that Medi-Cal and Medicare guidance for ICPs conflict, plans should follow Medicare guidance.

The ICP must identify any carved-out services the member needs and how the D-SNP will facilitate access and document referrals (including at least three (3) outreach attempts), including but not limited to referrals and connections to:

- Community Based Organizations such as those serving members with disabilities (e.g. independent living centers) and those serving members with dementia (e.g. Alzheimer's organizations)
- County mental health and substance use disorder services
- Housing and homelessness providers

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- Community Supports (formerly ILOS) providers in the aligned MCP network
- 1915(c) waiver programs, including MSSP
- LTSS programs, including IHSS and Community-Based Adult Services (CBAS)
- Medi-Cal transportation to access Medicare and Medi-Cal services

D-SNP care coordinators/managers participating in the ICT must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS programs, including home- and community-based services and long-term institutional care. The ICT should include providers of any Medi-Cal services the member is receiving, including LTSS and Community Supports.

Irrespective of having a formal Alzheimer's or dementia diagnosis, if the member has documented dementia care needs, including but not limited to: wandering, home safety concerns, poor self-care, behavioral issues, issues with medication adherence, poor compliance with management of co-existing conditions, and/or inability to manage ADLs/IADLS, the ICT must include the member's caregiver and a trained dementia care specialist to the extent possible and as consistent with the member's preferences. Dementia care specialists must be trained in: understanding Alzheimer's Disease and Related Dementias (ADRD); symptoms and progression; understanding and managing behaviors and communication problems caused by ADRD; caregiver stress and its management; and, community resources for enrollees and caregivers. D-SNPs should leverage available training content from community-based organizations with expertise in serving people with dementia when developing training content for dementia care specialists.

These ICT members must be included in the development of the member's ICP to the extent possible and as consistent with the member's preference.

Care Transitions

D-SNPs must identify individuals (either plan staff or delegated entity staff) to serve as liaisons for the LTSS provider community to help facilitate member care transitions. These staff must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home- and community-based services and long-term institutional care, including payment and coverage rules. Health plan social services staff serving as liaisons for the LTSS provider community should be engaged in the ICT, as appropriate for members accessing those services. It is not required that an LTSS liaison be a licensed position. D-SNPs must identify these individuals and their contact information in materials for providers and beneficiaries.

Medi-Cal Enhanced Care Management (ECM) and Dual Eligible Beneficiaries

From January 2022 to July 2024, DHCS will implement the Medi-Cal ECM requirement for MCPs throughout the state. DHCS' requirements for MCPs to implement ECM are contained in the CalAIM ECM Policy Guide, ECM and ILOS Contract Template (ECM and ILOS Contract A), which will become part of the MCPs' contract with DHCS, and the DHCS' ECM and ILOS Standard Provider Terms and Conditions. The Medi-Cal ECM benefit represents an opportunity for MCPs to work with providers, counties and community-based organizations (CBOs) to deliver a strong set of integrated supports for those who need them most, including dual eligible beneficiaries.

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Some EAE D-SNP members needing care management services through EAE D-SNPs may also meet the criteria for ECM populations of focus. However, there is significant overlap across the D-SNP model of care and ECM requirements, which could result in duplication and confusion for members and care teams if a member receives care management from both programs. Since member care management, as well as coordination across Medicare and Medi-Cal benefits, is a primary function of D-SNPs, DHCS intends for EAE D-SNPs to provide sufficient care management to members so that those members that would otherwise qualify for Medi-Cal ECM are not adversely impacted by receiving care management exclusively through their D-SNP. For 2023, DHCS guidance for EAE D-SNPs is to provide integrated care management across Medicare and Medi-Cal benefits with the intent that beneficiaries will receive any ECM-like services they may need through the D-SNP. For members already receiving Medi-Cal ECM from their MCP, D-SNPs shall provide ongoing continuity of care with existing ECM providers when possible, until the member graduates from ECM.

<table>
<tr><th></th><th>2022</th><th>2023</th><th>2024</th></tr>
<tr><td>Most Dual Eligible MCP Enrollees
In MA or Medicare FFS</td><td colspan="3">• ECM provided by their MCP
• Member must meet Population of Focus (POF) requirements</td></tr>
<tr><td>Non-EAE D-SNP Enrollees</td><td>• Same as above</td><td>• Same as above</td><td rowspan="2">• ECM-like care management provided through D-SNP
• Requirements to be outlined in D-SNP Policy Guide</td></tr>
<tr><td>EAE D-SNP Enrollees</td><td>• ECM-like care management provided by Cal MediConnect Plan</td><td>• ECM-like care management provided by EAE D-SNP</td></tr>
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II. Information Sharing Policy

Background

This section provides state-specific information sharing requirements to health plans operating D-SNPs in California, beginning January 1, 2023. These requirements are applicable to both exclusively aligned enrollment D-SNPs (EAE D-SNPs) and non-EAE D-SNPs. DHCS intends to build on these requirements to continue to enhance integrated care for dually eligible beneficiaries in future years.

Policy

For 2023, the information sharing policy is specified in the D-SNP State Medicaid Agency Contracts (SMACs), and that language is provided below. Additional details on the policy beyond the contract is noted in italics below.

1. D-SNP Contractor is responsible for complying with State policy implementing federal information sharing requirements for D-SNPs (42 CFR 422.107(d)(1)), for the purpose of coordinating Medicare and Medi-Cal covered services between settings of care. This State policy is in addition to federal requirements for hospitals for electronic notifications listed in 42 CFR 482.24(d). The goal of the information sharing policy is for D-SNP contractor, either directly or through contracted providers or other entities, to timely notify the Member’s Medi-Cal Plan (MCP) of hospital and SNF admissions, particularly if the MCP is a different organization than the D-SNP. Timely notification supports the coordination of and referrals to Medicare and Medi-Cal covered services, including home and community based services.
2.
   a) To the extent permissible under applicable federal and state law and regulations, and not inconsistent with the Member's expressed privacy preferences, D-SNP Contractor will require their contracted hospitals to use secure email, data exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform the D-SNP and the Member’s MCP of any hospital admission for all Members. D-SNP Contractor will require their contracted hospitals to make this notification either immediately prior to, or at the time of, the Member’s discharge or transfer from the hospital’s inpatient services (if applicable).
   b) As an alternative to the hospital’s notification to the Member’s MCP, the D-SNP Contractor may notify the Member’s MCP, in the same timeframe and method referenced in paragraph a, of any hospital admission for all Members. The D-SNP must coordinate any necessary Medicare and Medi-Cal services for the Member with the MCP.
   c) To the extent permissible under applicable federal and state law and regulations, and not inconsistent with the Member's expressed privacy preferences, D-SNP Contractor will require their contracted Skilled Nursing Facilities (SNFs) to use secure email, data exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform the D-SNP and the member’s MCP of any SNF admission, discharge, or transfer for all Members. For SNF admissions, D-SNP Contractor will

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require their contracted SNFs to make this notification within 48 hours after any SNF admission. For SNF discharges or transfers, D-SNP Contractor will require their contracted SNFs to make this notification in advance if at all possible, or at the time of, the Member's discharge or transfer from the SNF.

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

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

f) For the first six months of 2023, DHCS may permit D-SNP contractor to propose and implement an alternate approach and compliance plan to meet federal information sharing requirements. *If there are extenuating circumstances and no other process identified above is available, including secure e-mail, then secure eFax is permitted, subject to DHCS review and approval.*

3. D-SNP Contractor will coordinate care management for their Members and facilitate Member access to needed Long-Term Services and Supports to support care transitions.

Submission of Alternate Approaches

D-SNPs intending to propose and implement an alternate approach, as defined in paragraph f above, should submit a proposal that includes, at a minimum, the following information to DSNPSubmissions@dhcs.ca.gov:

- *How the proposal meets the state and federal requirements and*
- *What the process will transition to after the first six months of 2023, if known.*

III. Network Guidance for EAE D-SNPs

The purpose of this section is to provide state-specific network requirements to health plans intending to operate EAE D-SNPs in California beginning January 1, 2023. These requirements are in addition to any existing federal Medicare Advantage network requirements and have been developed per Welfare and Institutions Code (WIC) Section 14184.208:

> "(e) Beginning in contract year 2023, the department shall include requirements for network adequacy, aligned networks, and continuity of care in the SMAC. The requirements shall be developed in consultation with affected stakeholders."

These requirements are included in California's State Medicaid Agency Contract (SMAC) for EAE D-SNPs in 2023. DHCS intends to build on these requirements to continue to enhance integrated care for dually eligible beneficiaries in future years.

Network Adequacy
Existing Medicare and Medi-Cal network adequacy requirements will be sufficient to meet WIC Section 14184.208(e).

Aligned Networks
The goal of aligned networks is to ensure continuity of access to providers across Medi-Cal and Medicare. For contract year 2023, DHCS intends to solicit information from EAE D-SNPs about the extent to which their networks are aligned and will be providing subsequent guidance on aligned network requirements.

To ensure network alignment, EAE D-SNPs must report to DHCS the percent, number, and demographic information (including NPIs) of contracted Medi-Cal physicians for the D-SNP's aligned Medi-Cal managed care plan who are also contracted Medicare physicians and hospitals with the exclusively aligned enrollment D-SNP. The Medi-Cal managed care plan network used for this calculation should be just for the plan aligned with the EAE D-SNP parent company. If the MCP is a prime or delegate plan, the calculation should only reflect the prime or delegate plan, not both plans.

This information must be provided to DHCS in the first quarter of 2023 and include the month of data used to conduct the calculation.

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DHCS will provide a report template for the D-SNPs to complete and submit through a designated SFTP site. This data should be reported at the county level. For the purposes ofthis report, Medicare and Medi-Cal providers reported should include the following provider types and be consistent in classification by using the DHCS Taxonomy Crosswalk. In order to classify the provider types, the most recent version of the DHCS Taxonomy Crosswalk must be utilized. The current DHCS Taxonomy Crosswalk is available on the DHCS Dual Special Needs Plans Contract and Policy Guide web page.

- Primary Care category:
  - Combine General Practice & Family Practice
  - Combine Internal Medicine & Preventative Medicine
  - Include Geriatric
  - Exclude Pediatrics and non-physician practitioners
- Specialty Care category:
  - Include Welfare and Institutions Code (WIC) 14917 Core Specialists and OB/GYN
  - Exclude Genetics, Maternal/Fetal Medicine, Pediatric Subspecialties, Pediatric Surgery, Vascular Surgery, and Chiropractor
- Facility category:
  - Include Acute Inpatient Hospitals
  - Include Long Term Care Facilities: Skilled Nursing, Subacute, and Intermediate Care
  - Include Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Care Providers (IHCP)

In future years, DHCS will require EAE D-SNPs to meet a minimum percentage of aligned networks and report on priority provider types, as noted above. Future report timing will be issued later in 2023. DHCS will continue to work towards requiring EAE D-SNPs to have integrated provider networks, including integrated benefit determinations and integrated provider directories.

Additionally, EAE D-SNPs must assess alignment in geographic location and language capabilities between their Medicare and Medi-Cal networks. This assessment must be submitted to DHCS with the network overlap assessment

and must note what steps are being taken to improve the overlap in these areas.

Medi-Cal Provider Network Reporting Requirements
DHCS will use the D-SNP's submission of the existing 274 monthly provider file on their Medi-Cal provider network for the Service Area to confirm what was noted in the network alignment template. The 274 monthly provider file must be completed utilizing the most current of the Companion Guide. To request the current Companion Guide, email MCQMDProviderData@DHCS.ca.gov

To assist with network building, plans can obtain information about Medi-Cal participating providers by reviewing the California Health and Human Services Open Data Portal. The California Health and Human Services Open Data Portal can be found at:https://data.chhs.ca.gov/dataset/enrolled-medi-cal-fee-for-service-provider.

Any D-SNPs affiliated with a companion Medi-Cal MCP can obtain the file from the affiliated Medi-Cal plan.

Report Type	Purpose	Frequency/Timing	Reporting Period
EAE D-SNPs			
Aligned Networks: Percentage of aligned networks	Plans to submit alignment percentage by county. DHCS to gather information and establish an alignment threshold for plans to report utilizing provided template.	Initial report: 2/1/2023	January 2023
		Subsequent report due no later than Q3 2023 when DHCS defines the alignment percentage.	
Aligned Network Geographic Overlap Assessment	Plans to submit a geographic access map to show where the county is not aligned.	Initial assessment: 2/1/2023	January 2023
Aligned Network Language Overlap Gap Assessment	Plans to submit a narrative assessment of the overlap gaps in language capabilities and geographic location in the county.	Initial assessment: 2/1/2023	January 2023

IV. Enrollment and Disenrollment

D-SNP shall implement and maintain procedures to ensure that all Members requesting enrollment, disenrollment, or information regarding the disenrollment process are provided relevant information about their choices and Medicare rules and that their enrollment choices are appropriately processed. D-SNPs must adhere to all existing Medicare and Medi-Cal rules on noticing; these are additional scenarios that apply to the new EAE environment.

Special Enrollment Periods

1. The intent of this language is to help ensure that members are able to disenroll from a D-SNP and enroll in another Medicare Advantage plan using the same Special Enrollment Period (SEP).

    a. D-SNP must inform Members about the rules guiding Medicare SEPs if they request disenrollment, including any information they may need to appropriately execute enrollment into another Medicare Advantage plan.
        i. Beneficiaries should be encouraged to proactively enroll in the plan of their choice, during a valid period, which will automatically disenroll them from their current plan.
        ii. This will avoid confusion related to returning to fee-for-service Medicare, potentially needing to wait three months to join a new Medicare Advantage plan, or any Part D issues that would arise when disenrolling through their current plan directly.

MMP and Medicare Eligibility

1. Eligibility Age
    a. EAE D-SNPs may only enroll beneficiaries 21 years of age or older.
2. In cases where a member loses Medicare eligibility but remains in the Medi-Cal Managed Care Plan, the D-SNP must send a disenrollment notice.

V. Medicare Continuity of Care Guidance for All D-SNPs

The purpose of this section is to provide state-specific Medicare continuity of care requirements to dual eligible special needs plans (D-SNPs) in California, beginning January 1, 2023. These requirements are in addition to any existing federal Medicare Advantage (MA) requirements. These requirements are in accordance with Assembly Bill 133 (Chapter 143, Statutes of 2021), the Health Omnibus Budget Trailer Bill, Welfare and Institutions Code Section 14184.208:

> "(e) Beginning in contract year 2023, the department shall include requirements for network adequacy, aligned networks, and continuity of care in the SMAC. The requirements shall be developed in consultation with affected stakeholders."

The intent of these state-specific Medicare continuity of care requirements for D-SNPs is to ensure continued access to Medicare providers and covered services for members joining the D-SNP. These requirements are for Medicare providers and Medicare covered services and are similar to requirements included in the Cal MediConnect (CMC) three-way contract, and are included in California's State Medicaid Agency Contract (SMAC) for all D-SNPs in 2023.

Continuity of care requirements for Medi-Cal providers and Medi-Cal covered services can be found in All Plan Letter 18-008.

Additional network requirements are covered in the Network Guidance chapter of this policy guide. The network requirements are designed to ensure overall network adequacy as well as to support continued access to existing providers for Medi-Cal only beneficiaries transitioning to dual eligible status and enrolling in a D-SNP.

Continuity of Care for Medicare Primary and Specialty Providers

Upon member request, or request by other authorized person as noted below, D-SNPs must offer continuity of care with out-of-network Medicare providers to all members if all of the following circumstances exist:

- A member has an existing relationship with a primary or specialty care provider. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or a specialty care provider at least once during the 12 months prior to the date of their initial enrollment in the D-SNP for a non-emergency visit;
- The provider is willing to accept, at a minimum, payment from the D-SNP based on the current Medicare fee schedule, as applicable; and
- The provider does not have any documented quality of care concerns that would cause the D-SNP to exclude the provider from its network.

If the member leaves the D-SNP and later rejoins the D-SNP, then the D-SNP must offer the member a 12-month continuity of care period based on the date of re-enrollment, regardless of whether the member received continuity of care in the past. If a member changes D-SNPs, the continuity of care period may start over one time. If the member

changes D-SNPs a second time (or more), the continuity of care period does not start over, meaning the D-SNP is not required to offer the member a new 12-month period.

Requirements Regarding Primary Care Providers and Delegated Entities

When a member transitions into a D-SNP, and has an existing relationship with a PCP that is in the D-SNP's network, as determined through 1) the HRA process; 2) review of prior utilization data; or 3) member request, the D-SNP must assign the member to the PCP, unless the member chooses a different PCP. If the D-SNP contracts with delegated entities, it must assign the member to a delegated entity that has the member's preferred PCP in its network.

When a member transitions into a D-SNP, has an existing relationship with a PCP and at least one specialist that is in the D-SNP's network, and the member wishes to continue to seek treatment from each of these providers, the D-SNP must allow the member to continue treatment with each of these providers for the continuity of care period. This is regardless of whether these providers are, or are not, in the network of the primary plan's delegated entity to which the member is assigned, as long as the continuity of care requirements are met.

For example, if a member has an existing relationship with a PCP and a specialist with the assigned Independent Physicians Association #1 (IPA #1) as well as a specialist in another IPA (IPA #2), where both IPAs are delegated entities of the same D-SNP, the D-SNP must assign the member to IPA #1 and allow the member to continue treatment with both specialists. The continuity of care agreement for the specialist in IPA #2 would last for up to 12 months.

D-SNPs are required to notify their delegated entities of these requirements and the delegated entities are also required to provide continuity of care to their assigned members.

Procedures for Requesting Continuity of Care

Members, their authorized representatives, or their providers, may make a direct request to a D-SNP for continuity of care. Only those providers who treat members who are eligible for continuity of care, as noted above, may make a request to the D-SNP for continuity of care.

D-SNPs must, at a minimum, accept requests for continuity of care over the telephone, according to the requestor's preference, and cannot require the requester to complete and submit a paper or computer form. To complete a telephone request, the D-SNP may take any necessary information from the requester over the telephone.

D-SNPs must accept and approve retroactive requests for continuity of care and pay claims that meet all continuity of care requirements noted above, with the exception of the requirement to abide by the D-SNP's utilization management policies. The services that are the subject of the request must have occurred after the member's enrollment into the D-SNP, and the D-SNP may require the member, their authorized representative, or their provider to demonstrate that there was an existing relationship between the member and

provider prior to the member's enrollment into the D-SNP. D-SNPs must approve any retroactive requests that:

- Have dates of services within 30 calendar days of the first date of service for which the provider is requesting, or has previously requested, continuity of care retroactive reimbursement; and
- Are submitted within 30 calendar days of the first service for which retroactive continuity of care is being requested or denial from another entity when the claim was incorrectly submitted.

The D-SNP must accept retroactive requests that are submitted more than 30 days after the first service if the provider can document that the reason for the delay is that the provider unintentionally sent the request to the incorrect entity and the request is sent within 30 days of the denial from the other entity. Examples include, but are not limited to, situations where the provider sent the claim to CMS (as a Medicare Fee-for-Service (FFS) claim), an MA plan, another D-SNP, or the primary plan instead of the delegate.

When a request for continuity of care is made, the D-SNP must process the request within five working days after receipt of the request. However, as noted below, the request must be completed in three calendar days if there is a risk of harm to the member. The continuity of care process begins when the D-SNP starts the process to determine if there is a pre-existing relationship and enters into an agreement with the provider.

A member or their provider may provide information to the D-SNP that demonstrates a pre-existing relationship with a provider. A member or provider may not attest to a pre-existing relationship (instead, actual documentation must be provided) unless the D-SNP makes this option available to them.

Following identification of a pre-existing relationship, the D-SNP must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement or other form of agreement in order to establish a continuity of care relationship for the member.

Request Completion Timeline

Each continuity of care request must be completed within:

- 30 calendar days from the date the D-SNP receives the request;
- 15 calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
- Three calendar days if there is risk of harm to the member.

A continuity of care request is considered completed when:

- The member is informed of their right to continued access or if the D-SNP and the out-of-network provider are unable to agree to terms;
- The D-SNP has documented quality of care issues with the provider; or
- The D-SNP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

Requirements after the Request Process is Completed

If a D-SNP and the out-of-network FFS or prior plan provider are unable to reach an agreement because they cannot agree to terms or a reimbursement rate, or the D-SNP has documented quality of care issues with the provider, the D-SNP must offer the member an in-network alternative. If the member does not make a choice, the member will be assigned to an in-network provider. Members maintain the right to pursue an appeal or grievance through the Medicare process.

If an out-of-network provider meets all of the necessary requirements, including entering into a contract, letter of agreement, single-case agreement, or other form of agreement with the D-SNP, the D-SNP must allow the member to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with the D-SNP for a shorter timeframe. In this case, the D-SNP must allow the member to have access to that provider for the shorter period of time.

At any time, a member may change providers regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the D-SNP must work with the out-of-network provider to establish a care plan for the member.

Upon completion of a continuity of care request, D-SNPs must notify members of the following within seven calendar days:

- The request approval or denial, and if denied, the member’s appeal and grievance rights;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the member’s care at the end of the continuity of care period; and
- The member’s right to choose a different provider from the D-SNP’s provider network.

D-SNPs must also notify members 30 calendar days before the end of the continuity of care period about the process that will occur to transition the member’s care at the end of the continuity of care period. This process must include engaging with the member and out-of-network provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

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D-SNP Extended Continuity of Care Option

D-SNPs may choose to work with a member's out-of-network provider past the continuity of care period, but D-SNPs are not required to do so.

Continuity of Care for Medicare Durable Medical Equipment and Medical Supply Providers

Additionally, D-SNPs must ensure members have access to medically necessary Medicare-covered Durable Medical Equipment (DME) and medical supplies. In addition to complying with Medicare continuity of care requirements for these services and providers as outlined in 42 CFR 422.100(l)(2)(iii), D-SNPs must comply with the following requirements.

- Members joining a D-SNP with existing DME rentals must be allowed to keep their existing rental equipment until the D-SNP can evaluate the member, equipment is in the possession of the member, and ready for use.
    - After 90 days (per 42 CFR 422.100(l)(2)(iii)) and when the D-SNP is able to reassess the member, and, if medically necessary, authorize a new rental and have an in-network provider deliver the medically necessary rental.
- Members joining a D-SNP that have an open authorization to receive Medicare-covered medical supplies may continue to use their existing provider:
    - For 90 days per 42 CFR 422.100(l)(2)(iii); and
    - Until the D-SNP is able to reassess the member, and, if medically necessary, authorize supplies and have an in-network provider deliver the medically necessary supplies.

Member and Provider Outreach and Education

D-SNPs must inform members, or their authorized representatives, of continuity of care protections within 30 days of enrollment, and must include information about these protections in member information materials and handbooks. This information must include how a member and provider initiate a continuity of care request with the D-SNP. These documents must be translated into threshold languages and must be made available in alternative formats in compliance with Medi-Cal requirements, currently in APL 21-0004. D-SNPs must provide training to call center and other staff who come into regular contact with members about continuity of care protections.

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VI. Quality and Reporting Requirements

The purpose of this section is to provide state-specific Medicare and Medi-Cal quality and reporting requirement metrics to EAE and non-EAE D-SNPs in California, beginning January 1, 2023. These requirements are in addition to existing federal Medicare Advantage (MA) requirements. Further information is provided in the Technical Specifications available here: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx.

Background

State-specific reporting requirements for D-SNPs are part of a larger quality strategy within DHCS, including a focus on the Comprehensive Quality Strategy focused on dual eligible individuals, the Long-Term Services and Supports (LTSS) dashboard, and the Master Plan for Aging.

D-SNPs have robust reporting requirements for both Medi-Cal and Medicare. DHCS monitors the quality of care and health equity provided to members in Medi-Cal through various reporting requirements, as detailed in the 2022 DHCS Comprehensive Quality Strategy and Medi-Cal contracts.

DHCS built upon promising practices and quality reporting metrics from Cal MediConnect (CMC) plans, particularly as statewide and plan-specific performance has been a helpful benchmark to evaluate members' experiences in CMC plans.

In developing the state-specific quality and reporting requirements for D-SNPs, DHCS considered:

1) Overall quality and integrated care goals for D-SNPs.
2) Clinical value, and alignment with Medicare and Medi-Cal goals and measures.
3) Existing data sent to CMS that DHCS can receive.
4) Existing DHCS data that can be analyzed.
5) CMC measures to maintain for initial enrollment transition monitoring.

State-Specific Quality and Reporting Requirements

In addition to all federally required reporting requirements, D-SNPs must submit the following measures to the state at the PBP level. D-SNPs must submit the data to DHCS according to the reporting schedule listed below in an SFTP determined by the state.

D-SNPs must internally validate all data and quality measures submitted to DHCS according to their usual processes.

Additionally, for the Healthcare Effectiveness Data and Information Set (HEDIS) measures listed below, the D-SNP performance rates must be validated by an

external entity (e.g., the National Committee for Quality Assurance, NCQA) prior to submission to DHCS.

When available, D-SNPs must consult the data measure steward for any technical questions (e.g., the NCQA for HEDIS measures). Please send questions to QualityandHealthEquityDiv@dhcs.ca.gov. Please see below for a list of the state-specific quality and reporting requirements. More information, including Technical Specifications for the measures, is available on the DHCS webpage here: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx.

Access/Availability of Care

I. HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP)[1]

Effectiveness of Care

II. HEDIS Controlling High Blood Pressure (CBP)[1]
III. HEDIS Poor HbA1c Control (>9.0%) (HBD-H9)[1]
IV. HEDIS Follow-Up After Emergency Department Visit for Mental Illness (FUM)[1]

Utilization and Risk Adjusted Utilization

V. HEDIS Plan All-Cause Readmissions (PCR)[1]

Care Coordination

VI. Members with an assessment completed within 90 days of enrollment (Core 2.1)
VII. Members with an annual reassessment (Core 2.3)
VIII. Members With a Care Plan Completed Within 90 Days of Enrollment (Core 3.2)
IX. Members with an Individualized Care Plan (ICP) Completed (CA 1.5)
X. Members with Documented Discussions of Care Goals (CA 1.6)

Organizational Structure and Staffing

XI. Care Coordinator to Member Ratio (Core 5.1)
XII. Care Coordinator Training for Supporting Self-Direction (CA 3.2)

[1] Measures selected for race/ethnicity stratification by NCQA. D-SNPs will be required to report race/ethnicity stratifications, per HEDIS General Guidelines, to DHCS.

Medi-Cal Long-Term Services and Supports

XIII. Community-Based Adult Services (CBAS)

XIV. In-Home Supportive Services (IHSS)

XV. Multipurpose Senior Services Program (MSSP)

XVI. Long-Term Care (LTC)

Alzheimer's/Dementia Quality of Care

XVII. Cognitive Health Assessment

Summary of 2023 State-Specific D-SNP Reporting Requirements

All plans must report measures at the Plan Benefit Package (PBP) level.

Measure	Name	Reporting Frequency	Plan Types Required to Report
Access/Availability of Care			
I.	HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP)	Annually	All D-SNPs
Effectiveness of Care			
II.	HEDIS Controlling High Blood Pressure (CBP)	Annually	All D-SNPs
III.	HEDIS Poor HbA1c Control (>9.0%) (HBD-H9)	Annually	All D-SNPs
IV.	HEDIS Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Annually	All D-SNPs
Utilization and Risk Adjusted Utilization			
V.	HEDIS Plan All-Cause Readmissions (PCR)	Annually	All D-SNPs
Care Coordination			
VI.	Members with an assessment completed within 90 days of enrollment (Core 2.1)	Quarterly	All D-SNPs

Measure	Name	Reporting Frequency	Plan Types Required to Report
VII.	Members with an annual reassessment (Core 2.3)	Annually	All D-SNPs
VIII.	Members With a Care Plan Completed Within 90 Days of Enrollment (Core 3.2)	Quarterly	All D-SNPs
IX.	Members with an Individualized Care Plan (ICP) Completed (CA 1.5)	Quarterly	All D-SNPs
X.	Members with Documented Discussions of Care Goals (CA 1.6)	Annually	All D-SNPs
Organizational Structure and Staffing			
XI.	Care Coordinator to Member Ratio (Core 5.1)	Annually	All D-SNPs
XII.	Care Coordinator Training for Supporting Self-Direction (CA 3.2)	Annually	All D-SNPs
Medi-Cal Long-Term Services and Supports			
XIII.	Community-Based Adult Services (CBAS)	Annually	EAE D-SNPs
XIV.	In-Home Supportive Services (IHSS)	Annually	EAE D-SNPs
XV.	Multipurpose Senior Services Program (MSSP)	Annually	EAE D-SNPs
XVI.	Long-Term Care (LTC)	Annually	EAE D-SNPs
Alzheimer's/Dementia Quality of Care			
XVII.	Cognitive Health Assessment	Annually	All D-SNPs

State-Specific Guidance for Quality Measures

HEDIS Measures (I, II, III, IV, V):

- EAE and non-EAE D-SNPs must prepare and submit validated state-specific and D-SNP-specific Medicare HEDIS measures directly to the state, with EAE D-SNP results separate from non EAE D-SNP results if the organization has both. MA (non-D-SNP PBPs) results should be excluded if the plan has both MA and D-SNP PBPs.
- HEDIS measures should be submitted annually to DHCS, based on the submission schedule provided by NCQA.
- Plans should refer to "HEDIS Volume 2: Technical Specifications for Health Plans" for detailed information on complete technical specifications for each measure.
- Note: The target population for each HEDIS measure should be EAE and non-EAE D-SNP members at the PBP level.

Race/Ethnicity Stratification for HEDIS Measures

DHCS is committed to working to eliminate disparities in health care, and, as part of these efforts, is working to publicly report program-specific health disparity measures. In support of this vision, DHCS is requiring D-SNPs to report race/ethnicity stratifications, per HEDIS General Guidelines, for all HEDIS measures (including AAP, CBP, HBD-H9, FUM, and PCR). As stated in guidance, HEDIS measures report race and ethnicity data according to the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.

Continued Core Reporting Requirements (VI, VII, VIII and XI)

- EAE and non-EAE D-SNPs must prepare and submit internally validated state-specific and D-SNP-specific measures directly to the state, with EAE D-SNP results separate from non-EAE D-SNP results if the organization has both. MA results should be excluded if the plan has both MA and D-SNP PBPs.
- Core measures 2.1 and 3.2 must be reported on a quarterly basis to DHCS. Care plans and care plan completeness should be defined as written in Technical Specifications.
- Core measures 2.3 and 5.1 must be reported on an annual basis to DHCS.

Continued California-Specific Reporting Requirements (IX, X, and XII)

- EAE and non-EAE D-SNPs must prepare and submit internally validated state-specific and D-SNP-specific measures directly to the state, with EAE D-SNP

results separate from non EAE D-SNP results if the organization has both. MA results should be excluded if the plan has both MA and D-SNP PBPs.

- CA 1.5 must be reported on a quarterly basis to DHCS.
- CA 3.2 and CA 1.6 must be reported on an annual basis to DHCS.

Long Term Services and Supports (XIII, XIV, XV and XVI)

- EAE D-SNPs must prepare and submit internally validated state-specific and D-SNP-specific measures directly to the state, with EAE D-SNP results separate from non EAE D-SNP results if the organization has both. MA results should be excluded if the plan has both MA and D-SNP PBPs.
- Non-EAE D-SNPs are not required to report these measures.
- Medi-Cal long-term services and supports measures must be reported on a quarterly basis to DHCS.

New Alzheimer's/Dementia Quality of Care Measure (XVII): Annual Cognitive Health Assessment for Patients 65 years and Older

- In recognition of the significant prevalence of Alzheimer's and related dementias among dually eligible beneficiaries, and the Department's Dementia Aware initiative, DHCS will require plans to report this measure. Similar to other measures, this should be reported to DHCS internally validated and at a state-specific and D-SNP PBP specific level, with EAE D-SNP results separate from non-EAE D-SNP results if the organization has both. MA results should be excluded if the plan has both MA and D-SNP PBPs.
- This measure should be reported on an annual basis to DHCS, for the reporting period January 1, 2023 to December 31, 2023, no later than June 1, 2024.

Additional detail and reference materials for each measure is provided below.

I. **HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP)**

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/adults-access-to-preventive-ambulatory-health-services/
- The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

II. HEDIS Controlling High Blood Pressure (CBP)

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/
- Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).

III. HEDIS Hemoglobin A1c Control for Patients with Diabetes (HBD) – HbA1c Poor Control (>9.0%)

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/
- Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0%).

IV. HEDIS Follow-Up After Emergency Department Visit for Mental Illness (FUM)

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/
- Assesses emergency department (ED) visits for adults and children 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness. Two rates are reported:
    - ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
    - ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

V. HEDIS Plan All-Cause Readmissions (PCR)

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/
- For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

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VI. Members with an Assessment Completed within 90 Days of Enrollment (Core 2.1)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

A. Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.

B. Total number of members who were documented as unwilling to participate in the assessment within 90 days of enrollment.

C. Total number of members the D-SNP was unable to reach, following three documented outreach attempts, to participate in the assessment within 90 days of enrollment.

D. Total number of members with an assessment completed within 90 days of enrollment.

E. Percentage of members who were documented as unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment. Percentage = (B / A) * 100

F. Percentage D-SNP was unable to reach, following three documented outreach attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment. Percentage = (C / A) * 100

G. Percentage who had an assessment completed within 90 days of enrollment. Percentage = (D / A) * 100

H. Percentage who were willing to participate and who could be reached who had an assessment completed within 90 days of enrollment. Percentage = (D / (A – B – C)) * 100

VII. Members with an Annual Reassessment (Core 2.3)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

A. Total number of members enrolled as of the last day of the current reporting period.

B. Total number of members who had an assessment completed during the previous reporting period.

C. Total number of members with a reassessment completed during the current reporting period.

D. Total number of members with a reassessment completed within 365 days of the most recent assessment completed.

E. Total number of members who did not have an assessment completed during the previous reporting period.

F. Total number of members with an assessment completed during the current reporting period.

G. Percentage who had an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period. Percentage = (C / B) * 100

H. Percentage who had an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period that was within 365 days of the most recent assessment completed during the previous reporting period. Percentage = (D / B) * 100

I. Percentage who were enrolled for at least 90 continuous days during the previous reporting period who did not have an assessment completed during the previous reporting period but had an assessment completed during the current reporting period. Percentage = (F / E) * 100

VIII. Members With a Care Plan Completed Within 90 Days of Enrollment (Core 3.2)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

A. Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.

B. Of the total reported in A, the number of members who were documented as unwilling to complete a care plan and who never had a care plan completed within 90 days of enrollment. Unwillingness to participate must be clearly documented.

C. Of the total reported in A, the number of members the D-SNP was unable to reach, following three documented outreach attempts, to complete a care plan and who never had a care plan completed within 90 days of enrollment. Three outreach attempts must be clearly documented.

D. Of the total reported in A, the number of members with a care plan completed within 90 days of enrollment. Completed care plans must be clearly documented.

E. Percentage of members who were documented as unwilling to complete a care plan and who never had a care plan completed within 90 days of enrollment. Percentage = (B / A) * 100

F. Percentage of members the D-SNP was unable to reach, following three documented outreach attempts, to complete a care plan and who never had a care plan completed within 90 days of enrollment. Percentage = (C / A) * 100

G. Percentage of members who had a care plan completed within 90 days of enrollment. Percentage = (D / A) * 100

H. Percentage of members who were willing to participate and who could be reached who had a care plan completed within 90 days of enrollment. Percentage = (D / (A – B – C)) * 100

IX. Members with an Individualized Care Plan (ICP) Completed (CA 1.5)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

A. Total number of high-risk members enrolled for 90 days or longer as of the end of the reporting period who were currently enrolled as of the last day of the reporting period.

B. Of the total reported in A, the number of high-risk members who had an initial ICP completed as of the end of the reporting period.

C. Total number of low-risk members enrolled for 90 days or longer as of the end of the reporting period who were currently enrolled as of the last day of the reporting period.

D. Of the total reported in C, the number of low-risk members who had an initial ICP completed as of the end of the reporting period.

E. Percentage of high-risk members enrolled for 90 days or longer who had an initial ICP completed as of the end of the reporting period. Percentage = (B / A) * 100

F. Percentage of low-risk members enrolled for 90 days or longer who had an initial ICP completed as of the end of the reporting period. Percentage = (D / C) * 100

X. Members with Documented Discussions of Care Goals (CA 1.6)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

A. Total number of members with an initial ICP completed during the reporting period.

B. Of the total reported in A, the number of members sampled that met inclusion criteria.

C. Of the total reported in B, the number of members with at least one documented discussion of care goals in the initial ICP.

D. Total number of existing ICPs revised during the reporting period.

E. Of the total reported in D, the number of revised ICPs sampled that met inclusion criteria.

F. Of the total reported in E, the number of revised ICPs with at least one documented discussion of new or existing care goals.

G. Percentage of members with an initial ICP completed during the reporting period who had evidence of creation of at least one care goal documented in the initial ICP. Percentage = (C / B) * 100

H. Percentage of existing ICPs revised during the reporting period that had at least one documented discussion of new or existing care goals. Percentage = (F / E) * 100

XI. Care Coordinator to Member Ratio (Core 5.1)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

A. Total number of FTE care coordinators working in the D-SNP as of the last day of the reporting period.

B. Of the total reported in A, the number of FTE care coordinators assigned to care management and conducting assessments during the reporting period.

C. Total number of FTE care coordinators that left the D-SNP during the reporting period.

D. Number of members per FTE care coordinator. Rate = (Total Members Enrolled / A)

E. Percentage of FTE care coordinators who were assigned to care management and conducting assessments. Percentage = (B / A) * 100

F. Percentage of FTE care coordinators that left the D-SNP during the reporting period. Percentage = (C / (C + A)) * 100

XII. Care Coordinator Training for Supporting Self-Direction (CA 3.2)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx.

A. Total number of full-time and part-time care coordinators who have been employed by the D-SNP for at least 30 days at any point during the reporting period.

B. Of the total reported in A, the number of care coordinators who have undergone training for supporting self-direction within the reporting period.

C. Percentage of full-time and part-time care coordinators who have undergone training for supporting self-direction within the reporting period. Percentage = (B / A) * 100

XIII. Community-Based Adult Services (CBAS)

A. Enter the total number of members currently receiving services during the reporting quarter.

B. Total number of referrals made for CBAS services for the reporting period.

C. Total number of initial member assessments completed by the CBAS centers for the reporting quarter. CBAS Eligibility Determination Tools (CEDTs) do not qualify as an initial assessment and should not be included.

D. Enter the total number of initial members approved for services for the reporting period.

E. Enter the total number of member reassessments completed by the D-SNP for the reporting period. Per Medi-Cal Managed Care boilerplate contract requirements (Exhibit A, Attachment 19), beneficiaries are required to be reassessed every six months to determine their eligibility for CBAS services.

F. Enter the total number of member reassessments that were approved by the D-SNP for the reporting quarter.

G. Enter the total number of members denied for CBAS services for the reporting quarter. Select only one of the 5 denial options for each member denial (Not Medically Necessary, Incomplete Assessment, Member Refused Service, Transition to Other Program or Setting, Other Reason).

XIV. In-Home Supportive Services (IHSS)

A. Enter the total number of ICTs w/ county social worker (county DPSS liaison) participation for the reporting quarter.

B. Enter the number of members referred to county for IHSS for the reporting period.

C. Enter the total number of member referrals received for IHSS for the reporting quarter.

XV. Multipurpose Senior Services Program (MSSP)

A. Total number of ICTs w/ MSSP Care Manager participation for the reporting period.

B. Total number of members receiving MSSP during the reporting period.

C. Total number of member referrals made for MSSP for the reporting period.

XVI. Long-Term Care (LTC)

A. Total number of members currently residing in LTC for >90 days during the reporting period.

B. Total number of member referrals received for LTC stays >90 days the reporting quarter. This column is for members being referred to LTC for a stay anticipated to be >90 days for the first time during the reporting period.

C. Enter the total number of initial member assessments for LTC stay >90 days completed for the reporting quarter. This column is for members being assessed for LTC for the first time during the reporting period.

D. Total number of members initially approved for LTC stay >90 days for the reporting quarter. This column is for members being approved for LTC stay for the first time during the reporting period.

E. Total number of members reassessed for LTC stay >90 days for the reporting quarter. This column is for members being reassessed for LTC for the first time during the reporting period.

F. Total number of member reassessment approved for LTC stay >90 days for the reporting quarter. This column is for members being reapproved for LTC stay for the first time during the reporting period.

G. Total number of members denied for LTC services for the reporting quarter. Use only one of the 5 denial options for each member denial (Not Medically Necessary, Incomplete Assessment, Member Refused Service, Transition to Other Program or Setting, Other Reason).

XVII. Annual Cognitive Assessment for Patients 65 Years and Older

- Additional information from the American Academy of Neurology (page 8): https://www.aan.com/siteassets/home-page/policy-and-guidelines/quality/quality-measures/2019.03.25-mci-measures.pdf
- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

A. Percentage of patients aged 65 and older who had cognition assessed within the measurement period.

D-SNP Reporting Requirements Clarifications

- D-SNPs are not required to submit state-specific measures at the county level. Reporting will be done at the PBP level.
- EAE and non-EAE D-SNPs must submit state-specific data, disaggregated by EAE and non-EAE D-SNP (if the organization has both) and excluding non-D-SNP PBPs.
- EAE D-SNPs are required to report on LTSS measures. Non-EAE D-SNPs are not required to report on LTSS measures. The LTSS reporting for EAE D-SNPs includes MCP values (that excludes EAE D-SNP values). This is in addition to

Medi-Cal only reporting done by MCPs, and will be a subset of the Medi-Cal reporting.

- DHCS provided a reporting template for plans to use to submit non-HEDIS measures. Plans should submit the HEDIS measures (stratified by race and ethnicity), certified via their usual EQRO process, prior to submission to DHCS.
- D-SNPs should use the DHCS Technical Specifications available here: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx.
- D-SNPs should refer to the American Academy of Neurology Mild Cognitive Impairment Quality Measurement Set for acceptable validated tools to assess patient cognition. Plans are encouraged to reference and direct providers to the Dementia Care Aware website and associated resources, available here: https://www.dementiacareaware.org/

VII. Integrated Materials for EAE D-SNPs

The purpose of this section is to provide state-specific integrated Member materials requirements for exclusively aligned enrollment (EAE) dual eligible special needs plans (D-SNPs) in California. The state requirements described in this section are in addition to all existing Medicare marketing and communications requirements outlined in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V and as described in the Medicare Communications and Marketing Guidelines (MCMG)[2]. These requirements are also included in California's SMAC for EAE D-SNPs in 2023.

EAE D-SNPs are responsible for providing integrated materials to Members. Required integrated Member materials include:

- Annual Notice of Change (ANOC)
- ANOC Coversheet
- Member Handbook/Evidence of Coverage (EOC)
- Summary of Benefits
- Member Identification (ID) Card
- Provider/Pharmacy Directory
- List of Covered Drugs (Formulary)

Integrated appeals and grievances materials will be detailed in a separate D-SNP policy guide chapter.

Program Name
The California-specific program name for EAE D-SNPs is Medicare Medi-Cal Plans (MMPs or Medi-Medi plans). The goal of this branded program name is to describe the type of plan and differentiate EAE D-SNPs from Medi-Cal plans, regular Medicare Advantage plans, unaligned D-SNPs, or PACE products. DHCS will also use this name for Health Care Options (HCO) and on the DHCS website. Though not required, DHCS recommends plans leverage the following naming convention:

First reference in each section or chapter: <Mandatory Plan Name> (Plan Type), a Medicare Medi-Cal Plan

Provider Directory
Plans must comply with existing federal and state guidelines regulating print and online provider directories. DHCS expects that print and online directories for EAE D-SNPs will reflect all contracted and in-network providers for D-SNP members, effective January 1, 2023, and be updated regularly through December 31, 2023. The intent of the provider directories is to show the providers that are in the D-SNP Medicare and/or Medi-Cal networks in a clear manner for D-SNP members. Plans are not required to indicate

[2] See https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.

whether the provider is contracted on the D-SNP or Medi-Cal side, to avoid member confusion.

Translation

EAE D-SNPs are required to make all integrated materials available in the threshold languages for their aligned managed care plan (MCP) Service Area. Threshold languages are defined as those languages that meet the more stringent of either:

- Medicare's five percent (5%) threshold for language translation[3]; or
- DHCS' prevalent language requirements (the DHCS threshold and concentration standard languages), as specified in annual guidance to Contractors on specific translation requirements for their Service Areas, currently found in APL 21-004.

EAE D-SNPs must have a process for ensuring that enrollees can make a standing request to receive materials in alternate formats and in all non-English languages, at the time of request and on an ongoing basis thereafter. The process should include how the plan will keep a record of the member's information and utilize it as an ongoing standing request so the member does not need to make a separate request for each material and how a member can change a standing request for preferred language and/or format. EAE D-SNPs may refer to Cal MediConnect marketing guidance for additional instruction on material formats and translations.

Submission and Review Process

DHCS will release templates for the required integrated Member materials to all EAE D-SNP plans in Q2, annually. In addition to the Integrated Member Materials, plans will receive the Department of Managed Health Care's (DMHC) filing checklist that includes the requirements for the filing that must be submitted to the DMHC.
Upon completing the templates, EAE D-SNPs are required to submit their completed integrated material templates to DMHC and DHCS for review and approval by close of business on the dates listed below. Plans must simultaneously submit their completed materials to DMHC through the DMHC portal and to the DHCS inbox 2PlanDeliverables@dhcs.ca.gov. The filings/submissions should include clean and redlined copies of each document. Plans should direct questions relating to DMHC materials approval to the assigned licensing reviewer. Note: The processes may change for CY2024 materials.

[3] Pursuant to 42 C.F.R. §§ 422.2268(a)(7) and 423.2268(a)(7), Medicare Part C plans and Part D sponsors (Sponsors) are required to translate vital materials into any non-English language that is the primary language of at least five (5) percent of the individuals in a plan benefit package (PBP) service area. The Sponsors that have service areas that meet the five (5) percent threshold must provide these translated materials on their websites and in hardcopy upon beneficiary request.

The Provider/Pharmacy Directory should be submitted with variable language populated, however it is not necessary for provider and pharmacy content to be added at the point of submission.

After approval from both DHCS and DMHC, the ANOC, Member Handbook/EOC, and Summary of Benefits should be submitted as file and use in HPMS a minimum of five (5) days prior to their use as described at 42 CFR section 422.2261(b)(3). The Member ID Card, Formulary, and Provider/Pharmacy Directory will not need to uploaded to HPMS.

Beneficiary Material	Deadline to Submit to DHCS and DMHC	Estimated State Approval Date	Date Materials to be Uploaded to HPMS	Due to Current Enrollees
Annual Notice of Change (ANOC)	July 20, 2022	August 31, 2022	September 30, 2022	September 30, 2022
Member Handbook/ Evidence of Coverage (EOC)	July 21, 2022	September 9, 2022	October 15, 2022	October 15, 2022
Summary of Benefits	August 1, 2022	August 31, 2022	October 15, 2022	October 15, 2022
Member ID Card	August 1, 2022	August 31, 2022	N/A	Within 10 days of when plan receives enrollment in their system (early November 2022)
Formulary	August 1, 2022	August 31, 2022	N/A	October 15, 2022
Provider and Pharmacy Directory	August 1, 2022	August 31, 2022	N/A	October 15, 2022

VIII. Integrated Appeals and Grievances Requirements for EAE D-SNPs

Introduction

The purpose of this section is to provide state-specific integrated appeals and grievances requirements to exclusively aligned enrollment (EAE) dual eligible special needs plans (D-SNPs) in California, beginning January 1, 2023.

The requirements are in accordance with 42 CFR § 422.629-634:

> "(e) General process. An applicable integrated plan must create integrated processes for Enrollees for integrated grievances, integrated organization determinations, and integrated reconsiderations."

As EAE D-SNPs in 2023 qualify as applicable integrated plans (AIP), the intent of this state-specific guidance is to ensure integrated processes for grievances, organization determinations, and reconsiderations for Enrollees. These requirements are similar to requirements included in the Cal MediConnect (CMC) three-way contract and are included in California's State Medicaid Agency Contract (SMAC) for EAE D-SNPs in 2023. These requirements are in accordance with federal and state requirements, whereby the state requirements may be more protective for Enrollees. Some differentiation is noted for plans with Knox-Keene licenses.

Grievance and appeal requirements for Medi-Cal managed care plans (MCP) can be found in All Plan Letter 21-011. Additional requirements are provided in Health and Safety Code (HSC) §§ 1367 and 1368.

While state regulations do not specifically distinguish "grievances" from "appeals," federal regulations define "grievance and appeal system" to mean the processes the plan implements to handle grievances and appeals, with the terms "grievance" and "appeal" each separately defined. Due to distinct processes delineated for the handling of each, EAE D-SNPs must adopt the federal definition but also incorporate applicable sections of the existing state definition that do not pose conflicts.

The following individuals or entities can request an integrated grievance, integrated organization determination, and integrated reconsideration:

- The Enrollee or Enrollee's representative
- An assignee or the Enrollee
- The legal representative of a deceased Enrollee's estate
- Any provider that furnishes, or intends to furnish, services to the Enrollee

In the case of a provider who is providing treatment to the Enrollee, that provider may, upon providing notice to the Enrollee, request a standard or expedited pre-service integrated reconsideration on behalf of an Enrollee.

EAE D-SNPs must establish, implement, maintain, and oversee an integrated grievance and appeal system to ensure the receipt, review, and resolution of integrated grievances and appeals.

Integrated Grievances

A **grievance** (or complaint) is any expression of dissatisfaction about any matter other than an adverse benefit determination. If the EAE D-SNP is unable to distinguish between a grievance and an inquiry, it must be considered a grievance.[4]

An Enrollee may file a grievance at any time. Expedited grievances must be made available to the Enrollee. Expedited grievances are defined as:

1) A case involving an imminent and serious threat to the health of a patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function;[5]
2) A decision to invoke an extension relating to an integrated organization determination or integrated reconsideration; or
3) Refusal to grant an Enrollee's request for an expedited integrated organization determination under 42 CFR § 422.631 or expedited integrated reconsideration under 42 CFR § 422.633.[6]

Upon receipt of the grievance, EAE D-SNPs must send a written acknowledgement of the grievance that is dated and postmarked within five (5) calendar days of receipt.[7] EAE D-SNPs must resolve standard grievances and send written resolution to the Enrollee as expeditiously as the Enrollee's health condition requires, but no later than 30 calendar days from receipt of the grievance. Expedited grievances must be resolved in 24 hours.[8]

Written notice of determination does not apply to grievances that were received by telephone, facsimile, email, or online through the plan's internet website, that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the next business day. However, there are exceptions, and a written notice of determination is required if the Enrollee requests a written response, if the grievance is related to quality of care, coverage disputes, or disputed health care services involving medical necessity or experimental investigational treatment, regardless of how the grievance is filed and when it is resolved.[9] Plans must log and report all grievances.

Integrated Organization Determinations

EAE D-SNPs must consider both Medicare and Medi-Cal coverage criteria and make a determination as to a full or partial denial of an integrated organization determination.

EAE D-SNPs must provide notice of standard integrated organization determinations as expeditiously as the Enrollee's health condition requires, and no later than 14 calendar

[4] An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other D-SNP processes.
[5] Health and Safety Code (HSC) § 1368.01(b); 28 CCR § 1300.68.01.
[6] 42 CFR § 422.630.
[7] HSC § 1368(a)(4)(A); 28 CCR § 1300.68(d)(1).
[8] 42 CFR § 422.630.
[9] 42 CFR § 422.630.

days from when it receives the request. For Knox-Keene licensed plans, standard organizational determinations (also referred to as utilization management [UM] decisions) are to be made within five (5) business days from the plan's receipt of information reasonably necessary to make the determination and no later than 14 calendar days from when it receives the request.[10]

In the case of expedited integrated organizational determinations, EAE D-SNPs must provide notice as expeditiously as the Enrollee's health condition requires and no later than 72 hours from when it receives the request.[11]

EAE D-SNPs may not extend the deadlines for integrated organization determinations.

Prior to terminating, suspending, or reducing a previously approved item or service, EAE D-SNPs must provide Enrollees with an integrated coverage determination at least ten (10) calendar days in advance of the effective date of the adverse organizational determination. In the event of the adverse organizational determination, the Enrollee must request continuation of benefits for the previously approved Medicare and/or Medicaid benefit(s) that the plan is terminating, suspending, or reducing within ten (10) calendar days of the notice's postmark date or by the intended effective date of the action, whichever is later.

Integrated Appeals/Reconsiderations

An **appeal** is federally defined as a review by the plan of an adverse benefit determination. EAE D-SNPs must use the federal definition of appeal and comply with all existing state regulations as they pertain to the handling of appeals. Additional definitions can be found in the All Plan Letter linked above.

An Enrollee must file an integrated reconsideration (appeal) within 60 calendar days from the date of the integrated Coverage Decision Letter. EAE D-SNPs must send each Enrollee written acknowledgement of receipt of all appeals within five (5) calendar days.[12]

The Medicaid External Appeals processes are to be in accordance with the Department of Managed Health Care's (DMHC's) Independent Medical Review (IMR) System set forth in Article 5.55 of the Knox-Keene Act and the regulations promulgated thereunder for Medicare second level appeals.

EAE D-SNPs must resolve standard integrated reconsiderations (appeals) as expeditiously as the Enrollee's health condition requires but not exceeding 30 calendar days from the date of receipt of the request for the integrated reconsideration (appeal); expedited integrated reconsiderations (appeals) must be resolved within 72 hours of receipt of the request.[13] D-SNPs may not extend timeframes for integrated reconsiderations (appeals) of Medicare and Medicaid services, per APL 21-011.

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[10] 42 CFR §422.631(d)(2)(i)(B); HSC § 1367.01(h)(1).
[11] 42 CFR § 422.631(d)(2)(iv); HSC § 1367.01(h)(2).
[12] 42 CFR § 422.629(g); HSC § 1368(a)(4)(A).
[13] 42 CFR § 422.633(f)

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Plans need to ensure they are obtaining all relevant information needed to make a decision within the required timeframes.

Notices

Integrated Organization Determinations[14]

EAE D-SNPs must provide an integrated Coverage Decision Letter within the required timeframes for all fully or partially denied integrated organization determinations and provide notice to Enrollees of their appeal and State fair hearing rights.

All EAE D-SNPs must attach to the integrated Coverage Decision Letter a separate notice informing Enrollees of their right to a State fair hearing after the plan's appeal process has been exhausted and include the most current State fair hearing form with this notice when the following requirements are met:

1) The denied integrated organization determination is not for a Medicare only service or benefit; and
2) The integrated organization determination is relating to a denial, in whole or in part, of a Medi-Cal service/benefit, including cases where there is an overlap of Medicare/Medi-Cal.

For Knox-Keene licensed plans, EAE D-SNPs must also inform Enrollees of their rights to an IMR and include the verbatim language required by HSC § 1368.02(b), the most recent IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC when the following requirements are met:

1) The denied integrated organization determination is for experimental or investigational therapy, or is a denial of urgent care or emergency service; and
2) The denied integrated organization determination is not for a Medicare only service or benefit; and
3) The integrated organization determination is relating to a denial, in whole or in part, of a Medi-Cal service/benefit, including cases where there is an overlap of Medicare/Medi-Cal.[15]

In summary, EAE D-SNPs that are not Knox-Keene licensed are required to send State Fair hearing information only. All Knox-Keene licensed EAE D-SNPs must send both State fair hearing information and IMR information, when the above requirements are met.

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[14] Integrated organization determinations are similar to adverse benefit determinations explained in APL 21-011. As such, the noticing requirements for an integrated Coverage Decision Letter are consistent with DHCS' Notice of Action noticing requirements. EAE D-SNPs must follow all applicable requirements accordingly.
[15] 28 CCR § 1300.70.4; HSC § 1368.03.

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Plans may refer to DHCS' "Your Rights" template for notices of action and modify the template language as necessary to inform Enrollees of their right to a State fair hearing and IMR.[16]

Integrated Appeals/Reconsiderations[17]

All EAE D-SNPs must provide Enrollees notice of its integrated reconsideration (appeal) decision within the required timeframes and inform Enrollees of their rights to a State fair hearing and include the most current State fair hearing form when the following requirements are met:

1) The denied integrated reconsideration (appeal) decision is not for a Medicare only service or benefit; and
2) The integrated reconsideration (appeal) is relating to a denial, in whole or in part, of a Medi-Cal service/benefit, including cases where there is an overlap of Medicare/Medi-Cal.

Additionally when the above requirements are met, Knox-Keene licensed plans must also inform Enrollees of their right to request an IMR and include the verbatim language required by HSC § 1368.02(b), the most recent IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC.

In summary, EAE D-SNPs that are not Knox-Keene licensed are required to send only State fair hearing information with the Enrollee's notice of its integrated reconsideration (appeal) decision. Knox-Keene licensed EAE D-SNPs must send both State fair hearing information and IMR information with the Enrollee's notice of its integrated reconsideration (appeal) decision.

In addition to the Coverage Decision Letters, additional model notices that meet federal requirements are available online: [18]

- Letter about Your Right to Make a Fast Complaint
  - This notice is used when the plan makes a decision on or after January 1, 2021, to 1) extend the timeframe for deciding an integrated organization determination or integrated reconsideration, or 2) deny a request for an expedited integrated organization determination or integrated reconsideration.

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[16] DHCS' "Your Rights" template for notices of action is available here: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/NOA-Your-Rights-Knox-Keene.pdf

[17] Integrated appeals/reconsiderations are similar to appeals explained in APL 21-011. As such, the noticing requirements for an integrated appeals decision letter are consistent with DHCS' Notice of Appeal Resolution noticing requirements. EAE D-SNPs must follow all applicable requirements accordingly.

18 The model notices "The Letter about Your Right to Make a Fast Complaint" and "Appeal Decision Letter" are not required but meet the requirements of 42 CFR §§ 422.631 and 422.633.

- Appeal Decision Letter
  - This notice explains the Enrollee's further appeal rights under both Medicare and the Medi-Cal program.
  - Plans must modify this notice to inform Enrollees of their right to a State fair hearing and for Knox-Keene licensed plans, also inform Enrollees of their right to an IMR. Plans may refer to DHCS' "Your Rights" template for notices of appeal resolution and modify the template language as necessary.[19]

Out-of-network providers may use the integrated appeals process on their own behalf for claims for services provided to Enrollees of D-SNPs and must complete a Waiver of Liability when requesting an integrated appeal. [20]

Reversal of decisions

If an EAE D-SNP reverses its decision to deny, limit, or delay services that were not provided while the appeal was pending, EAE D-SNP must authorize or provide the service under dispute:

- As expeditiously as the Enrollee's health condition requires and within 72 hours of the date it reverses its determination; or
- With the exception of a Medicare Part B drug, 30 calendar days after the date the applicable EAE D-SNP receives the request for the integrated reconsideration (or no later than upon expiration of an extension described in 42 CFR § 422.633(f); or
- For a Medicare Part B drug, seven (7) calendar days after the date the EAE D-SNP receives the request for the integrated reconsideration.

If a State fair hearing officer reverses an EAE D-SNP's integrated appeal decision to deny, limit, or delay services that were not provided while the appeal was pending, the EAE D-SNP must authorize or provide the disrupted service(s) as expeditiously as the Enrollee's health condition requires but no later than 72 hours of the date it receives notice reversing the determination.

If the Part C independent review entity, an administrative law judge or attorney adjudicator at the Office of Medicare Hearings and Appeals, or the Medicare Appeals Council reverses the decision it must be effectuated under same timelines applicable to other Medicare Advantage plans as specified in §§ 422.618 and 422.619. Upon

[19] The "Your Rights" template for notices of appeal resolution is available here: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/NAR-Your-Rights-Knox-Keene.pdf
[20] The Waiver of Liability form is available here: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.

receiving the decision of an IMR that a disputed health care service is medically necessary, Knox-Keene licensed plans must promptly implement the decision.[21]

In the event that a case is dismissed for being late without good cause, EAE D-SNPs do not automatically forward cases to the Integrated Administrative Hearing Officer (IAHO) and instead must notify Enrollees of appeal rights.

Quality Improvement Organization Program

The Medicare Quality Improvement Organization (QIO) Program exists to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries; this includes the requirement that the QIO expeditiously addresses individual complaints, such as Enrollee complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

Considerations for EAE D-SNPs

EAE D-SNPs must provide information about the integrated grievance and integrated appeal system to all providers and subcontractors at the time they enter into a contract, including, at a minimum, information on integrated grievance, integrated reconsideration, and State fair hearing procedures and timeframes, as applicable.

EAE D-SNPs must maintain records of the integrated grievances, integrated organization determinations and integrated appeals, whereby MCPs must review the Medicaid related information as part of its ongoing monitoring procedures, as well as for updates and revisions to the state quality strategy. The record of each integrated grievance, integrated organization determination or integrated appeal must be accurately maintained in a manner accessible to the state and available upon request to CMS.

General Medicare Advantage Medicare Part B drug regulations apply for authorization requests and appeals.

Medicare Part D process and timing are not included in the integrated grievances, integrated organization determinations and integrated appeals for EAE D-SNPs; therefore, plans should follow all existing Medicare Part D requirements related to appeals and grievances.

A comparison of the requirements under the Integrated Appeals and Grievance regulations (42 CFR §§ 422.629-634, Cal MediConnect, Medicare Advantage, and Medi-Cal) are available on the CalAIM D-SNP Contract and Policy Guide website.

[21] HSC §1374.34.

Additional Guidance

Medicare Parts C & D guidance:

https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf

Applicable Integrated Plan D-SNP guidance:

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs

IX. Appendices

Appendix A: LTSS Questions for Inclusion in EAE D-SNP HRA

The questions are organized in the following two tiers and EAE D-SNPs must take a holistic view of questions in both tiers to identify beneficiaries in need of follow-up assessments:

- Tier 1 contains questions directly related to LTSS eligibility criteria, and should trigger a follow-up assessment to determine if the beneficiary is eligible for LTSS services.
- Tier 2 contains questions that identify contributory risk factors, which would put a beneficiary at higher risk for needing LTSS services when combined with risk factors identified in Tier 1.

The headings in bold are not part of the questions, but provide the intent of the questions.

Tier 1 LTSS Questions:
Activities of Daily Living Functional Limitations / Instrumental Activities of Daily Living

Limitations / Functional Supports (Functional Capacity Risk Factor)
Question 1: Do you need help with any of these actions? (Yes/No to each individual action)
a) Taking a bath or shower
b) Going up stairs
c) Eating
d) Getting Dressed
e) Brushing teeth, brushing hair, shaving
f) Making meals or cooking
g) Getting out of a bed or a chair
h) Shopping and getting food
i) Using the toilet
j) Walking
k) Washing dishes or clothes
l) Writing checks or keeping track of money
m) Getting a ride to the doctor or to see your friends
n) Doing house or yard work
o) Going out to visit family or friends
p) Using the phone
q) Keeping track of appointments

If yes, are you getting all the help you need with these actions?
Housing Environment / Functional Supports (Social Determinants Risk Factor)

Question 2: Can you live safely and move easily around in your home? (Yes/No)
If no, does the place where you live have: (Yes/No to each individual item)
a) Good lighting
b) Good heating
c) Good cooling
d) Rails for any stairs or ramps
e) Hot water
f) Indoor toilet
g) A door to the outside that locks
h) Stairs to get into your home or stairs inside your home
i) Elevator
j) Space to use a wheelchair
k) Clear ways to exit your home

Low Health Literacy (Social Determinants Risk Factor)
Question 3: “I would like to ask you about how you think you are managing your health conditions”
a) Do you need help taking your medicines? (Yes/No)
b) Do you need help filling out health forms? (Yes/No)
c) Do you need help answering questions during a doctor’s visit? (Yes/No)

Caregiver Stress (Social Determinants Risk Factor)
Question 4: Do you have family members or others willing and able to help you when you need it? (Yes/No)

Question 5: Do you ever think your caregiver has a hard time giving you all the help you need? (Yes/No)

Abuse and Neglect (Social Determinants Risk Factor)
Question 6a: Are you afraid of anyone or is anyone hurting you? (Yes/No)
Question 6b: Is anyone using your money without your ok? (Yes/No)

Cognitive Impairment (Functional Capacity, Medical Conditions, Behavioral Health Condition Risk Factor)
Question 7: Have you had any changes in thinking, remembering, or making decisions? (Yes/No)

Tier 2 LTSS Questions:
Fall Risk (Functional Capacity Risk Factor)
Question 8a: Have you fallen in the last month? (Yes/No)
Question 8b: Are you afraid of falling? (Yes/No)

Financial Insecurity or Poverty (Social Determinants Risk Factor)
Question 9: Do you sometimes run out of money to pay for food, rent, bills, and medicine? (Yes/No)

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Isolation (Social Determinants Risk Factor)
Question 10: Over the past month (30 days), how many days have you felt lonely? (Check one)
None – I never feel lonely
Less than 5 days
More than half the days (more than 15)
Most days – I always feel lonely

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Appendix B: 2023 CalAIM EAE D-SNP Components Template

Please complete and submit this document with the 2023 EAE D-SNP Model of Care to your DHCS contract manager by 8pm Pacific Time on February 16, 2022

Applicant's Contract Name (as provided in HPMS):	
Applicant's CMS Contract Number:	

DHCS issued state-specific care coordination requirements to health plans intending to operate EAE D-SNPs in California, beginning January 1, 2023 through the D-SNP Policy Guide, December 2021

The state requirements described in the policy guide are in addition to all existing Medicare D-SNP Model of Care requirements outlined in 42 CFR §422.101(f) and Chapter 5 of the Medicare Managed Care Manual.

Please populate the table below to indicate the location of the state-specific requirements in the 2023 D-SNP Model of Care.

MOC 2: Care Coordination	
Requirement	**Corresponding Document Section and Page Number**
Risk Stratification D-SNP risk stratification of enrollees must account for identified member needs covered by Medi-Cal. At a minimum, this process must include a review of: • Any available utilization data, including Medicaid utilization data available through the aligned Medi-Cal managed care plan (including long-term care utilization) and utilization data from the member's CMC plan (for members transitioning from the CMC to the D-SNP in 2023); • Any other relevant and available data from delivery systems outside of the managed care plans such as In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), other 1915(c) and home-and community-based waiver programs, behavioral health (both mental health and substance use disorder data, if available), and pharmacy data; • The results of previously administered CMC or Medi-Cal Health Risk Assessments (HRAs), if available; and • Any data and risk stratification available through the DHCS Population Health Management Platform (when it becomes available).	

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Health Risk Assessment (HRA) To the extent possible, while still meeting both Medicare and Medi-Cal requirements, the D-SNP should work with the aligned Medi-Cal managed care plan to create efficiencies in their respective HRA tools and processes to minimize the burden on members. Plans must make best efforts to create a single, unified HRA to meet the requirements for both the D-SNP and Medi-Cal managed care plans. Plans have flexibility in the design of their HRA tools as long the content specified below is included. Plans should rely on Medicare timeframes for the completion of initial and annual HRAs. To the extent that Medi-Cal and Medicare guidance for HRAs conflict, plans should follow Medicare guidance. D-SNPs must ensure their HRA identifies the following elements: 1. Medi-Cal services the member currently accesses. 2. Any Long-Term Services and Supports (LTSS) needs the member may have or potentially need, utilizing the LTSS questions provided in Appendix A or similar questions. If a plan intends to use a variation on the LTSS questions provided, the question must be reviewed and approved by DHCS. Plans may incorporate the questions into their HRA in any order. 3. Populations that may need additional screening or services specific to that population, including dementia and Alzheimer's disease. If a member identifies a caregiver, assessment of caregiver support needs should be included as part of the D-SNPs assessment process. HRAs must directly inform the development of member's Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT), per federal requirements.	
Individualized Care Plans (ICPs) and Interdisciplinary Care Teams (ICTs) Both the ICP and ICT meeting should include, to the extent possible, services and providers from the Medi-Cal managed care and carved-out delivery systems, as appropriate for the member and consistent with their preferences. Plans must encourage participation of both members and primary care providers in development of the ICP and ICT activities.	

The ICP should be person-centered and informed by the member's HRA and past utilization of both Medicare and Medi-Cal services. One ICP should be used to meet both Medicare and Medi-Cal ICP requirements. To the extent that Medi-Cal and Medicare guidance for ICPs conflict, plans should follow Medicare guidance. The ICP must identify any carved-out services the member needs and how the D-SNP will facilitate access and document referrals (including at least three (3) outreach attempts), including but not limited to referrals and connections to: o Community Based Organizations such as those serving members with disabilities (e.g. independent living centers) and those serving members with dementia (e.g. Alzheimer's organizations) o County mental health and substance use disorder services o Housing and homelessness providers o Enhanced Care Management (ECM) and Community Supports (formerly ILOS) providers in the aligned MCP network o 1915(c) waiver programs, including MSSP o LTSS programs, including IHSS and Community-Based Adult Services (CBAS) o Medi-Cal transportation to access Medicare and Medi-Cal services D-SNP care coordinators/managers participating in the ICT must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS programs, including home- and community-based services and long-term institutional care. The ICT should include providers of any Medi-Cal services the member is receiving, including LTSS and Community Supports. Irrespective of having a formal Alzheimer's or dementia diagnosis, if the member has documented dementia care needs, including but not limited to: wandering, home safety concerns, poor self-care, behavioral issues, issues with medication adherence, poor compliance with management of co-existing conditions, and/or inability to manage ADLs/IADLS, the ICT must include the member's caregiver and a trained dementia care specialist to the extent possible and as consistent with the member's preferences. Dementia care specialists must be trained in: understanding Alzheimer's Disease and Related Dementias (ADRD); symptoms and	

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progression; understanding and managing behaviors and communication problems caused by ADRD; caregiver stress and its management; and, community resources for enrollees and caregivers. These ICT members must be included in the development of the member's ICP to the extent possible and as consistent with the member's preference.	
Care Transitions D-SNPs must identify individuals (either plan staff or delegated entity staff) to serve as liaisons for the LTSS provider community to help facilitate member care transitions. These staff must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home- and community-based services and long-term institutional care, including payment and coverage rules. Health plan social services staff serving as liaisons for the LTSS provider community should be engaged in the ICT, as appropriate for members accessing those services. It is not required that an LTSS liaison be a licensed position. D-SNPs must identify these individuals and their contact information in materials for providers and beneficiaries.	

CalOptima Health Board Action Agenda Referral

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

Consent Calendar

5. Authorize Proposed Budget Allocation Change in the CalOptima Health Fiscal Year 2022-23 Operating Budget for Cultural & Linguistic Expenses

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Action

Authorize the reallocation of budgeted but unused funds in the amount of $320,000 from Medi-Cal: Printing & Postage to Medi-Cal: Purchased Services to fund Cultural & Linguistic expenses through June 30, 2023.

Background

Under the CalOptima Health's Fiscal Year (FY) 2022-23 Operating Budget, Cultural & Linguistics increased purchased services by 16% (from $1,258,600 to $1,491,400) to account for expected increase in cost of translating member materials in threshold languages and face-to-face and telephonic interpreter services in any language for the Medi-Cal line of business. However, the utilization of these services was higher than anticipated.

Discussion

The Cultural & Linguistics department has experienced a 28% increase in monthly expenses from FY 2021-22 compared to FY 2022-23 (from $109,600 to $153,260). The main drivers for the increase in utilization are face-to-face interpreter requests and the implementation of two regulatory requirements (full translation of Notices of Action and Alternative Format Request), which require CalOptima Health to provide members with full translations of member notices and in alternative format such as braille, large print, and/or audio. Based on these increases, anticipated expenditures for translations services, face-to-face, and telephonic interpreting requirements are now projected to exceed the approved budgeted amount by $320,000 by June 30, 2023.

To address this shortfall, management proposes to reallocate budgeted but unused funds of $320,000 from Medi-Cal: Printing & Postage. Management budgeted for two potential ad hoc mailings California Advancing and Innovating Medi-Cal (CalAIM) and CalFresh, which were not needed. The CalAIM information was included in the Member Handbook, and the CalFresh information was communicated by other means, thereby making these funds available for reallocation.

Fiscal Impact

The recommended action is budget neutral. Unspent budgeted funds from Medi-Cal: Printing & Postage, approved in the CalOptima Health FY 2022-23 Operating Budget on June 2, 2022, will fund the total budget reallocation of $320,000 for this action.

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Rationale for Recommendation

CalOptima Health is obligated to provide members with appropriate and timely translations in all threshold languages, alternative formats, and face-to-face and telephonic interpreting services in any language upon request. The recommendation will ensure CalOptima Health remains compliant with contractual and statutory requirements.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *02/23/2023*
Authorized Signature **Date**

CalOptima Health Board Action Agenda Referral

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

Consent Calendar
6. Approve CalOptima Health Position on Proposed Legislation

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions
1. Approve CalOptima Health's formal support position on Assembly Bill (AB) 271 (Quirk-Silva).
2. Authorize the Chief Executive Officer, or designee, to implement legislative advocacy efforts in alignment with the approved CalOptima Health position.

Background
According to the Point in Time Count for 2019, approximately 6,200 individuals experienced homelessness in Orange County; the number of people experiencing homelessness in north Orange County is nearly 60 percent higher than the last official estimate in 2017. To resolve the homelessness issue, an array of short- and long-term innovative strategies are needed.

In January 2022, the Orange County Sheriff-Coroner, Don Barnes, commissioned the County's first Homeless Death Review Committee consisting of technical experts from both the public and private sectors. The goal of the Homeless Death Review Committee is to explore the root causes of the reviewed deaths and determine what, if any, factors contributing to the deaths were preventable. CalOptima Health is a member of the Homeless Death Review Committee.

Discussion
The Homeless Death Review Committee met throughout 2022 and determined that the in-depth sharing of data necessary to look at each death of an individual experiencing homelessness would not be possible without authorization in statute. As a result, the committee's first report will be based on aggregate data only. AB 271 authorizes counties to create a Homeless Death Review Committee. The committee would establish procedures to collect and share data in order to provide in-depth data of deaths from individuals who were experiencing homelessness. AB 271 will assist policymakers and counties in identifying factors contributing to those deaths that could have been preventable, as well as to develop prevention strategies.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
AB 271 will provide the necessary authorization for a more complete review of deaths of individuals experiencing homelessness.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. AB 271 Fact Sheet
2. AB 271 Text

/s/ Michael Hunn *02/23/2023*
Authorized Signature **Date**

AB 271 (Quirk-Silva): Homeless Death Review Committee

Summary

AB 271 allows counties to establish a homeless review committee for the purpose of collecting information to identify root causes of deaths from individuals who were experiencing homelessness. This information would assist in determining strategies to reduce preventable deaths in our homeless population.

Background

California, and the nation, has been facing a housing crisis especially as it relates to homelessness. According to the United States Department of Housing and Urban Development, California has the highest rates of homelessness in the nation. On a single night, there has been up to 129,972 Californians experiencing homelessness throughout our state.

According to the 2019 Point in Time Count for 2019, approximately 6,200 individuals experienced homelessness in Orange County; the number or homeless people in North Orange County is nearly 60 percent higher than the last official estimate in 2017. To resolve the homelessness issue we need an array of innovative strategies – both short and long term. In January 2022, the Orange County Sheriff-Coroner, Don Barnes commissioned the County's first Homeless Death Review Committee. The Homeless Death Review Committee, consisting of technical experts from both the public and private sectors, goal is to explore the root causes of the reviewed deaths and determine what, if any, factors contributing to the deaths were preventable.

While the Sheriff's Department and Orange County Coroner's Office have tracked deaths of people experiencing homelessness for many years, the Homeless Death Review Committee will provide an extensive and in-depth review. Based on this review, the committee will develop an independent report with recommendations to Sheriff-Coroner Barnes and policymakers to find solutions that assist in reducing the number of preventable deaths of people experiencing homelessness.

A Mortality Review Committee is a recommended best practice by the National Health Care for the Homeless Council. Several jurisdictions have established the use of these committees to assist in developing policies aimed at reducing preventable deaths.

These Committees have met multiple times since March of 2022. In the course of their work, it was determined that the in-depth sharing of data that would be necessary to look at each individual homeless death would not be possible without authorization in statute. A result the Committee's first report (expected be released in early 2023) will be based on aggregate data only.

Homeless Death Review Committees presents an opportunity to make data-driven policy decisions that will ultimately result in lives saved and an enhanced quality of life for our community.

Solution

AB 271 authorizes counties to create a Homeless Death Review Committee. The committee would establish procedures to collect and share data in order to provide in-depth data of deaths from individuals who were homeless.

AB 271 will assist policymakers and counties in identifying factors contributing to those deaths that could have been preventable as well as to develop prevention strategies.

Support

- Orange County Sheriff (Sponsor)

Opposition

- None on file

Contact

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Updated: January 26, 2023

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AMENDED IN ASSEMBLY FEBRUARY 16, 2023

CALIFORNIA LEGISLATURE—2023–24 REGULAR SESSION

ASSEMBLY BILL No. 271

Introduced by Assembly Member Quirk-Silva
(Principal coauthor: Senator Newman)

January 23, 2023

An act to add Article 2.4 (commencing with Section 11163.70) to Chapter 2 of Title 1 of Part 4 of the Penal Code, relating to homelessness.

LEGISLATIVE COUNSEL'S DIGEST

AB 271, as amended, Quirk-Silva. Homeless death review committees.

Existing law authorizes counties to establish interagency child death teams and elder death teams to assist local agencies in identifying and reviewing suspicious deaths and facilitating communications between local organizations for the purposes of reducing the incidence of abuse and neglect.

This bill would authorize counties to establish a homeless death review committee for the purposes of gathering information to identify the root causes of death of homeless individuals and to determine strategies to improve coordination of services for the homeless population. The bill would establish procedures for the sharing or disclosure of information by a homeless death review committee.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Article 2.4 (commencing with Section 11163.70) is added to Chapter 2 of Title 1 of Part 4 of the Penal Code, to read:

Article 2.4. Homeless Death Review Committees

11163.70. For purposes of this article, unless the context requires otherwise, “homeless” has the same meaning as in subdivision (d) of Section 16523 of the Welfare and Institutions Code.

11163.71. (a) A county may establish a homeless death review committee to assist local agencies in identifying the root causes of death of homeless individuals and facilitating communication among persons who perform autopsies and the various persons and agencies involved in supporting the homeless population.

(b) A county that establishes a homeless death review committee pursuant to subdivision (a) may develop a protocol to be used as guidelines by persons performing autopsies on homeless individuals to assist coroners and other persons who perform autopsies in the identification of the cause and mode of death of the individual.

11163.72. (a) An oral or written communication or a document shared within or produced by a homeless death review committee related to a homeless death review is confidential and not subject to disclosure or discoverable by another third party.

(b) An oral or written communication or a document provided by a third party to a homeless death review committee, or between a third party and a homeless death review committee, is confidential and not subject to disclosure or discoverable by a third party.

(c) Notwithstanding subdivisions (a) and (b), recommendations of a homeless death review committee upon the completion of a review may be disclosed at the discretion of a majority of the members of the homeless death review committee.

~~11163.72.~~

11163.73. (a) An organization represented on the homeless death review committee may share with other members of the committee information in its possession concerning the decedent

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who is the subject of the review or any person who was in contact with the decedent and any other information deemed by the organization to be pertinent to the review. Information shared by an organization with other members of a team is confidential. The intent of this subdivision is to permit the disclosure to members of the committee of any information deemed confidential, privileged, or prohibited from disclosure by any other law.

(b) (1) Written and oral information may be disclosed to a homeless death review committee established pursuant to this article. The team may make a request in writing for the information sought and any person with information of the kind described in paragraph (3) may rely on the request in determining whether information may be disclosed to the team.

(2) An individual or agency that has information governed by this article shall not be required to disclose information. The intent of this subdivision is to allow the voluntary disclosure of information by the individual or agency that has the information.

(3) The following information may be disclosed pursuant to this article:

(A) Notwithstanding Section 56.10 of the Civil Code, medical information.

(B) Notwithstanding Section 5328 of the Welfare and Institutions Code, mental health information.

(C) State summary criminal history information, criminal offender record information, and local summary criminal history information, as defined in Sections 11075, 11105, and 13300.

(D) Notwithstanding Section 11163.2, information pertaining to reports by health practitioners of persons suffering from physical injuries inflicted by means of a firearm or of persons suffering physical injury where the injury is a result of assaultive or abusive conduct.

(E) Information provided to probation officers in the course of the performance of their duties, including, but not limited to, the duty to prepare reports pursuant to Section 1203.10, as well as the information on which these reports are based.

(c) Written and oral information may be disclosed under this section notwithstanding Sections 2263, 2918, 4982, and 6068 of the Business and Professions Code, the lawyer-client privilege protected by Article 3 (commencing with Section 950) of Chapter 4 of Division 8 of the Evidence Code, the physician-patient

privilege protected by Article 6 (commencing with Section 990) of Chapter 4 of Division 8 of the Evidence Code, and the psychotherapist-patient privilege protected by Article 7 (commencing with Section 1010) of Chapter 4 of Division 8 of the Evidence Code.

~~11163.73.~~

11163.74. Information gathered by the homeless death review committee and any recommendations made by the committee shall be used by the county to develop education and prevention strategies that will lead to improved coordination of services for the homeless population.

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Financial Summary

January 31, 2023

Board of Directors Meeting
March 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.

Financial Highlights: January 2023

January Actual	January Budget	January $ Variance	January % Variance		July - January Actual	July - January Budget	July - January $ Variance	July - January % Variance
973,571	917,263	56,308	6.1%	Member Months	6,585,826	6,392,767	193,059	3.0%
323,205,298	331,088,317	(7,883,019)	(2.4%)	Revenues	2,300,826,825	2,343,665,979	(42,839,155)	(1.8%)
291,715,309	315,942,824	24,227,515	7.7%	Medical Expenses	2,137,607,072	2,203,561,870	65,954,798	3.0%
16,025,792	18,485,640	2,459,848	13.3%	Administrative Expenses	104,345,874	123,561,019	19,215,145	15.6%
15,464,197	**(3,340,147)**	**18,804,344**	**563.0%**	**Operating Margin**	**58,873,879**	**16,543,090**	**42,330,789**	**255.9%**
				Non-Operating Income (Loss)				
14,237,134	500,000	13,737,134	2747.4%	Net Investment Income/Expense	41,048,549	3,500,000	37,548,549	1072.8%
122,735	90,835	31,900	35.1%	Net Rental Income/Expense	801,254	635,845	165,409	26.0%
(272)	-	(272)	(100.0%)	Net MCO Tax	22,861	-	22,861	100.0%
(863,636)	(2,077,922)	1,214,286	58.4%	Grant Expense	(21,045,455)	(9,610,388)	(11,435,067)	(119.0%)
(25,863)	-	(25,863)	(100.0%)	Other Income/Expense	45	-	45	100.0%
13,470,098	**(1,487,087)**	**14,957,185**	**1005.8%**	**Total Non-Operating Income (Loss)**	**20,827,255**	**(5,474,543)**	**26,301,798**	**480.4%**
28,934,294	**(4,827,234)**	**33,761,528**	**699.4%**	**Change in Net Assets**	**79,701,133**	**11,068,547**	**68,632,586**	**620.1%**
90.3%	95.4%	(5.2%)		Medical Loss Ratio	92.9%	94.0%	(1.1%)	
5.0%	5.6%	0.6%		Administrative Loss Ratio	4.5%	5.3%	0.7%	
4.8%	(1.0%)	5.8%		Operating Margin Ratio	2.6%	0.7%	1.9%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
90.3%	95.4%	(5.2%)		*MLR (excluding Directed Payments)	92.5%	94.0%	(1.5%)	
5.0%	5.6%	0.6%		*ALR (excluding Directed Payments)	4.8%	5.3%	0.5%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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Consolidated Performance: January 2023 (in millions)

January				July-January		
Actual	Budget	Variance	**Operating Income (Loss)**	Actual	Budget	Variance
16.0	(2.2)	18.2	Medi-Cal	61.3	24.9	36.3
0.2	(0.0)	0.2	OCC	(1.1)	(3.0)	1.9
(1.0)	(1.1)	0.1	OneCare	(1.4)	(4.8)	3.3
0.3	0.0	0.3	PACE	0.6	(0.4)	1.0
(0.1)	(0.0)	(0.0)	MSSP	(0.5)	(0.3)	(0.2)
15.5	**(3.3)**	**18.8**	**Total Operating Income (Loss)**	**58.9**	**16.5**	**42.3**
			Non-Operating Income (Loss)			
14.2	0.5	13.7	Net Investment Income/Expense	41.0	3.5	37.5
0.1	0.1	0.0	Net Rental Income/Expense	0.8	0.6	0.2
(0.0)	0.0	(0.0)	Net Operating Tax	0.0	0.0	0.0
(0.9)	(2.1)	1.2	Grant Expense	(21.0)	(9.6)	(11.4)
(0.0)	0.0	(0.0)	Net Other Income/Expense	0.0	0.0	0.0
13.5	**(1.5)**	**15.0**	**Total Non-Operating Income/(Loss)**	**20.8**	**(5.5)**	**26.3**
28.9	**(4.8)**	**33.8**	**TOTAL**	**79.7**	**11.1**	**68.6**

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FY 2022-23: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) January 2023: $28.9 million, favorable to budget $33.8 million or 699.4%
  - Year To Date (YTD) July – January 2023: $79.7 million, favorable to budget $68.6 million or 620.1%
- Enrollment
  - MTD: 973,571 members, favorable to budget 56,308 or 6.1%
  - YTD: 6,585,826 members, favorable to budget 193,059 or 3.0%
  - 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 transitioned to One Care

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Revenue
  - MTD: $323.2 million, unfavorable to budget $7.9 million or 2.4% driven by Medi-Cal Line of Business (MC LOB):
    - $38.5 million due to COVID-19 and Proposition 56 risk corridor reserves
    - Offset by $31.6 million of favorable volume related variance and premium capitation rates
  - YTD: $2,300.8 million, unfavorable to budget $42.8 million or 1.8% driven by MC LOB:
    - $272.2 million due to COVID-19, Proposition 56, and ECM risk corridor reserves
    - Offset by $135.2 million of Fiscal Year (FY) 2021 hospital Directed Payments (DP) and $82.4 million due to favorable volume related variance, Prior Year (PY) retroactive eligibility changes and favorable premium capitation rates

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FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - MTD: $291.7 million, favorable to budget $24.2 million or 7.7% driven by MC LOB:
    - Managed Long-Term Services and Supports (MLTSS) favorable variance of $12.4 million due to low utilization and Incurred But Not Reported (IBNR) claims
    - Facilities Claims favorable variance of $8.4 million
    - Net favorable variance of $3.1 million from all other medical expense categories

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FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - YTD: $2,137.6 million, favorable to budget $66.0 million or 3.0% driven by MC LOB:
    - Provider Capitation favorable variance of $117.9 million primarily due to updated logic for Proposition 56
    - Favorable variances totaling $60.6 million from Facilities, Professional and MLTSS due to lower than budgeted utilization and IBNR
    - Offset by $120.8 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: $16.0 million, favorable to budget $2.5 million or 13.3%
    - Other Non-Salary expenses favorable variance of $1.7 million
    - Salaries & Benefits expense favorable variance of $0.8 million
  - YTD: $104.3 million, favorable to budget $19.2 million or 15.6%
    - Other Non-Salary expenses favorable variance of $11.8 million
    - Salaries & Benefits expense favorable variance of $7.5 million

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FY 2022-23:Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: $13.5 million, favorable to budget $15.0 million or 1,005.8%
    - Non-operating gain is primarily due to interest income of $8.4 million and $6.9 million of unrealized gain on investments
  - YTD: $20.8 million, favorable to budget $26.3 million or 480.4%

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FY 2022-23: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 90.3% (90.3% excluding DP), Budget 95.4%
  - YTD: Actual 92.9% (92.5% excluding DP), Budget 94.0%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 5.0% (5.0% excluding DP), Budget 5.6%
  - YTD: Actual 4.5% (4.8% excluding DP), Budget 5.3%
- 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 $101.6 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations

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Enrollment Summary: January 2023

January					July - January			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category	Actual	Budget	$ Variance	% Variance
143,475	138,003	5,472	4.0%	SPD	892,289	874,058	18,231	2.1%
304,723	304,433	290	0.1%	TANF Child	2,126,122	2,141,392	(15,270)	(0.7%)
138,733	131,359	7,374	5.6%	TANF Adult	944,393	939,657	4,736	0.5%
3,310	3,475	(165)	(4.7%)	LTC	22,798	23,485	(687)	(2.9%)
353,764	310,698	43,066	13.9%	MCE	2,393,355	2,207,738	185,617	8.4%
11,819	11,820	(1)	(0.0%)	WCM	82,768	82,381	387	0.5%
955,824	**899,788**	**56,036**	**6.2%**	**Medi-Cal Total**	**6,461,725**	**6,268,711**	**193,014**	**3.1%**
26		**26**	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,293	**16,996**	**297**	**1.7%**	**OneCare**	**34,882**	**32,923**	**1,959**	**6.0%**
428	**479**	**(51)**	**(10.6%)**	**PACE**	**3,034**	**3,246**	**(212)**	**(6.5%)**
467	**568**	**(101)**	**(17.8%)**	**MSSP**	**3,306**	**3,976**	**(670)**	**(16.9%)**
973,571	**917,263**	**56,308**	**6.1%**	**CalOptima Total**	**6,585,826**	**6,392,767**	**193,059**	**3.0%**

*CalOptima Health Total does not include MSSP

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Consolidated Revenue & Expenses: January 2023 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	590,241	353,764	11,819	955,824	26	17,293	428	467	973,571
REVENUES									
Capitation Revenue	150,613,868	$ 119,014,712	$ 20,514,706	$ 290,143,286	$ (1,030,314)	$ 30,163,024	$ 3,721,808	$ 207,494	$ 323,205,298
Total Operating Revenue	150,613,868	119,014,712	20,514,706	290,143,286	(1,030,314)	30,163,024	3,721,808	207,494	323,205,298
MEDICAL EXPENSES									
Provider Capitation	46,023,258	51,467,100	7,295,019	104,785,376	68,547	12,250,775			117,104,699
Facilities	32,411,838	24,867,468	4,108,321	61,387,626	50,421	4,170,244	759,954		66,368,246
Professional Claims	25,751,254	14,728,870	1,283,143	41,763,267	27,829	1,390,434	897,652		44,079,182
Prescription Drugs	(205,911)	(380,314)		(586,225)	(932,462)	9,695,686	342,390		8,519,389
MLTSS	35,521,448	4,553,343	1,254,580	41,329,371	151,596	80,154	103,499	24,415	41,689,035
Incentive Payments	2,750,372	3,080,048	54,107	5,884,527	(887,807)	388,844	5,350		5,390,914
Medical Management	2,913,159	2,103,344	391,655	5,408,158	228,334	978,061	1,064,979	155,980	7,835,511
Other Medical Expenses	435,015	281,500	11,818	728,333					728,333
Total Medical Expenses	145,600,434	100,701,356	14,398,644	260,700,434	(1,293,543)	28,954,198	3,173,825	180,395	291,715,309
Medical Loss Ratio	96.7%	84.6%	70.2%	89.9%	125.5%	96.0%	85.3%	86.9%	90.3%
GROSS MARGIN	**5,013,434**	**18,313,355**	**6,116,062**	**29,442,851**	**263,229**	**1,208,826**	**547,984**	**27,099**	**31,489,988**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				9,823,784	36,341	853,973	146,123	76,022	10,936,243
Professional Fees				835,153	1	8,131	1,378	1,333	845,996
Purchased Services				155,580	22,419	228,341	61,701		468,041
Printing & Postage				551,318	4,208	164,518	(21,056)		698,988
Depreciation & Amortization				357,092			739		357,830
Other Expenses				2,334,942	59	196	6,749	5,842	2,347,788
Indirect Cost Allocation, Occupancy				(574,303)		925,930	13,808	5,471	370,905
Total Administrative Expenses				**13,483,566**	**63,027**	**2,181,088**	**209,441**	**88,669**	**16,025,792**
Admin Loss Ratio				4.6%	-6.1%	7.2%	5.6%	42.7%	5.0%
INCOME (LOSS) FROM OPERATIONS				15,959,285	200,201	(972,263)	338,542	(61,569)	15,464,197
INVESTMENT INCOME									14,237,134
NET RENTAL INCOME									122,735
TOTAL MCO TAX				(272)					(272)
TOTAL GRANT EXPENSE				(863,636)					(863,636)
OTHER INCOME				(25,863)					(25,863)
CHANGE IN NET ASSETS				**$ 15,069,514**	**$ 200,201**	**$ (972,263)**	**$ 338,542**	**$ (61,569)**	**$ 28,934,294**
BUDGETED CHANGE IN NET ASSETS				(4,280,762)	(42,368)	(1,077,361)	27,311	(44,889)	(4,827,234)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 19,350,276	$ 242,569	$ 105,098	$ 311,231	$ (16,680)	$ 33,761,528

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Consolidated Revenue & Expenses: January 2023 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	3,985,602	2,393,355	82,768	6,461,725	86,185	34,882	3,034	3,306	6,585,826
REVENUES									
Capitation Revenue	1,041,789,165	$ 847,949,380	$ 156,541,243	$ 2,046,279,788	$ 175,404,558	$ 52,558,054	$ 25,202,214	$ 1,382,210	$ 2,300,826,825
Total Operating Revenue	1,041,789,165	847,949,380	156,541,243	2,046,279,788	175,404,558	52,558,054	25,202,214	1,382,210	2,300,826,825
MEDICAL EXPENSES									
Provider Capitation	251,037,022	311,654,163	62,084,761	624,775,946	72,005,004	18,556,046			715,336,996
Facilities	226,546,080	200,894,157	39,027,412	466,467,649	27,507,746	10,080,115	6,043,423		510,098,933
Professional Claims	155,777,778	98,107,266	10,072,862	263,957,905	8,667,015	2,266,014	6,385,091		281,276,025
Prescription Drugs	(2,024,035)	(2,287,072)	5,604	(4,305,503)	40,079,787	16,804,358	2,796,017		55,374,659
MLTSS	277,316,461	31,092,666	13,749,567	322,158,694	10,106,747	80,154	1,143,404	202,824	333,691,823
Incentive Payments	21,899,783	24,268,733	675,961	46,844,476	1,642,548	551,569	37,925		49,076,519
Medical Management	19,742,373	13,967,963	3,099,512	36,809,848	6,551,128	1,303,839	6,781,834	1,063,274	52,509,924
Other Medical Expenses	75,338,347	56,584,767	8,319,079	140,242,192					140,242,192
Total Medical Expenses	1,025,633,808	734,282,643	137,034,758	1,896,951,208	166,559,975	49,642,096	23,187,694	1,266,098	2,137,607,072
Medical Loss Ratio	98.4%	86.6%	87.5%	92.7%	95.0%	94.5%	92.0%	91.6%	92.9%
GROSS MARGIN	**16,155,357**	**113,666,737**	**19,506,486**	**149,328,580**	**8,844,583**	**2,915,958**	**2,014,520**	**116,111**	**163,219,753**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				64,340,710	4,157,957	1,641,698	955,682	526,930	71,622,976
Professional Fees				4,095,367	24,509	174,844	3,106	9,333	4,307,160
Purchased Services				6,469,459	522,208	426,457	133,069		7,551,192
Printing & Postage				2,242,748	259,908	549,832	153,696		3,206,184
Depreciation & Amortization				2,582,501			4,253		2,586,755
Other Expenses				12,059,007	8,838	5,566	73,405	40,883	12,187,699
Indirect Cost Allocation, Occupancy				(3,733,548)	4,929,832	1,551,678	97,652	38,294	2,883,908
Total Administrative Expenses				**88,056,244**	**9,903,252**	**4,350,075**	**1,420,863**	**615,440**	**104,345,874**
Admin Loss Ratio				4.3%	5.6%	8.3%	5.6%	44.5%	4.5%
INCOME (LOSS) FROM OPERATIONS				61,272,336	(1,058,669)	(1,434,117)	593,657	(499,328)	58,873,879
INVESTMENT INCOME									41,048,549
NET RENTAL INCOME									801,254
TOTAL MCO TAX				22,861					22,861
TOTAL GRANT EXPENSE				(21,045,455)					(21,045,455)
OTHER INCOME				45					45
CHANGE IN NET ASSETS				**$ 40,249,787**	**$ (1,058,669)**	**$ (1,434,117)**	**$ 593,657**	**$ (499,328)**	**$ 79,701,133**
BUDGETED CHANGE IN NET ASSETS				15,334,470	(2,970,731)	(4,751,180)	(374,566)	(305,291)	11,068,547
VARIANCE TO BUDGET - FAV (UNFAV)				$ 24,915,317	$ 1,912,062	$ 3,317,063	$ 968,223	$ (194,037)	$ 68,632,586

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Balance Sheet: As of January 2023

ASSETS

Current Assets	
Operating Cash	$661,507,328
Short-term Investments	1,500,815,121
Capitation Receivable	391,985,165
Receivables - Other	89,479,342
Prepaid Expenses	21,455,087
Total Current Assets	**2,665,242,042**
Capital Assets	
Furniture & Equipment	50,138,637
Building/Leasehold Improvements	5,059,408
Construction in Progress	5,065,308
505 City Parkway West	52,951,401
500 City Parkway West	22,631,500
	135,846,254
Less: Accumulated Depreciation	(68,438,744)
Capital Assets, Net	67,407,511
GASB 96 Capital Assets	
GASB 96 Subscription Assets	-
Less: GASB 96 Accumulated Depreciation	-
GASB 96 Capital Assets, Net	-
Total Capital Assets	67,407,511
Other Assets	
Restricted Deposit & Other	300,000
Homeless Health Reserve	536,739
Board-Designated Assets:	
Cash and Cash Equivalents	5,892,800
Investments	567,889,317
Total Board-Designated Assets	573,782,117
Total Other Assets	574,618,856
TOTAL ASSETS	**3,307,268,409**
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	**3,316,894,002**

LIABILITIES & NET POSITION

Current Liabilities	
Accounts Payable	$9,574,979
Medical Claims Liability	1,619,559,330
Accrued Payroll Liabilities	15,910,964
Deferred Revenue	20,749,941
Deferred Lease Obligations	70,880
Capitation and Withholds	97,039,123
Total Current Liabilities	**1,762,905,218**
Other Liabilities	
GASB 96 Subscription Liabilities	-
Other (than pensions) Post Employment Benefits Liability	22,451,525
Net Pension Liabilities	577,854
Bldg. 505 Development Rights	-
TOTAL LIABILITIES	**1,785,934,597**
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
Net Position	
TNE	101,579,422
Funds in Excess of TNE	1,397,590,479
TOTAL NET POSITION	1,499,169,901
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**3,316,894,002**

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Board Designated Reserve and TNE Analysis: As of January 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	233,668,422				
	Tier 1 - MetLife	231,895,620				
Board-designated Reserve		465,564,041	333,641,762	520,165,127	131,922,279	(54,601,085)
	Tier 2 - Payden & Rygel	54,271,057				
	Tier 2 - MetLife	53,947,018				
TNE Requirement		108,218,076	101,579,422	101,579,422	6,638,653	6,638,653
	Consolidated:	**573,782,117**	**435,221,184**	**621,744,549**	**138,560,933**	**(47,962,432)**
	Current reserve level	*1.85*	*1.40*	*2.00*		

Net Assets Analysis: As of January 2023

Category	Item Description	Amount (millions)	Approved Initiative	Spend to Date	%
	Total Net Position @ 1/31/2023	**$1,499.2**			**100.0%**
Resources Assigned	Board Designated Reserve*	**573.8**			**38.3%**
	Capital Assets, net of depreciation	**67.4**			**4.5%**
Resources Allocated	Homeless Health Initiative**	$63.3	$100.0	$36.7	4.2%
	Intergovernmental Transfers (IGT)	61.7	111.7	50.0	4.1%
	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	10.2%
	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	95.3	100.0	4.7	6.4%
	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:	**$448.1**	**$566.2**	**$118.1**	**29.9%**
Resources Available for New Initiative	Unallocated/Unassigned*	**$409.9**			**27.3%**

*Total of Board-designated reserve and unallocated reserve amount can support approximately 100 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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Homeless Health Initiative and Allocated Funds: As of January 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Homeless Coordination at Hospitals	10,000,000	9,197,577	802,423
Recuperative Care	8,250,000	6,194,190	2,055,810
Street Medicine	8,000,000	-	8,000,000
Outreach and Engagement	7,000,000	-	7,000,000
CalOptima Homeless Response Team	6,000,000	1,681,734	4,318,266
Homeless Clinical Access Program (HCAP) and CalOptima Days*	2,700,000	3,135,200	(435,200)
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 Days, HCAP and FQHC Administrative Support	963,261	688,762	274,499
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
FQHC (Community Health Center) Expansion	300,000	21,902	278,098
Medical Respite	250,000	250,000	-
Housing and Homelessness Incentive Program (HHIP): 40.1 million			
Capital Projects	21,000,000	-	21,000,000
Infrastructure Projects	10,500,000	-	10,500,000
Equity Grants for Programs Serving Underrepresented Populations	5,000,000	-	5,000,000
Office of Care Coordination	2,200,000	-	2,200,000
Pulse For Good	800,000	-	800,000
Consultant	600,000	-	600,000
Subtotal of Approved Initiatives	**$99,463,261**	**$36,724,013**	**$62,739,248**
Program Commitment Balance, available for new Initiatives	536,739		536,739
Program Total	**$100,000,000**	**$36,724,013**	**$63,275,987**

Note*
At the February 2, 2023 Board meeting, the Board approved an additional $498,400 to cover the deficit from the HCAP and HCAP Expansion Program which will be reflected in the February 2023 financial reports

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UNAUDITED FINANCIAL STATEMENTS

January 31, 2023

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CalOptima Health - Consolidated
Financial Highlights
For the Seven Months Ended January 31, 2023

January					July - January			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
973,571	917,263	56,308	6.1%	Member Months	6,585,826	6,392,767	193,059	3.0%
323,205,298	331,088,317	(7,883,019)	(2.4%)	Revenues	2,300,826,825	2,343,665,979	(42,839,155)	(1.8%)
291,715,309	315,942,824	24,227,515	7.7%	Medical Expenses	2,137,607,072	2,203,561,870	65,954,798	3.0%
16,025,792	18,485,640	2,459,848	13.3%	Administrative Expenses	104,345,874	123,561,019	19,215,145	15.6%
15,464,197	**(3,340,147)**	**18,804,344**	**563.0%**	**Operating Margin**	**58,873,879**	**16,543,090**	**42,330,789**	**255.9%**
				Non-Operating Income (Loss)				
14,237,134	500,000	13,737,134	2747.4%	Net Investment Income/Expense	41,048,549	3,500,000	37,548,549	1072.8%
122,735	90,835	31,900	35.1%	Net Rental Income/Expense	801,254	635,845	165,409	26.0%
(272)	-	(272)	(100.0%)	Net MCO Tax	22,861	-	22,861	100.0%
(863,636)	(2,077,922)	1,214,286	58.4%	Grant Expense	(21,045,455)	(9,610,388)	(11,435,067)	(119.0%)
(25,863)	-	(25,863)	(100.0%)	Other Income/Expense	45	-	45	100.0%
13,470,098	**(1,487,087)**	**14,957,185**	**1005.8%**	**Total Non-Operating Income (Loss)**	**20,827,255**	**(5,474,543)**	**26,301,798**	**480.4%**
28,934,294	**(4,827,234)**	**33,761,528**	**699.4%**	**Change in Net Assets**	**79,701,133**	**11,068,547**	**68,632,586**	**620.1%**
90.3%	95.4%	(5.2%)		Medical Loss Ratio	92.9%	94.0%	(1.1%)	
5.0%	5.6%	0.6%		Administrative Loss Ratio	4.5%	5.3%	0.7%	
4.8%	(1.0%)	5.8%		Operating Margin Ratio	2.6%	0.7%	1.9%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
90.3%	95.4%	(5.2%)		*MLR (excluding Directed Payments)	92.5%	94.0%	(1.5%)	
5.0%	5.6%	0.6%		*ALR (excluding Directed Payments)	4.8%	5.3%	0.5%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

CalOptima Health
Financial Dashboard
For the Seven Months Ended January 31, 2023

JANUARY

Enrollment	Actual	Budget		Fav / (Unfav)	
Medi-Cal	955,824	899,788	↑	56,036	6.2%
OneCare Connect	26	-	↑	26	100.0%
OneCare	17,293	16,996	↑	297	1.7%
PACE	428	479	↓	(51)	(10.6%)
MSSP	467	568	↓	(101)	(17.8%)
Total*	973,571	917,263	↑	56,308	6.1%

Change in Net Assets (000)	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ 15,070	$ (4,281)	↑	19,351	452.0%
OneCare Connect	200	(42)	↑	242	576.2%
OneCare	(972)	(1,077)	↑	105	9.7%
PACE	339	27	↑	312	1155.6%
MSSP	(62)	(45)	↓	(17)	(37.8%)
Buildings	123	91	↑	32	35.2%
Investment Income/Expense	14,237	500	↑	13,737	2747.4%
Total	$ 28,935	$ (4,827)	↑	33,762	699.4%

MLR	Actual	Budget		% Point Var
Medi-Cal	89.9%	95.5%	↓	(5.6)
OneCare Connect	125.5%	0.0%	↑	125.5
OneCare	96.0%	95.3%	↑	0.7

Administrative Cost (000)	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ 13,484	$ 15,667	↑	$ 2,183	13.9%
OneCare Connect	63	15	↓	(48)	(316.7%)
OneCare	2,181	2,437	↑	256	10.5%
PACE	209	268	↑	59	21.9%
MSSP	89	99	↑	10	10.4%
Total	$ 16,026	$ 18,486	↑	$ 2,460	13.3%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,190	1,323	133
OneCare Connect	17	2	(15)
OneCare	166	222	56
PACE	97	115	17
MSSP	21	23	2
Total	1,491	1,684	193

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	803	680	(123)
OneCare Connect	2	-	(2)
OneCare	104	77	(28)
PACE	4	4	(0)
MSSP	22	25	3
Total	653	545	(108)

JULY - JANUARY

Year To Date Enrollment	Actual	Budget		Fav / (Unfav)	
Medi-Cal	6,461,725	6,268,711	↑	193,014	3.1%
OneCare Connect	86,185	87,887	↓	(1,702)	(1.9%)
OneCare	34,882	32,923	↑	1,959	6.0%
PACE	3,034	3,246	↓	(212)	(6.5%)
MSSP	3,306	3,976	↓	(670)	(16.9%)
Total*	6,585,826	6,392,767	↑	193,059	3.0%

Change in Net Assets (000)	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ 40,250	$ 15,334	↑	24,916	162.5%
OneCare Connect	(1,059)	(2,971)	↑	1,912	64.4%
OneCare	(1,434)	(4,751)	↑	3,317	69.8%
PACE	594	(375)	↑	969	258.4%
MSSP	(499)	(305)	↓	(194)	(63.6%)
Buildings	801	636	↑	165	25.9%
Investment Income/Expense	41,049	3,500	↑	37,549	1072.8%
Total	$ 79,702	$ 11,068	↑	68,634	620.1%

MLR	Actual	Budget		% Point Var
Medi-Cal	92.7%	93.8%	↓	(1.1)
OneCare Connect	95.0%	95.1%	↓	(0.2)
OneCare	94.5%	100.7%	↓	(6.2)

Administrative Cost (000)	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ 88,056	$ 105,469	↑	$ 17,413	16.5%
OneCare Connect	9,903	11,109	↑	1,206	10.9%
OneCare	4,350	4,442	↑	92	2.1%
PACE	1,421	1,857	↑	436	23.5%
MSSP	615	684	↑	68	10.0%
Total	$ 104,346	$ 123,561	↑	$ 19,215	15.6%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	8,088	9,178	1,089
OneCare Connect	993	1,183	189
OneCare	268	368	100
PACE	664	798	134
MSSP	142	161	19
Total	10,156	11,686	1,531

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	799	683	(116)
OneCare Connect	87	74	(12)
OneCare	130	90	(41)
PACE	5	4	(1)
MSSP	23	25	1
Total	648	547	(101)

Note:* Total membership does not include MSSP

CalOptima Health - Consolidated
Statement of Revenues and Expenses
For the One Month Ended January 31, 2023

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	973,571		917,263		56,308	
REVENUE						
Medi-Cal	$ 290,143,286	$ 303.55	$ 298,107,252	$ 331.31	$ (7,963,966)	$ (28)
OneCare Connect	(1,030,314)	(39,627.47)	-	-	(1,030,314)	(39,627.47)
OneCare	30,163,024	1,744.23	28,639,865	1,685.09	1,523,159	59.14
PACE	3,721,808	8,695.81	4,087,683	8,533.78	(365,875)	162.03
MSSP	207,494	444.31	253,517	446.33	(46,023)	(2.02)
Total Operating Revenue	323,205,298	331.98	331,088,317	360.95	(7,883,019)	(28.97)
MEDICAL EXPENSES						
Medi-Cal	260,700,434	272.75	284,643,539	316.35	23,943,105	43.60
OneCare Connect	(1,293,543)	(49,751.66)	27,242	-	1,320,785	49,751.66
OneCare	28,954,198	1,674.33	27,280,439	1,605.11	(1,673,759)	(69.22)
PACE	3,173,825	7,415.48	3,792,124	7,916.75	618,299	501.27
MSSP	180,395	386.28	199,480	351.20	19,085	(35.08)
Total Medical Expenses	291,715,309	299.63	315,942,824	344.44	24,227,515	44.81
GROSS MARGIN	31,489,988	32.35	15,145,493	16.51	16,344,495	15.84
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	10,936,243	11.23	11,708,217	12.76	771,974	1.53
Professional Fees	845,996	0.87	971,567	1.06	125,571	0.19
Purchased Services	468,041	0.48	1,862,277	2.03	1,394,236	1.55
Printing & Postage	698,988	0.72	571,776	0.62	(127,212)	(0.10)
Depreciation & Amortization	357,830	0.37	525,900	0.57	168,070	0.20
Other Expenses	2,347,788	2.41	2,445,892	2.67	98,104	0.26
Indirect Cost Allocation, Occupancy	370,905	0.38	400,011	0.44	29,106	0.06
Total Administrative Expenses	16,025,792	16.46	18,485,640	20.15	2,459,848	3.69
INCOME (LOSS) FROM OPERATIONS	15,464,197	15.88	(3,340,147)	(3.64)	18,804,344	19.52
INVESTMENT INCOME						
Interest Income	8,880,414	9.12	500,000	0.55	8,380,414	8.57
Realized Gain/(Loss) on Investments	(1,545,093)	(1.59)	-	-	(1,545,093)	(1.59)
Unrealized Gain/(Loss) on Investments	6,901,813	7.09	-	-	6,901,813	7.09
Total Investment Income	14,237,134	14.62	500,000	0.55	13,737,134	14.07
NET RENTAL INCOME	122,735	0.13	90,835	0.10	31,900	0.03
TOTAL MCO TAX	(272)	-	-	-	(272)	-
TOTAL GRANT EXPENSE	(863,636)	(0.89)	(2,077,922)	(2.27)	1,214,286	1.38
OTHER INCOME	(25,863)	(0.03)	-	-	(25,863)	(0.03)
CHANGE IN NET ASSETS	**28,934,294**	**29.72**	**(4,827,234)**	**(5.26)**	**33,761,528**	**34.98**
MEDICAL LOSS RATIO	**90.3%**		**95.4%**		**(5.2%)**	
ADMINISTRATIVE LOSS RATIO	**5.0%**		**5.6%**		**0.6%**	

CalOptima Health- Consolidated
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2023

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	6,585,826		6,392,767		193,059	
REVENUE						
Medi-Cal	$ 2,046,279,788	$ 316.68	2,099,997,819	$ 335.00	$ (53,718,031)	$ (18.32)
OneCare Connect	175,404,558	2,035.21	167,628,057	1,907.31	7,776,501	127.90
OneCare	52,558,054	1,506.74	47,388,047	1,439.36	5,170,007	67.38
PACE	25,202,214	8,306.60	26,877,437	8,280.17	(1,675,223)	26.43
MSSP	1,382,210	418.09	1,774,619	446.33	(392,409)	(28.24)
Total Operating Revenue	2,300,826,825	349.36	2,343,665,979	366.61	(42,839,155)	(17.25)
MEDICAL EXPENSES						
Medi-Cal	1,896,951,208	293.57	1,969,583,473	314.19	72,632,265	20.62
OneCare Connect	166,559,975	1,932.59	159,489,464	1,814.71	(7,070,511)	(117.88)
OneCare	49,642,096	1,423.14	47,697,348	1,448.75	(1,944,748)	25.61
PACE	23,187,694	7,642.62	25,395,225	7,823.54	2,207,531	180.92
MSSP	1,266,098	382.97	1,396,360	351.20	130,262	(31.77)
Total Medical Expenses	2,137,607,072	324.58	2,203,561,870	344.70	65,954,798	20.12
GROSS MARGIN	163,219,753	24.78	140,104,109	21.91	23,115,644	2.87
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	71,622,976	10.88	79,077,219	12.37	7,454,243	1.49
Professional Fees	4,307,160	0.65	6,576,109	1.03	2,268,949	0.38
Purchased Services	7,551,192	1.15	9,983,206	1.56	2,432,014	0.41
Printing & Postage	3,206,184	0.49	3,633,398	0.57	427,214	0.08
Depreciation & Amortization	2,586,755	0.39	3,681,300	0.58	1,094,545	0.19
Other Expenses	12,187,699	1.85	17,053,570	2.67	4,865,871	0.82
Indirect Cost Allocation, Occupancy	2,883,908	0.44	3,556,217	0.56	672,309	0.12
Total Administrative Expenses	104,345,874	15.84	123,561,019	19.33	19,215,145	3.49
INCOME (LOSS) FROM OPERATIONS	58,873,879	8.94	16,543,090	2.59	42,330,789	6.35
INVESTMENT INCOME						
Interest Income	41,887,497	6.36	3,500,000	0.55	38,387,497	5.81
Realized Gain/(Loss) on Investments	(6,338,278)	(0.96)	-	0.00	(6,338,278)	(0.96)
Unrealized Gain/(Loss) on Investments	5,499,331	0.84	-	0.00	5,499,331	0.84
Total Investment Income	41,048,549	6.23	3,500,000	0.55	37,548,549	5.68
NET RENTAL INCOME	801,254	0.12	635,845	0.10	165,409	0.02
TOTAL MCO TAX	22,861	0.00	-	0.00	22,861	0.00
TOTAL GRANT EXPENSE	(21,045,455)	(3.20)	(9,610,388)	(1.50)	(11,435,067)	(1.70)
OTHER INCOME	45	0.00	-	0.00	45	0.00
CHANGE IN NET ASSETS	**79,701,133**	**12.10**	**11,068,547**	**1.73**	**68,632,586**	**10.37**
MEDICAL LOSS RATIO	**92.9%**		**94.0%**		**(1.1%)**	
ADMINISTRATIVE LOSS RATIO	**4.5%**		**5.3%**		**0.7%**	

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended January 31, 2023

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	590,241	353,764	11,819	955,824	26	17,293	428	467	973,571
REVENUES									
Capitation Revenue	150,613,868	$ 119,014,712	$ 20,514,706	$ 290,143,286	$ (1,030,314)	$ 30,163,024	$ 3,721,808	$ 207,494	$ 323,205,298
Total Operating Revenue	150,613,868	119,014,712	20,514,706	290,143,286	(1,030,314)	30,163,024	3,721,808	207,494	323,205,298
MEDICAL EXPENSES									
Provider Capitation	46,023,258	51,467,100	7,295,019	104,785,376	68,547	12,250,775			117,104,699
Facilities	32,411,838	24,867,468	4,108,321	61,387,626	50,421	4,170,244	759,954		66,368,246
Professional Claims	25,751,254	14,728,870	1,283,143	41,763,267	27,829	1,390,434	897,652		44,079,182
Prescription Drugs	(205,911)	(380,314)		(586,225)	(932,462)	9,695,686	342,390		8,519,389
MLTSS	35,521,448	4,553,343	1,254,580	41,329,371	151,596	80,154	103,499	24,415	41,689,035
Incentive Payments	2,750,372	3,080,048	54,107	5,884,527	(887,807)	388,844	5,350		5,390,914
Medical Management	2,913,159	2,103,344	391,655	5,408,158	228,334	978,061	1,064,979	155,980	7,835,511
Other Medical Expenses	435,015	281,500	11,818	728,333					728,333
Total Medical Expenses	145,600,434	100,701,356	14,398,644	260,700,434	(1,293,543)	28,954,198	3,173,825	180,395	291,715,309
Medical Loss Ratio	96.7%	84.6%	70.2%	89.9%	125.5%	96.0%	85.3%	86.9%	90.3%
GROSS MARGIN	**5,013,434**	**18,313,355**	**6,116,062**	**29,442,851**	**263,229**	**1,208,826**	**547,984**	**27,099**	**31,489,988**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				9,823,784	36,341	853,973	146,123	76,022	10,936,243
Professional Fees				835,153	1	8,131	1,378	1,333	845,996
Purchased Services				155,580	22,419	228,341	61,701		468,041
Printing & Postage				551,318	4,208	164,518	(21,056)		698,988
Depreciation & Amortization				357,092			739		357,830
Other Expenses				2,334,942	59	196	6,749	5,842	2,347,788
Indirect Cost Allocation, Occupancy				(574,303)		925,930	13,808	5,471	370,905
Total Administrative Expenses				**13,483,566**	**63,027**	**2,181,088**	**209,441**	**88,669**	**16,025,792**
Admin Loss Ratio				4.6%	-6.1%	7.2%	5.6%	42.7%	5.0%
INCOME (LOSS) FROM OPERATIONS				15,959,285	200,201	(972,263)	338,542	(61,569)	15,464,197
INVESTMENT INCOME									14,237,134
NET RENTAL INCOME									122,735
TOTAL MCO TAX				(272)					(272)
TOTAL GRANT EXPENSE				(863,636)					(863,636)
OTHER INCOME				(25,863)					(25,863)
CHANGE IN NET ASSETS				**$ 15,069,514**	**$ 200,201**	**$ (972,263)**	**$ 338,542**	**$ (61,569)**	**$ 28,934,294**
BUDGETED CHANGE IN NET ASSETS				(4,280,762)	(42,368)	(1,077,361)	27,311	(44,889)	(4,827,234)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 19,350,276	$ 242,569	$ 105,098	$ 311,231	$ (16,680)	$ 33,761,528

Note:* Total membership does not include MSSP

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Seven Months Ended January 31, 2023

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	3,985,602	2,393,355	82,768	6,461,725	86,185	34,882	3,034	3,306	6,585,826
REVENUES									
Capitation Revenue	1,041,789,165	$ 847,949,380	$ 156,541,243	$ 2,046,279,788	$ 175,404,558	$ 52,558,054	$ 25,202,214	$ 1,382,210	$ 2,300,826,825
Total Operating Revenue	1,041,789,165	847,949,380	156,541,243	2,046,279,788	175,404,558	52,558,054	25,202,214	1,382,210	2,300,826,825
MEDICAL EXPENSES									
Provider Capitation	251,037,022	311,654,163	62,084,761	624,775,946	72,005,004	18,556,046			715,336,996
Facilities	226,546,080	200,894,157	39,027,412	466,467,649	27,507,746	10,080,115	6,043,423		510,098,933
Professional Claims	155,777,778	98,107,266	10,072,862	263,957,905	8,667,015	2,266,014	6,385,091		281,276,025
Prescription Drugs	(2,024,035)	(2,287,072)	5,604	(4,305,503)	40,079,787	16,804,358	2,796,017		55,374,659
MLTSS	277,316,461	31,092,666	13,749,567	322,158,694	10,106,747	80,154	1,143,404	202,824	333,691,823
Incentive Payments	21,899,783	24,268,733	675,961	46,844,476	1,642,548	551,569	37,925		49,076,519
Medical Management	19,742,373	13,967,963	3,099,512	36,809,848	6,551,128	1,303,839	6,781,834	1,063,274	52,509,924
Other Medical Expenses	75,338,347	56,584,767	8,319,079	140,242,192					140,242,192
Total Medical Expenses	1,025,633,808	734,282,643	137,034,758	1,896,951,208	166,559,975	49,642,096	23,187,694	1,266,098	2,137,607,072
Medical Loss Ratio	98.4%	86.6%	87.5%	92.7%	95.0%	94.5%	92.0%	91.6%	92.9%
GROSS MARGIN	**16,155,357**	**113,666,737**	**19,506,486**	**149,328,580**	**8,844,583**	**2,915,958**	**2,014,520**	**116,111**	**163,219,753**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				64,340,710	4,157,957	1,641,698	955,682	526,930	71,622,976
Professional Fees				4,095,367	24,509	174,844	3,106	9,333	4,307,160
Purchased Services				6,469,459	522,208	426,457	133,069		7,551,192
Printing & Postage				2,242,748	259,908	549,832	153,696		3,206,184
Depreciation & Amortization				2,582,501			4,253		2,586,755
Other Expenses				12,059,007	8,838	5,566	73,405	40,883	12,187,699
Indirect Cost Allocation, Occupancy				(3,733,548)	4,929,832	1,551,678	97,652	38,294	2,883,908
Total Administrative Expenses				**88,056,244**	**9,903,252**	**4,350,075**	**1,420,863**	**615,440**	**104,345,874**
Admin Loss Ratio				4.3%	5.6%	8.3%	5.6%	44.5%	4.5%
INCOME (LOSS) FROM OPERATIONS				61,272,336	(1,058,669)	(1,434,117)	593,657	(499,328)	58,873,879
INVESTMENT INCOME									41,048,549
NET RENTAL INCOME									801,254
TOTAL MCO TAX				22,861					22,861
TOTAL GRANT EXPENSE				(21,045,455)					(21,045,455)
OTHER INCOME				45					45
CHANGE IN NET ASSETS				**$ 40,249,787**	**$ (1,058,669)**	**$ (1,434,117)**	**$ 593,657**	**$ (499,328)**	**$ 79,701,133**
BUDGETED CHANGE IN NET ASSETS				15,334,470	(2,970,731)	(4,751,180)	(374,566)	(305,291)	11,068,547
VARIANCE TO BUDGET - FAV (UNFAV)				$ 24,915,317	$ 1,912,062	$ 3,317,063	$ 968,223	$ (194,037)	$ 68,632,586

Note:* Total membership does not include MSSP

CalOptima Health
January 31, 2023 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $28.9 million, $33.8 million favorable to budget
- Operating surplus is $15.5 million, with a surplus in non-operating income of $13.5 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $79.7 million, $68.6 million favorable to budget
- Operating surplus is $58.9 million, with a surplus in non-operating income of $20.8 million

Change in Net Assets by Line of Business (LOB) ($ millions):

January				July-January		
Actual	Budget	Variance	**Operating Income (Loss)**	Actual	Budget	Variance
16.0	(2.2)	18.2	Medi-Cal	61.3	24.9	36.3
(1.0)	(1.1)	0.1	OneCare	(1.4)	(4.8)	3.3
0.2	(0.0)	0.2	OCC	(1.1)	(3.0)	1.9
0.3	0.0	0.3	PACE	0.6	(0.4)	1.0
(0.1)	(0.0)	(0.0)	MSSP	(0.5)	(0.3)	(0.2)
15.5	**(3.3)**	**18.8**	**Total Operating Income (Loss)**	**58.9**	**16.5**	**42.3**
			Non-Operating Income (Loss)			
14.2	0.5	13.7	Net Investment Income/Expense	41.0	3.5	37.5
0.1	0.1	0.0	Net Rental Income/Expense	0.8	0.6	0.2
(0.0)	0.0	(0.0)	Net Operating Tax	0.0	0.0	0.0
(0.9)	(2.1)	1.2	Grant Expense	(21.0)	(9.6)	(11.4)
(0.0)	0.0	(0.0)	Net Other Income/Expense	0.0	0.0	0.0
13.5	**(1.5)**	**15.0**	**Total Non-Operating Income/(Loss)**	**20.8**	**(5.5)**	**26.3**
28.9	**(4.8)**	**33.8**	**TOTAL**	**79.7**	**11.1**	**68.6**

CalOptima Health - Consolidated
Enrollment Summary
For the Seven Months Ended January 31, 2023

January					July - January			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
143,475	138,003	5,472	4.0%	SPD	892,289	874,058	18,231	2.1%
304,723	304,433	290	0.1%	TANF Child	2,126,122	2,141,392	(15,270)	(0.7%)
138,733	131,359	7,374	5.6%	TANF Adult	944,393	939,657	4,736	0.5%
3,310	3,475	(165)	(4.7%)	LTC	22,798	23,485	(687)	(2.9%)
353,764	310,698	43,066	13.9%	MCE	2,393,355	2,207,738	185,617	8.4%
11,819	11,820	(1)	(0.0%)	WCM	82,768	82,381	387	0.5%
955,824	**899,788**	**56,036**	**6.2%**	**Medi-Cal Total**	**6,461,725**	**6,268,711**	**193,014**	**3.1%**
26		**26**	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,293	**16,996**	**297**	**1.7%**	**OneCare**	**34,882**	**32,923**	**1,959**	**6.0%**
428	**479**	**(51)**	**(10.6%)**	**PACE**	**3,034**	**3,246**	**(212)**	**(6.5%)**
467	**568**	**(101)**	**(17.8%)**	**MSSP**	**3,306**	**3,976**	**(670)**	**(16.9%)**
973,571	**917,263**	**56,308**	**6.1%**	**CalOptima Total**	**6,585,826**	**6,392,767**	**193,059**	**3.0%**
				Enrollment (by Network)				
265,336	207,445	57,891	27.9%	HMO	1,637,322	1,472,073	165,249	11.2%
191,900	236,663	(44,763)	(18.9%)	PHC	1,523,808	1,670,073	(146,265)	(8.8%)
231,296	218,614	12,682	5.8%	Shared Risk Group	1,592,273	1,549,289	42,984	2.8%
267,292	237,066	30,226	12.8%	Fee for Service	1,708,322	1,577,276	131,046	8.3%
955,824	**899,788**	**56,036**	**6.2%**	**Medi-Cal Total**	**6,461,725**	**6,268,711**	**193,014**	**3.1%**
26	**0**	**26**	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,293	**16,996**	**297**	**1.7%**	**OneCare**	**34,882**	**32,923**	**1,959**	**6.0%**
428	**479**	**(51)**	**(10.6%)**	**PACE**	**3,034**	**3,246**	**(212)**	**(6.5%)**
467	**568**	**(101)**	**(17.8%)**	**MSSP**	**3,306**	**3,976**	**(670)**	**(16.9%)**
973,571	**917,263**	**56,308**	**6.1%**	**CalOptima Total**	**6,585,826**	**6,392,767**	**193,059**	**3.0%**

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	14,044						87,155	76,811	10,344
TANF Child	58,966	58,892	58,837	58,847	69,892	69,736	69,972						445,142	415,217	29,925
TANF Adult	38,926	38,983	39,331	39,640	48,530	48,844	49,255						303,509	291,322	12,187
LTC	1	2	2	1									6		6
MCE	99,022	99,788	100,301	101,292	127,939	128,438	129,823						786,603	673,898	112,705
WCM	2,034	2,020	2,021	2,050	2,272	2,268	2,242						14,907	14,825	82
Total	**210,186**	**210,935**	**211,782**	**213,118**	**262,635**	**263,330**	**265,336**						**1,637,322**	**1,472,073**	**165,249**
PHCs															
SPD	7,040	7,022	7,037	7,029	4,408	4,387	4,435						41,358	48,967	(7,609)
TANF Child	158,385	158,345	158,767	159,067	148,298	148,419	148,820						1,080,101	1,116,944	(36,843)
TANF Adult	16,704	16,780	16,830	16,855	8,478	8,499	8,550						92,696	122,832	(30,136)
LTC		1	1	3		2							7		7
MCE	47,505	47,574	47,748	48,051	22,411	22,545	22,920						258,754	330,548	(71,794)
WCM	7,366	7,472	7,340	7,301	7,096	7,142	7,175						50,892	50,782	110
Total	**237,000**	**237,194**	**237,723**	**238,306**	**190,691**	**190,994**	**191,900**						**1,523,808**	**1,670,073**	**(146,265)**
Shared Risk Groups															
SPD	10,824	10,928	10,995	10,954	11,023	11,046	11,181						76,951	71,351	5,600
TANF Child	57,419	57,075	56,762	56,460	56,201	55,828	55,913						395,658	418,129	(22,471)
TANF Adult	40,518	40,260	40,370	40,566	40,961	41,218	41,636						285,529	284,561	968
LTC	2	1	3	6	2								14		14
MCE	114,819	115,585	116,539	117,839	118,935	119,808	121,272						824,797	765,500	59,297
WCM	1,360	1,341	1,332	1,369	1,325	1,303	1,294						9,324	9,748	(424)
Total	**224,942**	**225,190**	**226,001**	**227,194**	**228,447**	**229,203**	**231,296**						**1,592,273**	**1,549,289**	**42,984**
Fee for Service (Dual)															
SPD	82,253	82,742	82,935	83,572	84,174	83,819	98,278						597,773	597,937	(164)
TANF Child	1	1	1	1	1	1	1						7		7
TANF Adult	1,675	1,712	1,743	1,742	1,767	1,776	2,271						12,686	13,217	(531)
LTC	2,894	2,874	2,845	2,879	2,929	2,915	2,943						20,279	21,150	(871)
MCE	6,480	6,749	7,030	7,314	7,498	7,795	8,014						50,880	40,219	10,661
WCM	20	18	24	17	16	18	14						127	107	20
Total	**93,323**	**94,096**	**94,578**	**95,525**	**96,385**	**96,324**	**111,521**						**681,752**	**672,630**	**9,122**
Fee for Service (Non-Dual - Total)															
SPD	11,984	12,003	16,296	8,528	12,224	12,480	15,537						89,052	78,992	10,060
TANF Child	28,613	28,702	29,350	29,540	30,022	28,970	30,017						205,214	191,102	14,112
TANF Adult	32,830	33,442	37,388	38,818	35,106	35,368	37,021						249,973	227,725	22,248
LTC	360	364	366	345	344	346	367						2,492	2,335	157
MCE	63,450	64,657	66,876	67,538	69,063	69,002	71,735						472,321	397,573	74,748
WCM	1,096	1,094	1,049	1,080	1,036	1,069	1,094						7,518	6,919	599
Total	**138,333**	**140,262**	**151,325**	**145,849**	**147,795**	**147,235**	**155,771**						**1,026,570**	**904,646**	**121,924**
Grand Totals															
SPD	123,338	123,945	128,553	121,371	125,831	125,776	143,475						892,289	874,058	18,231
TANF Child	303,384	303,015	303,717	303,915	304,414	302,954	304,723						2,126,122	2,141,392	(15,270)
TANF Adult	130,653	131,177	135,662	137,621	134,842	135,705	138,733						944,393	939,657	4,736
LTC	3,257	3,242	3,217	3,234	3,275	3,263	3,310						22,798	23,485	(687)
MCE	331,276	334,353	338,494	342,034	345,846	347,588	353,764						2,393,355	2,207,738	185,617
WCM	11,876	11,945	11,766	11,817	11,745	11,800	11,819						82,768	82,381	387
Total MediCal MM	**903,784**	**907,677**	**921,409**	**919,992**	**925,953**	**927,086**	**955,824**						**6,461,725**	**6,268,711**	**193,014**
OneCare Connect	**14,203**	**14,771**	**14,405**	**14,198**	**14,197**	**14,385**	**26**						**86,185**	**87,887**	**(1,702)**
OneCare	**2,764**	**2,874**	**2,905**	**2,964**	**3,015**	**3,067**	**17,293**						**34,882**	**32,923**	**1,959**
PACE	**435**	**434**	**437**	**430**	**433**	**437**	**428**						**3,034**	**3,246**	**(212)**
MSSP	**466**	**470**	**478**	**478**	**476**	**471**	**467**						**3,306**	**3,976**	**(670)**
Grand Total	**921,186**	**925,756**	**939,156**	**937,584**	**943,598**	**944,975**	**973,571**						**6,585,826**	**6,392,767**	**193,059**

Note:* Total membership does not include MSSP

ENROLLMENT:

Overall, January enrollment was 973,571

- Favorable to budget 56,308 or 6.1%
- Increased 28,596 or 3.0% from Prior Month (PM) (December 2022)
- Increased 93,936 or 10.7% from Prior Year (PY) (January 2022)

Medi-Cal enrollment was 955,824

- Favorable to budget 56,036 or 6.2% 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 43,066
  - ➢ Temporary Assistance for Needy Families (TANF) favorable 7,664
  - ➢ Seniors and Persons with Disabilities (SPD) favorable 5,472
  - ➢ Long-Term Care (LTC) unfavorable 165
  - ➢ Whole Child Model (WCM) unfavorable 1
- Increased 28,738 from PM

OneCare enrollment was 17,293

- Favorable to budget 297 or 1.7%
- Increased 14,226 from PM due to transition of OCC members to OC, effective January 1, 2023

OneCare Connect enrollment was 26 due to retroactive enrollment adjustments

- Favorable to budget 26
- Decreased 14,359 from PM

PACE enrollment was 428

- Unfavorable to budget 51 or 10.6%
- Decreased 9 from PM

MSSP enrollment was 467

- Unfavorable to budget 101 or 17.8% due to MSSP currently being understaffed. There is a staff to member ratio that must be met
- Decreased 4 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2023

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
955,824	**899,788**	**56,036**	**6.2%**	**Member Months**	**6,461,725**	**6,268,711**	**193,014**	**3.1%**
				Revenues				
290,143,286	298,107,252	(7,963,966)	(2.7%)	Medi-Cal Capitation Revenue	2,046,279,788	2,099,997,819	(53,718,031)	(2.6%)
290,143,286	**298,107,252**	**(7,963,966)**	**(2.7%)**	**Total Operating Revenue**	**2,046,279,788**	**2,099,997,819**	**(53,718,031)**	**(2.6%)**
				Medical Expenses				
104,785,376	104,859,998	74,622	0.1%	Provider Capitation	624,775,946	742,673,490	117,897,544	15.9%
61,387,626	69,821,450	8,433,824	12.1%	Facilities Claims	466,467,649	477,699,449	11,231,800	2.4%
41,763,267	43,175,846	1,412,579	3.3%	Professional Claims	263,957,905	283,984,133	20,026,228	7.1%
41,329,371	53,708,945	12,379,574	23.0%	MLTSS	322,158,694	351,481,855	29,323,161	8.3%
(586,225)	-	586,225	100.0%	Prescription Drugs	(4,305,503)	-	4,305,503	100.0%
5,884,527	4,639,953	(1,244,574)	(26.8%)	Incentive Payments	46,844,476	32,727,902	(14,116,574)	(43.1%)
5,408,158	6,863,275	1,455,117	21.2%	Medical Management	36,809,848	47,498,141	10,688,293	22.5%
728,333	1,574,072	845,739	53.7%	Other Medical Expenses	140,242,192	33,518,503	(106,723,689)	(318.4%)
260,700,434	**284,643,539**	**23,943,105**	**8.4%**	**Total Medical Expenses**	**1,896,951,208**	**1,969,583,473**	**72,632,265**	**3.7%**
29,442,851	**13,463,713**	**15,979,138**	**118.7%**	**Gross Margin**	**149,328,580**	**130,414,346**	**18,914,234**	**14.5%**
				Administrative Expenses				
9,823,784	10,361,968	538,184	5.2%	Salaries, Wages & Employee Benefits	64,340,710	69,793,919	5,453,209	7.8%
835,153	935,239	100,086	10.7%	Professional Fees	4,095,367	6,256,813	2,161,446	34.5%
155,580	1,375,639	1,220,059	88.7%	Purchased Services	6,469,459	8,469,947	2,000,488	23.6%
551,318	383,940	(167,378)	(43.6%)	Printing & Postage	2,242,748	2,687,214	444,466	16.5%
357,092	525,000	167,908	32.0%	Depreciation & Amortization	2,582,501	3,675,000	1,092,499	29.7%
2,334,942	2,410,427	75,485	3.1%	Other Operating Expenses	12,059,007	16,866,215	4,807,208	28.5%
(574,303)	(325,660)	248,643	76.4%	Indirect Cost Allocation, Occupancy	(3,733,548)	(2,279,620)	1,453,928	63.8%
13,483,566	**15,666,553**	**2,182,987**	**13.9%**	**Total Administrative Expenses**	**88,056,244**	**105,469,488**	**17,413,244**	**16.5%**
				Non-Operating Income (Loss)				
(272)	-	(272)	(100.0%)	Net Operating Tax	22,861	-	22,861	100.0%
(863,636)	(2,077,922)	1,214,286	58.4%	Grant Expense	(21,045,455)	(9,610,388)	(11,435,067)	(119.0%)
-	-	-	0.0%	Net QAF & IGT Income/Expense	-	-	-	0.0%
(25,863)	-	(25,863)	(100.0%)	Other Income	45	-	45	100.0%
(889,771)	**(2,077,922)**	**1,188,151**	**57.2%**	**Total Non-Operating Income (Loss)**	**(21,022,549)**	**(9,610,388)**	**(11,412,161)**	**(118.7%)**
15,069,514	**(4,280,762)**	**19,350,276**	**452.0%**	**Change in Net Assets**	**40,249,787**	**15,334,470**	**24,915,317**	**162.5%**
89.9%	***95.5%***	***(5.6%)***		***Medical Loss Ratio***	***92.7%***	***93.8%***	***(1.1%)***	
4.6%	***5.3%***	***0.6%***		***Admin Loss Ratio***	***4.3%***	***5.0%***	***0.7%***	

MEDI-CAL INCOME STATEMENT– JANUARY MONTH:

REVENUES of $290.1 million are unfavorable to budget $8.0 million driven by:

- Favorable volume related variance of $18.6 million
- Unfavorable price related variance of $26.5 million
  - $38.5 million due to COVID-19 and Proposition 56 risk corridor reserves
  - Offset by:
    - $13.0 million due to PY retroactive eligibility changes and favorable premium capitation rates

MEDICAL EXPENSES of $260.7 million are favorable to budget $23.9 million driven by:

- Unfavorable volume related variance of $17.7 million
- Favorable price related variance of $41.7 million
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $15.7 million due to low utilization and Incurred But Not Reported (IBNR) claims
  - Facilities Claims expense favorable variance of $12.8 million due to IBNR
  - Provider Capitation expense favorable variance of $6.6 million
  - Professional Claims expense favorable variance of $4.1
  - All other expenses net favorable variance of $2.5 million

ADMINISTRATIVE EXPENSES of $13.5 million are favorable to budget $2.2 million driven by:

- Other Non-Salary expense favorable to budget $1.6 million
- Salaries & Benefit expense favorable to budget $0.5 million

CHANGE IN NET ASSETS is $15.1 million, favorable to budget $19.4 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2023

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
17,293	**16,996**	**297**	**1.7%**	**Member Months**	**34,882**	**32,923**	**1,959**	**6.0%**
				Revenues				
21,652,457	21,696,477	(44,020)	(0.2%)	Medicare Part C Revenue	37,329,946	34,177,309	3,152,637	9.2%
8,510,567	6,943,388	1,567,179	22.6%	Medicare Part D Revenue	15,228,108	13,210,738	2,017,370	15.3%
30,163,024	**28,639,865**	**1,523,159**	**5.3%**	**Total Operating Revenue**	**52,558,054**	**47,388,047**	**5,170,007**	**10.9%**
				Medical Expenses				
12,250,775	11,095,472	(1,155,303)	(10.4%)	Provider Capitation	18,556,046	15,691,441	(2,864,605)	(18.3%)
4,170,244	4,825,057	654,813	13.6%	Inpatient	10,080,115	12,201,603	2,121,488	17.4%
1,390,434	1,149,939	(240,495)	(20.9%)	Ancillary	2,266,014	1,720,124	(545,890)	(31.7%)
80,154	71,549	(8,605)	(12.0%)	MLTSS	80,154	71,549	(8,605)	(12.0%)
9,695,686	8,074,706	(1,620,980)	(20.1%)	Prescription Drugs	16,804,358	15,064,503	(1,739,855)	(11.5%)
388,844	631,460	242,616	38.4%	Incentive Payments	551,569	783,250	231,681	29.6%
978,061	1,432,256	454,195	31.7%	Medical Management	1,303,839	2,164,878	861,039	39.8%
28,954,198	**27,280,439**	**(1,673,759)**	**(6.1%)**	**Total Medical Expenses**	**49,642,096**	**47,697,348**	**(1,944,748)**	**(4.1%)**
1,208,826	**1,359,426**	**(150,600)**	**(11.1%)**	**Gross Margin**	**2,915,958**	**(309,301)**	**3,225,259**	**1042.8%**
				Administrative Expenses				
853,973	1,069,262	215,289	20.1%	Salaries, Wages & Employee Benefits	1,641,698	1,926,326	284,628	14.8%
8,131	34,583	26,452	76.5%	Professional Fees	174,844	182,081	7,237	4.0%
228,341	407,292	178,951	43.9%	Purchased Services	426,457	514,200	87,743	17.1%
164,518	203,268	38,750	19.1%	Printing & Postage	549,832	435,120	(114,712)	(26.4%)
196	16,242	16,046	98.8%	Other Operating Expenses	5,566	16,242	10,676	65.7%
925,930	706,140	(219,790)	(31.1%)	Indirect Cost Allocation, Occupancy	1,551,678	1,367,910	(183,768)	(13.4%)
2,181,088	**2,436,787**	**255,699**	**10.5%**	**Total Administrative Expenses**	**4,350,075**	**4,441,879**	**91,804**	**2.1%**
(972,263)	**(1,077,361)**	**105,098**	**9.8%**	**Change in Net Assets**	**(1,434,117)**	**(4,751,180)**	**3,317,063**	**69.8%**
96.0%	***95.3%***	***0.7%***		***Medical Loss Ratio***	***94.5%***	***100.7%***	***(6.2%)***	
7.2%	***8.5%***	***1.3%***		***Admin Loss Ratio***	***8.3%***	***9.4%***	***1.1%***	

ONECARE INCOME STATEMENT– JANUARY MONTH:

REVENUES of $30.2 million are favorable to budget $1.5 million driven by:

- Favorable volume related variance of $0.5 million
- Favorable price related variance of $1.0

MEDICAL EXPENSES of $29.0 million are unfavorable to budget $1.7 million driven by:

- Unfavorable volume related variance of $0.5 million
- Unfavorable price related variance of $1.2 million
  - Prescription Drugs expense unfavorable variance of $1.5 million
  - Provider Capitation expense unfavorable variance of $1.0 million
  - All other expenses net favorable variance of $1.2 million

ADMINISTRATIVE EXPENSES of $2.2 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 $40,409

CHANGE IN NET ASSETS is ($1.0) million, favorable to budget $0.1 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Seven Months Ending January 31, 2023

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
26	**-**	**26**	**100.0%**	**Member Months**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
				Revenues				
46,924	-	46,924	100.0%	Medi-Cal Revenue	16,147,394	16,971,109	(823,715)	(4.9%)
(176,414)	-	(176,414)	(100.0%)	Medicare Part C Revenue	121,260,036	117,560,580	3,699,456	3.1%
(900,823)	-	(900,823)	(100.0%)	Medicare Part D Revenue	37,997,128	33,096,368	4,900,760	14.8%
(1,030,314)	**-**	**(1,030,314)**	**(100.0%)**	**Total Operating Revenue**	**175,404,558**	**167,628,057**	**7,776,501**	**4.6%**
				Medical Expenses				
68,547	-	(68,547)	(100.0%)	Provider Capitation	72,005,004	69,401,413	(2,603,591)	(3.8%)
50,421	-	(50,421)	(100.0%)	Facilities Claims	27,507,746	24,684,406	(2,823,340)	(11.4%)
27,829	-	(27,829)	(100.0%)	Ancillary	8,667,015	7,214,705	(1,452,310)	(20.1%)
151,596	-	(151,596)	(100.0%)	MLTSS	10,106,747	8,924,314	(1,182,433)	(13.2%)
(932,462)	-	932,462	100.0%	Prescription Drugs	40,079,787	38,194,494	(1,885,293)	(4.9%)
(887,807)	-	887,807	100.0%	Incentive Payments	1,642,548	3,304,554	1,662,006	50.3%
228,334	27,242	(201,092)	(738.2%)	Medical Management	6,551,128	7,765,578	1,214,450	15.6%
(1,293,543)	**27,242**	**1,320,785**	**4848.3%**	**Total Medical Expenses**	**166,559,975**	**159,489,464**	**(7,070,511)**	**(4.4%)**
263,229	**(27,242)**	**290,471**	**1066.3%**	**Gross Margin**	**8,844,583**	**8,138,593**	**705,990**	**8.7%**
				Administrative Expenses				
36,341	15,126	(21,215)	(140.3%)	Salaries, Wages & Employee Benefits	4,157,957	5,551,939	1,393,982	25.1%
1	-	(1)	(100.0%)	Professional Fees	24,509	124,998	100,489	80.4%
22,419	35,666	13,247	37.1%	Purchased Services	522,208	693,301	171,093	24.7%
4,208	(35,666)	(39,874)	(111.8%)	Printing & Postage	259,908	369,425	109,517	29.6%
59	-	(59)	(100.0%)	Other Operating Expenses	8,838	36,561	27,723	75.8%
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	4,929,832	4,333,100	(596,732)	(13.8%)
63,027	**15,126**	**(47,901)**	**(316.7%)**	**Total Administrative Expenses**	**9,903,252**	**11,109,324**	**1,206,072**	**10.9%**
				Non-Operating Income (Loss)				
-	-	-	0.0%	Net Operating Tax	-	-	-	0.0%
-	**-**	**-**	**-**	**Total Non-Operating Income (Loss)**	**-**	**-**	**-**	**-**
200,201	**(42,368)**	**242,569**	**572.5%**	**Change in Net Assets**	**(1,058,669)**	**(2,970,731)**	**1,912,062**	**64.4%**
125.5%	***0.0%***	***125.5%***		***Medical Loss Ratio***	***95.0%***	***95.1%***	***(0.2%)***	
(6.1%)	***0.0%***	***6.1%***		***Admin Loss Ratio***	***5.6%***	***6.6%***	***1.0%***	

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
428	**479**	(51)	(10.6%)	**Member Months**	**3,034**	**3,246**	**(212)**	**(6.5%)**
				Revenues				
2,774,409	3,085,995	(311,586)	(10.1%)	Medi-Cal Capitation Revenue	19,523,918	20,646,897	(1,122,979)	(5.4%)
679,762	797,970	(118,208)	(14.8%)	Medicare Part C Revenue	4,236,336	4,849,485	(613,149)	(12.6%)
267,638	203,718	63,919	31.4%	Medicare Part D Revenue	1,441,960	1,381,055	60,905	4.4%
3,721,808	**4,087,683**	**(365,875)**	**(9.0%)**	**Total Operating Revenue**	**25,202,214**	**26,877,437**	**(1,675,223)**	**(6.2%)**
				Medical Expenses				
1,064,979	1,147,464	82,485	7.2%	Medical Management	6,781,834	7,867,085	1,085,251	13.8%
831,397	914,589		0.0%	Medical Management	5,234,881	6,256,134		0.0%
233,582	232,875		0.0%	Medical Management	1,546,953	1,610,951		0.0%
			0.0%					0.0%
759,954	970,901	210,947	21.7%	Facilities Claims	6,043,423	6,446,197	402,774	6.2%
716,252	976,540	260,288	26.7%	Professional Claims	5,221,293	6,480,538	1,259,245	19.4%
342,390	418,124	75,734	18.1%	Prescription Drugs	2,796,017	2,758,816	(37,201)	(1.3%)
103,499	74,798	(28,701)	(38.4%)	MLTSS	1,143,404	472,257	(671,147)	(142.1%)
181,400	198,199	16,799	8.5%	Patient Transportation	1,163,798	1,329,387	165,589	12.5%
5,350	6,098	748	12.3%	Incentive Payments	37,925	40,945	3,020	7.4%
3,173,825	**3,792,124**	**618,299**	**16.3%**	**Total Medical Expenses**	**23,187,694**	**25,395,225**	**2,207,531**	**8.7%**
547,984	**295,559**	**252,425**	**85.4%**	**Gross Margin**	**2,014,520**	**1,482,212**	**532,308**	**35.9%**
				Administrative Expenses				
146,123	179,968	33,845	18.8%	Salaries, Wages & Employee Benefits	955,682	1,240,708	285,026	23.0%
1,378	412	(966)	(234.5%)	Professional Fees	3,106	2,886	(220)	(7.6%)
61,701	43,680	(18,021)	(41.3%)	Purchased Services	133,069	305,758	172,689	56.5%
(21,056)	20,234	41,290	204.1%	Printing & Postage	153,696	141,639	(12,057)	(8.5%)
739	900	161	17.9%	Depreciation & Amortization	4,253	6,300	2,047	32.5%
6,749	10,073	3,324	33.0%	Other Operating Expenses	73,405	70,510	(2,895)	(4.1%)
13,808	12,981	(827)	(6.4%)	Indirect Cost Allocation, Occupancy	97,652	88,977	(8,675)	(9.7%)
209,441	**268,248**	**58,807**	**21.9%**	**Total Administrative Expenses**	**1,420,863**	**1,856,778**	**435,915**	**23.5%**
				Non-Operating Income (Loss)				
-	-	-	0.0%	Net Operating Tax	-	-	-	0.0%
-	**-**	**-**	**-**	**Total Non-Operating Income (Loss)**	**-**	**-**	**-**	**-**
338,542	**27,311**	**311,231**	**1139.6%**	**Change in Net Assets**	**593,657**	**(374,566)**	**968,223**	**258.5%**
85.3%	***92.8%***	***(7.5%)***		***Medical Loss Ratio***	***92.0%***	***94.5%***	***(2.5%)***	
5.6%	***6.6%***	***0.9%***		***Admin Loss Ratio***	***5.6%***	***6.9%***	***1.3%***	

CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2023

Month					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
467	**568**	**(101)**	**(17.8%)**	**Member Months**	**3,306**	**3,976**	**(670)**	**(16.9%)**
				Revenues				
207,494	253,517	(46,023)	(18.2%)	Revenue	1,382,210	1,774,619	(392,409)	(22.1%)
207,494	**253,517**	**(46,023)**	**(18.2%)**	**Total Operating Revenue**	**1,382,210**	**1,774,619**	**(392,409)**	**(22.1%)**
				Medical Expenses				
155,980	166,522	10,542	6.3%	Medical Management	1,063,274	1,165,654	102,380	8.8%
24,415	32,958	8,543	25.9%	Waiver Services	202,824	230,706	27,882	12.1%
155,980	166,522	10,542	6.3%	Total Medical Management	1,063,274	1,165,654	102,380	8.8%
24,415	32,958	8,543	25.9%	Total Waiver Services	202,824	230,706	27,882	12.1%
180,395	**199,480**	**19,085**	**9.6%**	**Total Program Expenses**	**1,266,098**	**1,396,360**	**130,262**	**9.3%**
27,099	**54,037**	**(26,938)**	**(49.9%)**	**Gross Margin**	**116,111**	**378,259**	**(262,148)**	**(69.3%)**
				Administrative Expenses				
76,022	81,893	5,871	7.2%	Salaries, Wages & Employee Benefits	526,930	564,327	37,397	6.6%
1,333	1,333	(0)	(0.0%)	Professional Fees	9,333	9,331	(2)	(0.0%)
5,842	9,150	3,308	36.1%	Other Operating Expenses	40,883	64,042	23,159	36.2%
5,471	6,550	1,079	16.5%	Indirect Cost Allocation, Occupancy	38,294	45,850	7,556	16.5%
88,669	**98,926**	**10,257**	**10.4%**	**Total Administrative Expenses**	**615,440**	**683,550**	**68,110**	**10.0%**
(61,569)	**(44,889)**	**(16,680)**	**(37.2%)**	**Change in Net Assets**	**(499,328)**	**(305,291)**	**(194,037)**	**(63.6%)**
86.9%	***78.7%***	***8.3%***		***Medical Loss Ratio***	***91.6%***	***78.7%***	***12.9%***	
42.7%	***39.0%***	***(3.7%)***		***Admin Loss Ratio***	***44.5%***	***38.5%***	***(6.0%)***	

CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2023

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
33,114	55,650	22,536	40.5%	Purchased Services	278,851	389,550	110,699	28.4%
208,693	224,250	15,557	6.9%	Depreciation & Amortization	1,477,270	1,569,750	92,480	5.9%
20,875	22,500	1,625	7.2%	Insurance Expense	146,125	157,500	11,375	7.2%
123,016	138,755	15,739	11.3%	Repair & Maintenance	916,444	971,285	54,841	5.6%
33,208	48,405	15,197	31.4%	Other Operating Expenses	427,626	338,835	(88,791)	(26.2%)
(418,905)	(489,560)	(70,655)	(14.4%)	Indirect Cost Allocation, Occupancy	(3,246,317)	(3,426,920)	(180,603)	(5.3%)
-	**-**	**-**	**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 Seven Months Ending January 31, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
181,333	172,500	8,833	5.1%	Rental Income	1,282,083	1,207,500	74,583	6.2%
181,333	**172,500**	**8,833**	**5.1%**	**Total Operating Revenue**	**1,282,083**	**1,207,500**	**74,583**	**6.2%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
12,050	13,333	1,283	9.6%	Purchased Services	88,668	93,331	4,663	5.0%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
-	2,733	2,733	100.0%	Insurance Expense	-	19,131	19,131	100.0%
38,282	25,666	(12,616)	(49.2%)	Repair & Maintenance	236,674	179,662	(57,012)	(31.7%)
8,266	39,933	31,667	79.3%	Other Operating Expenses	155,487	279,531	124,044	44.4%
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
58,598	**81,665**	**23,067**	**28.2%**	**Total Administrative Expenses**	**480,829**	**571,655**	**90,826**	**15.9%**
122,735	**90,835**	**31,900**	**35.1%**	**Change in Net Assets**	**801,254**	**635,845**	**165,409**	**26.0%**

OTHER INCOME STATEMENTS – JANUARY MONTH:

ONECARE CONNECT INCOME STATEMENT

CHANGE IN NET ASSETS is $0.2 million, favorable to budget $0.2 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.3 million favorable to budget $0.3 million

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($61,569), unfavorable to budget $16,680

BUILDING 500 INCOME STATEMENT

CHANGE IN NET ASSETS is $122,735, favorable to budget $31,900

- Net of $181,333 in rental income and $58,598 in expenses for the month of January

INVESTMENT INCOME

- Favorable variance of $13.7 million is due to interest income of $8.4 million and $6.9 million of unrealized gains from investments

CalOptima Health
Balance Sheet
January 31, 2023

ASSETS

Current Assets	
Operating Cash	$661,507,328
Short-term Investments	1,500,815,121
Capitation Receivable	391,985,165
Receivables - Other	89,479,342
Prepaid Expenses	21,455,087
Total Current Assets	**2,665,242,042**
Capital Assets	
Furniture & Equipment	50,138,637
Building/Leasehold Improvements	5,059,408
Construction in Progress	5,065,308
505 City Parkway West	52,951,401
500 City Parkway West	22,631,500
	135,846,254
Less: Accumulated Depreciation	(68,438,744)
Capital Assets, Net	67,407,511
GASB 96 Capital Assets	
GASB 96 Subscription Assets	-
Less: GASB 96 Accumulated Depreciation	-
GASB 96 Capital Assets, Net	-
Total Capital Assets	67,407,511
Other Assets	
Restricted Deposit & Other	300,000
Homeless Health Reserve	536,739
Board-Designated Assets:	
Cash and Cash Equivalents	5,892,800
Investments	567,889,317
Total Board-Designated Assets	573,782,117
Total Other Assets	574,618,856
TOTAL ASSETS	**3,307,268,409**
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	**3,316,894,002**

LIABILITIES & NET POSITION

Current Liabilities	
Accounts Payable	$9,574,979
Medical Claims Liability	1,619,559,330
Accrued Payroll Liabilities	15,910,964
Deferred Revenue	20,749,941
Deferred Lease Obligations	70,880
Capitation and Withholds	97,039,123
Total Current Liabilities	**1,762,905,218**
Other Liabilities	
GASB 96 Subscription Liabilities	-
Other (than pensions) Post Employment Benefits Liability	22,451,525
Net Pension Liabilities	577,854
Bldg. 505 Development Rights	-
TOTAL LIABILITIES	**1,785,934,597**
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
Net Position	
TNE	101,579,422
Funds in Excess of TNE	1,397,590,479
TOTAL NET POSITION	1,499,169,901
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**3,316,894,002**

CalOptima Health
Board Designated Reserve and TNE Analysis
as of January 31, 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	233,668,422				
	Tier 1 - MetLife	231,895,620				
Board-designated Reserve		465,564,041	333,641,762	520,165,127	131,922,279	(54,601,085)
	Tier 2 - Payden & Rygel	54,271,057				
	Tier 2 - MetLife	53,947,018				
TNE Requirement		108,218,076	101,579,422	101,579,422	6,638,653	6,638,653
	Consolidated:	**573,782,117**	**435,221,184**	**621,744,549**	**138,560,933**	**(47,962,432)**
	Current reserve level	*1.85*	*1.40*	*2.00*		

CalOptima Health
Statement of Cash Flows
January 31, 2023

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	28,934,294	79,701,133
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	566,523	4,152,693
Changes in assets and liabilities:		
Prepaid expenses and other	(1,654,884)	1,137,168
Catastrophic reserves		
Capitation receivable	13,508,566	(4,599,921)
Medical claims liability	46,316,702	341,543,981
Deferred revenue	10,491,958	12,645,897
Payable to health networks	3,121,644	(96,175,505)
Accounts payable	(46,018,372)	(42,741,908)
Accrued payroll	2,247,614	(3,383,050)
Other accrued liabilities	(3,114)	(21,291)
Net cash provided by/(used in) operating activities	57,510,932	292,259,195
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	(179,019,434)	(486,354,618)
Change in Property and Equipment	(461,952)	(4,696,168)
Change in Restricted Deposit & Other	-	51
Change in Board designated reserves	(5,213,390)	(3,290,476)
Change in Homeless Health Reserve	-	40,100,000
Net cash provided by/(used in) investing activities	(184,694,776)	(454,241,212)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(127,183,844)	(161,982,017)
CASH AND CASH EQUIVALENTS, beginning of period	$788,691,172	823,489,344
CASH AND CASH EQUIVALENTS, end of period	**661,507,328**	**661,507,328**

BALANCE SHEET – JANUARY MONTH:

ASSETS of $3.3 billion increased $45.1 million from December or 1.4%

- Operating Cash and Short-term Investments net increase of $51.8 million due to timing of cash receipts from the Department of Health Care Services (DHCS) and a decrease in claim payments
- Offset by:
  - Capitation Receivables decreased $14.2 million due to higher State capitation rates

LIABILITIES of $1.8 billion increased $16.2 million from December or 0.9%

- Claims Liabilities increased $46.3 million due to Proposition 56 risk corridor estimates, COVID-19 risk corridor estimates and timing of claim payments
- Deferred Revenue increased $10.5 million
- Offset by
  - Accounts Payable decreased $46.0 million due primarily to the payment of Managed Care Organization (MCO) taxes in the month

NET ASSETS of $1.5 billion, increased $28.9 million from December or 2.0%

CalOptima Health - Consolidated
Net Assets Analysis
For the Seven Months Ended January 31, 2023

Category	Item Description	Amount (millions)	Approved Initiative	Spend to Date	%
	Total Net Position @ 1/31/2023	**$1,499.2**			**100.0%**
Resources Assigned	Board Designated Reserve*	**573.8**			**38.3%**
	Capital Assets, net of depreciation	**67.4**			**4.5%**
Resources Allocated	Homeless Health Initiative**	$63.3	$100.0	$36.7	4.2%
	Intergovernmental Transfers (IGT)	61.7	111.7	50.0	4.1%
	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	10.2%
	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	95.3	100.0	4.7	6.4%
	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:	**$448.1**	**$566.2**	**$118.1**	**29.9%**
Resources Available for New Initiatives	Unallocated/Unassigned*	**$409.9**			**27.3%**

*Total of Board Designated reserve and unallocated reserve amount can support approximately 100 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 January 2023

	Item Name	Month-to-Date (January 2023)					FY 2023 Year-to-Date (January 2023)				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	*Member Months*	973,571	917,263	56,308	6.1%		6,585,826	6,392,767	193,059	3.0%	
	*Operating Revenue **	323,205,298	331,088,317	(7,883,019)	(2.4%)		2,300,826,825	2,343,665,979	(42,839,155)	(1.8%)	
	*Medical Expenses **	291,715,309	315,942,824	24,227,515	7.7%		2,137,607,072	2,203,561,870	65,954,798	3.0%	
	General and Administrative Expense	16,025,792	18,485,640	2,459,848	13.3%		104,345,874	123,561,019	19,215,145	15.6%	
	Non-Operating Income/(Loss)	13,470,098	(1,487,087)	14,957,185	1005.8%		20,827,255	(5,474,543)	26,301,798	480.4%	
	Summary of Income & Expenses	28,934,294	(4,827,234)	33,761,528	699.4%		79,701,133	11,068,547	68,632,586	620.1%	
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	90.3%	95.4%	(5.2%)			92.9%	94.0%	(1.1%)		
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	5.0%	5.6%	0.6%			4.5%	5.3%	0.7%		

Key:	
> 0%	Green
> -20%, < 0%	Yellow
< -20%	Red

	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
Investment	*@1/31/2023*	2,060,037,620	1,878,834,534	181,203,086	9.6%
	Unallocated/Unassigned Reserve Balance	Current Month @ January 2023	Fiscal Year Ending June 2022	Change	%
	Consolidated	409,897,070	448,294,548	(38,397,478)	(8.6%)
	*Days Cash On Hand***	100			

*$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 100 days of CalOptima Health's current operations.

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Seven Months Ending January 31, 2023

	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	**288,860**	**3,238,000**	**2,949,140**	**91.1%**	**3,204,214**	**35,021,000**	**31,816,786**	**90.9%**
Operating Expenses:								
Salaries, Wages & Benefits	339,845	525,169	185,324	35.3%	936,633	2,711,533	1,774,900	65.5%
Professional Fees	90,088	186,041	95,954	51.6%	90,088	1,302,287	1,212,200	93.1%
Purchased Services	-	13,333	13,333	100.0%	-	93,331	93,331	100.0%
Depreciation Expenses	-	-	-	0.0%	-	-	-	0.0%
Other Expenses	144,514	274,365	129,851	47.3%	449,251	1,920,555	1,471,304	76.6%
Total Operating Expenses	**574,447**	**998,908**	**424,461**	**42.5%**	**1,475,972**	**6,027,706**	**4,551,734**	**75.5%**

Funding Balance Tracking:	**Actual Spend**	**Approved Budget**
Beginning Funding Balance	100,000,000	100,000,000
Less:		
FY2022-23	4,680,186	47,323,113
FY2023-24		
FY2024-25		
Ending Funding Balance	**95,319,814**	**52,676,887**

CalOptima Health

Summary of Homeless Health Initiatives (HHI) and Allocated Funds

As of January 31, 2023

Funds Allocation, approved initiatives:	**Allocated Amount**	**Utilized Amount**	**Remaining Approved Amount**
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Homeless Coordination at Hospitals	10,000,000	9,197,577	802,423
Recuperative Care	8,250,000	6,194,190	2,055,810
Street Medicine	8,000,000	-	8,000,000
Outreach and Engagement	7,000,000	-	7,000,000
CalOptima Homeless Response Team	6,000,000	1,681,734	4,318,266
Homeless Clinical Access Program (HCAP) and CalOptima Days*	2,700,000	3,135,200	(435,200)
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 Days, HCAP and FQHC Administrative Support	963,261	688,762	274,499
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
FQHC (Community Health Center) Expansion	300,000	21,902	278,098
Medical Respite	250,000	250,000	-
Housing and Homelessness Incentive Program (HHIP): 40.1 million			
Capital Projects	21,000,000	-	21,000,000
Infrastructure Projects	10,500,000	-	10,500,000
Equity Grants for Programs Serving Underrepresented Populations	5,000,000	-	5,000,000
Office of Care Coordination	2,200,000	-	2,200,000
Pulse For Good	800,000	-	800,000
Consultant	600,000	-	600,000
Subtotal of Approved Initiatives	**$99,463,261**	**$36,724,013**	**$62,739,248**
Program Commitment Balance, available for new Initiatives	536,739		536,739
Program Total	**$100,000,000**	**$36,724,013**	**$63,275,987**

Note*

At the February 2, 2023 Board meeting, the Board approved an additional $498,400 to cover the deficit from the HCAP and HCAP Expansion Program which will be reflected in the February 2023 financial reports

CalOptima Health
Budget Allocation Changes
Reporting Changes for January 2023

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
January	Medi-Cal	Facilities - Comp Supply/Minor Equipment	Facilities - R&M Building	$70,000	To reallocate funds from Facilities Comp Supply/Minor Equipment to Facilities R&M Building to cover any remaining purchases that will be incurred in FY23.	2022-23
January	OCC	Sales & Marketing - Printing & Postage	Cultural & Linguistic Services - Purchased Services	$18,000	To reallocate funds from Sales & Marketing Printing Postage & Customer Service Postage to Cultural Linguistic Purchased OCC-803 (C&L translations/interpreter services) needed an additional $58K to pay outstanding invoices.	2022-23
January	OCC	Customer Service - Postage	Cultural & Linguistic Services - Purchased Services	$40,000	To reallocate funds from Sales & Marketing Printing Postage & Customer Service Postage to Cultural Linguistic Purchased OCC-803 (C&L translations/interpreter services) needed an additional $58K to pay outstanding invoices.	2022-23
January	OC	Sales & Marketing - Purchased Services General	Cultural & Linguistic Services - Purchased Services	$50,000	To reallocate funds from Sales & Marketing - Purchased Services to Cultural & Linguistic - Purchased Services for translations/interpreter services.	2022-23
January	Medi-Cal	Medical Management - Food Services	Medical Management - Professional Dues	$12,000	To reallocate funds from Medical Management Food Services to Medical Management Professional Dues to pay for Orange County Medical Association dues for the Medical Directors.	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
March 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

- Calendar Year (CY) 21 Medicare Part D Improper Payment Measure (IPM) *(applicable to OneCare (OC) and OneCare Connect (OCC))*:

  - ➢ On January 13, 2023, the Centers for Medicare & Medicaid Services (CMS) informed CalOptima that its OC and OCC programs have been selected to participate in the Part D IPM 21. CMS conducts the Part D IPM activity to validate the accuracy of Prescription Drug Encounter (PDE) data submitted by Medicare Part D Sponsors to CMS for payments.
  - ➢ On January 27, 2023, the submission window opened, and contract specific documentation was made available. CalOptima has set an internal deadline of March 06, 2023, to meet the Early Submission regulatory deadline of March 10, 2023.

- 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.
  - ➢ On January 10, 2023, CMS issued the Revalidation Notification Letter. CalOptima Health had a call with CMS the same day to address the IVA report. Per the IVA report, 5 out of the 10 findings were not fully remediated. As three of the conditions were for OCC, which nonrenewed as of December 31, 2022, CMS is not requiring revalidation of these three conditions.
  - ➢ For the two conditions applicable to OC, 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. Both CAP responses were submitted by the CMS due date of January 18, 2023.
  - ➢ On January 27, 2023, CMS requested a revised CAP for Formulary Administration (FA) 2.06. The revised CAP was submitted to CMS on February 2, 2023.

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- ➢ Once both CAP responses are reviewed and approved by CMS, both conditions will undergo another focused validation audit.
- ➢

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.

- 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.
  - ➢ Grievances Part C and Part D reporting measures were submitted to CMS on February 1, 2023. The remaining Part C and D reporting measures will be submitted no later than the regulatory deadline of 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 contract year.
  - ➢ Regulatory Affairs and Compliance (RAC) led the 2023 Readiness Checklist activities with all departments to ensure compliance for requirements impacting their respective operational area(s).
  - ➢ The validation audit activities were completed, and the audit closed on January 30, 2023. All elements were met on the Readiness Checklist.

2. Medi-Cal

- 2024 Managed Care Plan (MCP) Operational Readiness Contract:

  Update:

  As of February 2, 2023, CalOptima Health has **submitted a total of 122 deliverables** for 2024 MCP operational readiness. To date, CalOptima Health has received **approval for 95** 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.

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On-track for all remaining deliverables.

Background – FYI Only

Throughout CY 2022 and CY 2023, MCPs, including CalOptima Health will be required to submit a series of contract readiness deliverables to 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:

  Update: Regulatory Affairs and Compliance (RAC) staff continues to work to ensure all DHCS audit deliverables are provided in a timely manner. To date, CalOptima Health has submitted all pre-audit supporting documentation, data universes, and DHCS-selected files.

  Background – FYI Only
  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

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- ➢ 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.

snip

- 2021 DHCS Medical Audit:

  Update: On December 22, 2022, CalOptima Health submitted its formal corrective action plan to DHCS. CalOptima Health must provide **monthly updates** on findings with future milestones. These monthly updates will continue until all milestones have been reached and/or DHCS determines the CAP is closed. CalOptima Health's January update was provided to DHCS timely, and we remain on-track for a timely February update.

- 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

  Update: CalOptima and DHCS met as scheduled on January 13, 2023, to discuss the notice of imposition of monetary sanctions. In follow-up to the meeting, CalOptima Health provided additional information and was informed that a final version of the quality sanctions would follow a DHCS review.

  In response to the original notice of imposition of monetary sanctions, received on December 13, 2022, CalOptima Health provided its timely submission of the revised comprehensive quality strategy. CalOptima awaits DHCS feedback.

  - ➢ **Background – FYI Only** 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 2

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measures of the Medi-Cal Managed Care Accountability Set (MCAS) 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.

C. Updates on Internal and Health Network Monitoring and Audits

- Internal Audits

  - Internal Audit of PACE Program
    - During the fourth quarter of 2022, CalOptima's Audit & Oversight (A&O) department conducted an internal audit of the PACE Center to ensure compliance with universe, timeliness, clinical decision-making, and processing requirements, as applicable for the review period of May 28, 2022, through November 28, 2022, for Table 1, 2, 3, 4, 5, and 7 & August 28, 2022, through November 28, 2022, for Table 6.
  - 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	Audit Scope	Files Reviewed	Files Passed	Final Audit Score
2023 PACE Compliance & Quality Improvement Tool				
Compliance And Quality Improvement Review	☒ Policy & Procedure			100%
2023 Table 1: Service Determination Requests (SDR) Audit Tool				
Universe Accuracy	☒ File Review	10	10	100%
SDR Denials	☒ File Review	2	0	0%
SDR Approvals	☒ File Review	10	10	100%
2023 Table 2: Appeal Requests (AR) Audit Tool				
Universe Integrity	☒File Review	1	1	100%
Approved Appeals	☒File Review	NTR	NTR	None Reported

Audit Area	Audit Scope	Files Reviewed	Files Passed	Final Audit Score
Denied Appeals	☒File Review	1	0	0%
2023 Table 3: Grievances (GR) Audit Tool				
Universe Integrity	☒File Review	10	3	Fail
Classification Score	☒File Review	10	10	100%
Grievance Acknowledged ≤ 5 Calendar Days of Receipt	☒ File Review	10	8	80%
Language Preference	☒ File Review	10	3	30%
Participant Notice Content	☒ File Review	10	3	30%
Resolution of Grievances resolved ≤ 30 Calendar Days of Receipt	☒ File Review	10	3	30%
2023 Table 4: List of Personnel (LOP) Audit Tool				
Universe Integrity	☒ File Review	10	10	100%
Licensure	☒ File Review	5	5	100%
OIG Exclusions	☒ File Review	10	8	80%
Background Checks	☒ File Review	10	8	80%
Clearance of Communicable Diseases	☒ File Review	10	9	90%
Personnel Training	☒ File Review	10	7	70%
2023 Table 5: List of Participant Medical Records (LOPMR)) Audit Tool				
Universe Integrity	☒File Review	30	27	Fail
Adequate Care	☒ File Review	30	29	97%
IDT Participation	☒ File Review	30	29	97%
Assessments	☒ File Review	30	30	100%
Medical Record Accuracy	☒ File Review	30	3	10%
Care Plan Development	☒ File Review	30	18	60%
Infection Control	☒ File Review	30	30	100%
Emergency Equipment	☒ File Review	30	30	100%
Transportation	☒ File Review	30	30	100%
2023 Table 6: On-Call OC Record Layout				
Universe Integrity	☒File Review	45	45	Pass
2023 Table 7: Contracted Entities and Providers (CEP) Record Layout				
Universe Integrity	☒File Review	279	279	Pass

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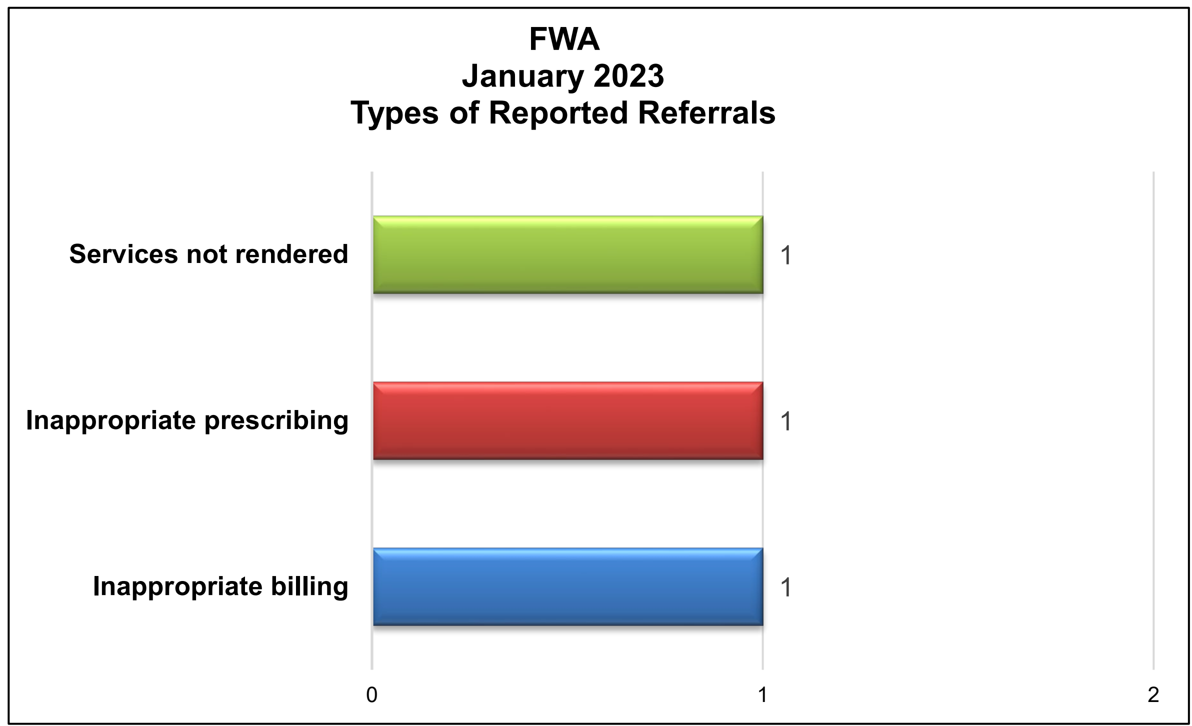
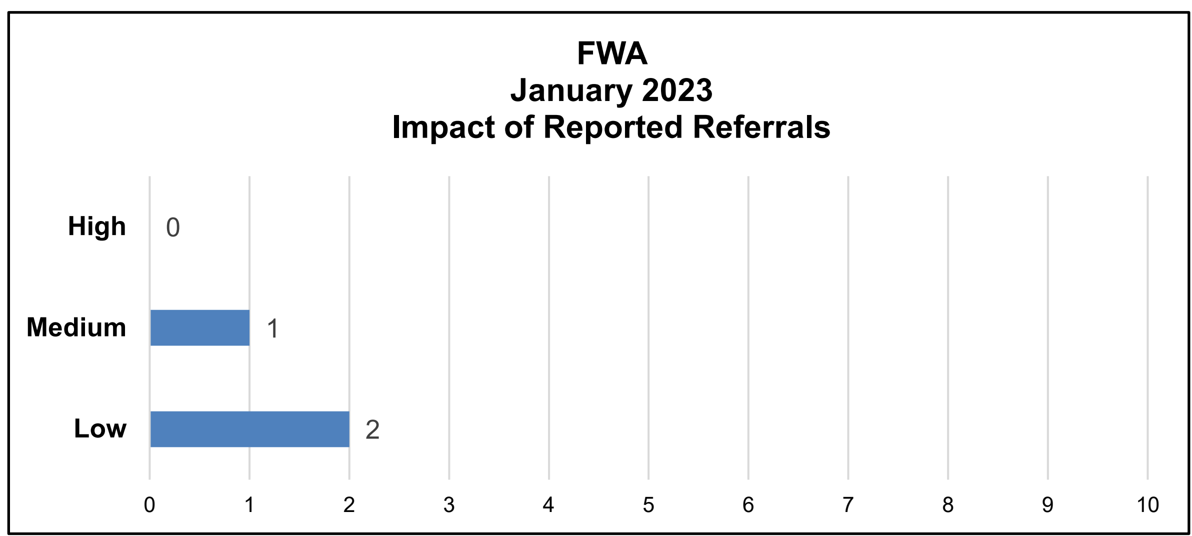
D. Fraud, Waste & Abuse (FWA) Investigations (January 2023)





Total Number of New Cases Referred to DHCS (State)	3
Total Number of New Cases Referred to DHCS and CMS*	2
Total Number of Referrals (Subjects) Reported to Regulatory Agencies	**3**

*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.

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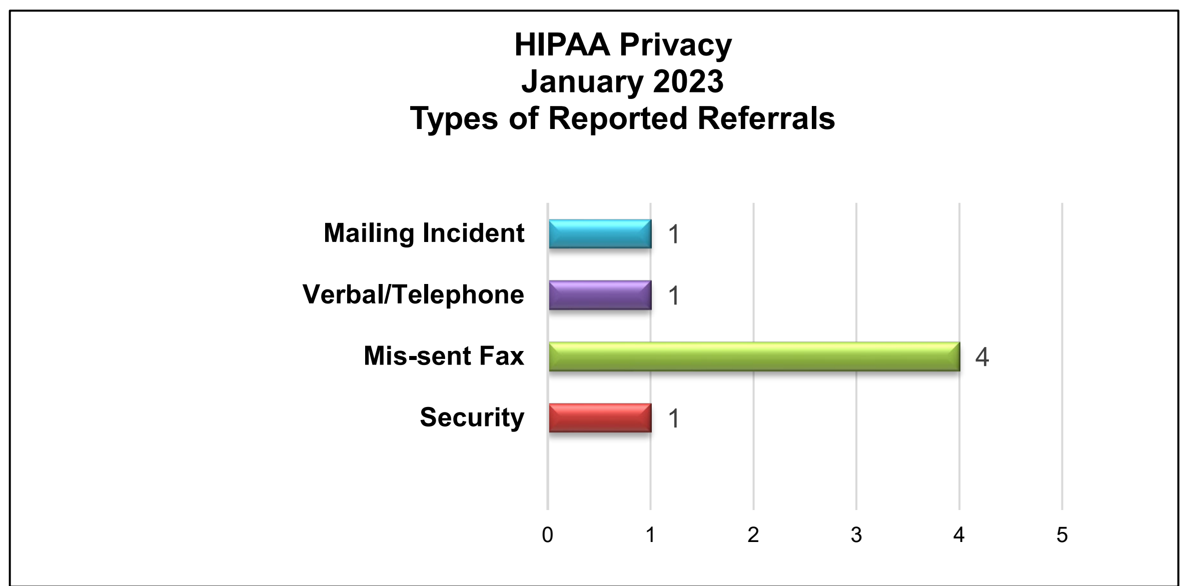
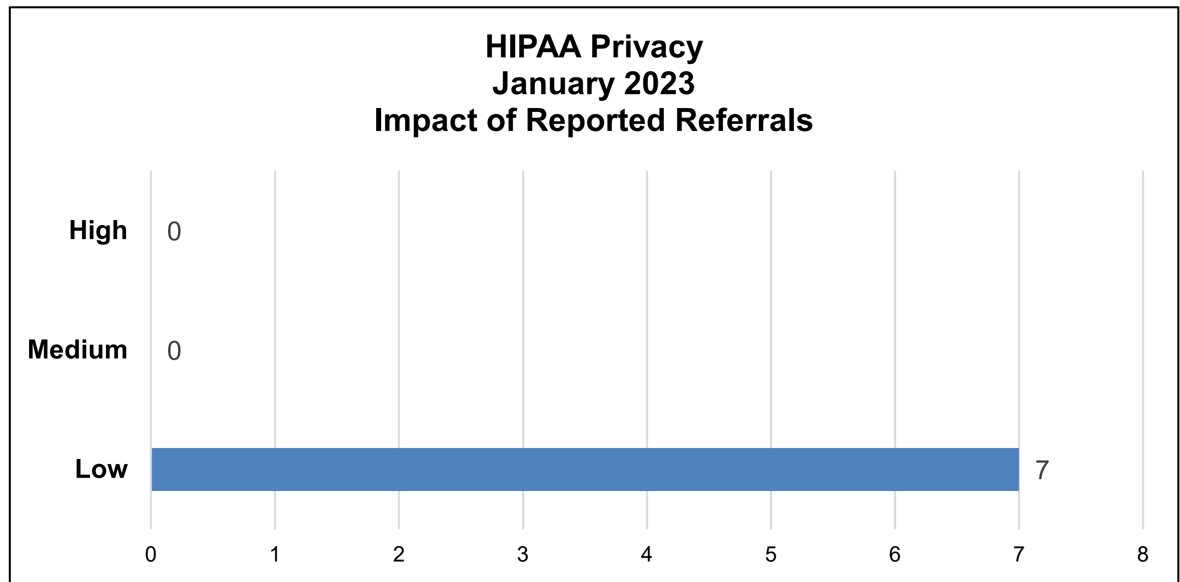
E. Privacy Update: (January 2023)





PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	7
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

MEMORANDUM

February 10, 2023

To: CalOptima Health

From: Potomac Partners DC & Strategic Health Care

Re: February Board of Directors Report

Fiscal Year 2024 Budget & Appropriations

President Biden delivered his State of the Union address to Congress and the nation on Tuesday, February 7th. During his speech, President Biden outlined his administration's priorities for the coming year, which include bolstering Medicaid and Medicare services, reducing drug prices, and resolving the debt ceiling limit without cutting healthcare spending. The President is expected to send his budget request to Congress in early March, officially starting the annual appropriations process. Community Project Funding, also known as earmarks or Congressionally Directed Spending in the Senate, is expected to continue in the 118th Congress following a vote in the House Republican Caucus approving the process last December. There have been some changes in leadership on the Subcommittees with jurisdiction over health spending. Rep. Robert Aderholt (R-AL) will serve as Chair of the House Appropriations Labor-Health and Human Services-Education Subcommittee, with Rep. Rosa DeLauro (D-CT) serving as the Ranking Member. Senator Patty Murray (D-WA) has been named Chair of the full Senate Appropriations Committee, with Senator Susan Collins (R-ME) serving as Vice Chair.

Public Health Emergency (PHE) Designation

The Biden Administration has announced it intends to end both the national emergency and the public health emergency for COVID-19 on May 11th, 2023. The Centers for Medicare and Medicaid Services (CMS) updated the home page for its waivers and flexibilities, promising more information as soon as possible. The notice is available here. The updated CMS webpage is available here. In January, the House passed H.R. 497 - *Freedom for Health Care Workers Act* by a vote of 227-203. TH.R. 497 would end the vaccine mandate for health workers. The House also passed H.R. 382 - *Pandemic is Over Act* by a vote of 220-210. H.R. 382, which would end the PHE immediately, was cited in the Administration's statement of policy, noting that the PHE will end on May 11th. Neither bill is likely to be considered by the Senate.

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TELEHEALTH

Telehealth flexibilities that will end with the PHE unless Congress intervenes:

- Based on the HHS OCR Guidance, available here, the enforcement discretion on the requirement to use a HIPAA-secure and BAA-covered video platform and patient communications tool will end.
- Providers will no longer be able to prescribe controlled substances to patients via telemedicine except in specific circumstances, most commonly when a patient is in a DEA-registered medical facility or the physical presence of a DEA-registered provider.
  - DEA plans to propose a rule soon to allow telehealth providers to continue prescribing controlled substances after the PHE ends. It remains to be seen if the rulemaking process will be completed by 5/11/23.

Telehealth items that will end on December 31, 2023:

- A virtual presence for direct supervision ends. CMS could address this in the Physician Fee Schedule Proposed Rule for CY 2024.
- In the Physician Fee Schedule for CY 2023, available here, CMS sought to align the end date of specific codes following the PHE. Extending these codes through December 31, 2024, will require additional rulemaking.
  - Category 3 codes, available here (Table 12), were extended through December 31, 2023.
  - Additional codes (not on Category 1, 2, or 3), available here (Table 14), were extended through December 31, 2023.

Telehealth flexibilities that were extended until December 31, 2024:

- Medicare reimbursement for telehealth services to patients at home.
- Medicare reimbursement for an expanded list of eligible providers.
- Medicare coverage of audio-only telehealth for non-mental health visits.
- Reimbursement of FQHCs and RHCs as distant site telehealth providers for non-mental health services.

Permanent Changes:

- Medicare reimbursement for mental health telehealth services (including audio-only in some cases), provided there is an in-person visit within the first six months of an initial telehealth visit and every 12 months thereafter. Implementation of this in-person requirement is delayed until January 1, 2025. Certain exceptions apply.
- Medicare reimbursement to FQHCs and RHC for mental health services delivered via audio-only or live video will no longer be billed the same or for telehealth specifically.

DEBT CEILING

On January 19th, U.S. Treasury Secretary Janet Yellen sent a letter (here) to House Speaker Kevin McCarthy (R-CA) informing him and the rest of Congressional Leadership that the Treasury Department has reached the debt limit and is taking extraordinary measures to meet the US Governments debt obligations. Speaker McCarthy later met with President Biden to discuss a debt limit increase to avoid a default, but both parties highlighted that the meeting itself did not signal a deal. Extraordinary measures employed by the US Treasury suspend investments in several government accounts, temporarily reducing the amount of debt below the borrowing ceiling and preventing additional debt from being added. The House Freedom Caucus, who initially opposed Speaker McCarthy, are opposed to increasing the debt limit, preferring to cut spending or employ austerity measures at certain federal agencies, including HHS and mandatory programs like Medicare or Social Security, as an alternative. Secretary Yellen estimates that extraordinary measures may last until June 5th, 2023.

DOJ WEBSITE FOR JUSTICE AND MENTAL HEALTH COLLABORATION

The Department of Justice has launched a new website aimed at strengthening connections between criminal justice agencies, behavioral health organizations, and the community. The Justice and Mental Health Collaboration Program (JMHCP) was launched in 2006. Its mission is to reduce criminal justice involvement for people with mental health conditions. JMHCP has funded over 600 grantees across 49 states and 2 U.S. territories. In 2020, BJA relaunched the *Connect and Protect: Law Enforcement Behavioral Health* grant program. The website (www.jmhcp.org) will serve as a landing page for funding announcements, justice and mental health news from DOJ, and as a resource for stakeholder opportunities in education resources and webinars.

Edelstein Gilbert Robson & Smith LLC

Donald B. Gilbert   Michael R. Robson   Trent E. Smith   Jason D. Ikerd Associate   Bridget E. McGowan Associate

February 17, 2023

CalOptima Health
LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

General Update

The bill introduction deadline is today, February 17. So far, the Legislature has introduced over 1,300 Assembly Bills and over 700 Senate bills, and it is anticipated that they will introduce another several hundred today that will go into print over the weekend. Many of these bills are "spot" or "intent" bills that do not yet have substantive language and are serving as placeholders until formal bill language is finalized. For these bills to move forward, they will need to be amended with substantive language before being heard in a policy committee.

Bills introduced must be in print for 30 days before a hearing. With the bulk of the bills introduced in the last week, committee hearings will ramp up in mid-March and continue until the policy committee deadline for fiscal bills on April 28.

This week, the Local Health Plans of California (LHPC) held a legislative briefing for legislative staff. At this briefing, CEO Michael Hunn and Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM provided a presentation on CalOptima Health and updates on CalAIM implementation on housing and homelessness.

Budget Update. On February 15, the Legislative Analyst's Office (LAO) released a report that estimates revenues will be lower than anticipated in the Govenor's January Budget Proposal, suggesting the deficit will be about $7 billion larger in May.

Budget hearings will begin to ramp up in March and continue through the presentation of the Governor's May Revision of the 2023-24 Budget.

Legislation of Interest

Public Meeting Bills – Since the onset of the COVID-19 pandemic, teleconferencing flexibilities have become a subject of interest in California's Legislature, with local government groups sponsoring various bills on the topic since 2021. This session is no exception, and multiple bills on the topic have been introduced:

> **AB 557 (Hart) - AB 361 Sunset Extension.** This bill would remove the sunset established in AB 361 (R. Rivas) as well as increase the time period when the

Board must renew the findings of an emergency or need for social distancing from 30 days to 45 days.

SB 411 (Portantino) - Teleconferencing for Appointed Bodies. This bill would allow local legislative bodies with appointed members to use teleconferencing indefinitely regardless of the presence of an emergency. We have heard however that this bill may be narrowed to apply to only LA neighborhood councils.

SB 537 (Becker) - Intent for Brown Act Teleconference Flexibilities. Senator Becker introduced a bill that declares his intent to expand public meetings through teleconference and remote access. We will monitor the bill for when substantive language is included.

Medi-Cal Bills – As we see every session, legislators have been introducing bills to expand the scope of services covered by Medi-Cal. Some of these proposals include but are not limited to covering pharmacogenomic testing for use with some medications (AB 425, Alvarez), adding climate change remediation to the list of CalAIM community supports (AB 586, Calderon), additional comprehensive perinatal assessments (AB 608, Schiavo), requiring plans to work with public transit agencies for reimbursement for nonmedical and nonemergency medical transportation trips (AB 719, Boerner Horvath), and expand the scope of pediatric palliative care services (AB 847, L. Rivas), among other bills.

Finally, while we heard a bill that would have required COHS to obtain Knox Keene Licensure was going to be reintroduced, we learned that the bill will not be returning for the time being.

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2023–24 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
	Behavioral Health		
AB 512 Waldron	**Behavioral Health Facilities Database:** Would require the California Health and Human Services Agency to create a committee to study how to develop a real-time, internet-based system, usable by hospitals, clinics, law enforcement, paramedics and emergency medical technicians, and other health care providers to display information about available beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities and residential alcoholism or substance abuse treatment facilities in order to identify available facilities for the temporary treatment of individuals experiencing a mental health or substance use disorder crisis.	**02/07/2023** Introduced	CalOptima Health: Watch
SB 363 Eggman	**Behavioral Health Facilities Database:** No later than January 1, 2025, would require the California Department of Health Care Services (DHCS) to develop a real-time, internet-based database to display information about beds in certain facilities, including chemical dependency recovery hospitals, acute psychiatric hospitals and mental health rehabilitation centers, to identify the availability of inpatient and residential mental health or substance use disorder treatment.	**02/08/2023** Introduced	CalOptima Health: Watch
	California Advancing and Innovating Medi-Cal (CalAIM)		
AB 586 Calderon	**Climate Change Remediation:** Would add "climate change remediation" as a Community Support option, defined as the coverage and installation of devices to address health-related complications, barriers or other factors linked to extreme weather or other climate events, including air conditioners, heaters, air filters and generators.	**02/09/2023** Introduced	CalOptima Health: Watch
	Covered Benefits		
AB 85 Weber	**Social Determinants of Health (SDOH) Screenings:** Beginning January 1, 2024, would add SDOH screenings as a covered Medi-Cal benefit. Would also require health plans to provide primary care providers with adequate access to community health workers (CHWs).	**12/16/2022** Introduced	CalOptima Health: Watch
AB 365 Aguiar-Curry	**Continuous Glucose Monitors (CGMs):** Would add CGMs and related supplies as a covered Medi-Cal benefit, subject to utilization controls based on clinical practice guidelines. Would also authorize DHCS to require a manufacturer of CGMs to enter into a rebate agreement with DHCS.	**02/01/2023** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 425 Alvarez	**Pharmacogenomics Advancing Total Health for All Act:** Would add pharmacogenomic testing as a covered Medi-Cal benefit, defined as laboratory genetic testing to identify how an individual's genetics may impact the efficacy, toxicity and safety of medications.	**02/06/2023** Introduced	CalOptima Health: Watch
AB 608 Schiavo	**Perinatal Services**: Would require DHCS to cover additional perinatal assessments, individualized care plans, visits and units of services during the one-year postpartum Medi-Cal eligibility period that are at least proportional to those available during pregnancy and the initial 60-day postpartum period. DHCS would be required to collaborate with the California Department of Public Health and stakeholders to determine the specific levels of additional coverage.	**02/09/2023** Introduced	CalOptima Health: Watch
AB 620 Connolly	**Digestive and Metabolic Disorders:** Beginning January 1, 2024, would require health plans to expand coverage for the testing and treatment of phenylketonuria (PKU) to include other digestive and inherited metabolic disorders. Coverage would include the formulas and special food products that are part of a prescribed diet.	**02/09/2023** Introduced	CalOptima Health: Watch
SB 257 Portantino	**Mammography:** Beginning January 1, 2025, would require health plans to cover, without cost sharing, screening mammography and medically necessary diagnostic breast imaging, including following an abnormal mammography result and for individuals with a risk factor associated with breast cancer.	**01/30/2023** Introduced	CalOptima Health: Watch
Medi-Cal Eligibility and Enrollment			
AB 564 Villapadua	**Medi-Cal Applications:** Would require DHCS to allow Medi-Cal applicants and providers to submit electronic signatures for all enrollment forms, including, but not limited to, claims and remit forms.	**02/08/2023** Introduced	CalOptima Health: Watch
SB 299 Eggman	**Medi-Cal Redeterminations:** Would remove the current requirement for a county to send a notice of action terminating Medi-Cal eligibility if the prepopulated redetermination form is returned as undeliverable and the purpose for the redetermination is loss of contact with the beneficiary.	**02/02/2023** Introduced	CalOptima Health: Watch
Medi-Cal Operations and Administration			
AB 557 Hart	**Brown Act Flexibilities:** Would permanently extend current Brown Act teleconferencing flexibilities — when a declared state of emergency is in effect — beyond January 1, 2024. Would also extend the period for a legislative body to make findings related to a continuing state of emergency from every 30 days to every 45 days.	**02/08/2023** Introduced	CalOptima Health: Watch
SB 324 Limón	**Endometriosis:** Beginning January 1, 2024, would prohibit health plans from requiring prior authorization or other utilization review for laparoscopic surgery for endometriosis.	**02/06/2023** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 411 Portantino	**Brown Act Flexibilities:** Would authorize an appointed board, commission or advisory body of a local agency to use alternate teleconferencing provisions, similar to current provisions in effect during the COVID-19 state of emergency, indefinitely and without regard to a state of emergency.	**02/09/2023** Introduced	CalOptima Health: Watch
	Older Adult Services		
SB 311 Eggman	**Medicare Part A Buy-In:** No later than January 1, 2024, would require DHCS to submit a Medicaid state plan amendment to enter into a Medicare Part A buy-in agreement with the Centers for Medicare and Medicaid Services (CMS).	**02/06/2023** Introduced	CalOptima Health: Watch
	Providers		
AB 236 Holden	**Provider Directory Audits:** Would require health plans to annually audit and delete inaccurate listings from its provider directories. Would also require a provider directory to be 60% accurate by January 1, 2024, with increasing percentage accuracy each year until the directories are 95% accurate by January 1, 2027. In addition, plans would be subject to penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. Finally, beginning July 1, 2024, would require plans to delete a provider from its directory if a plan has not reimbursed the provider in the prior year.	**01/13/2023** Introduced	CalOptima Health: Watch
	Rates & Financing		
AB 488 Nguyen, S.	**Vision Loss:** Would modify the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program measures and milestones to include program access, staff training and capital improvement measures aimed at addressing the needs of SNF residents with vision loss.	**02/07/2023** Introduced	CalOptima Health: Watch
AB 576 Weber	**Abortion Reimbursement**: Would require DHCS to fully reimburse Medi-Cal providers for providing medication to terminate a pregnancy that aligns with clinical guidelines, evidence-based research and provider discretion.	**02/08/2023** Introduced	CalOptima Health: Watch
SB 340 Eggman	**Eyeglasses Reimbursement**: Would authorize a provider to purchase eyeglasses from a private entity instead of from the Prison Industry Authority for the purpose of Medi-Cal reimbursement for covered optometric services.	**02/07/2023** Introduced	CalOptima Health: Watch
	Social Determinants of Health		
AB 257 Hoover	**Encampment Restrictions:** Would prohibit a person from sitting, lying, sleeping or placing personal property in any street, sidewalk or other public property within 500 feet of a school, daycare center, park or library.	**01/19/2023** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 271 Quirk-Silva	**Homeless Death Review Committee:** Would authorize counties to establish a homeless death review committee for the purpose of gathering information to identify the root causes of the deaths of homeless individuals and to determine strategies to improve coordination of services for the homeless population.	**01/23/2023** Introduced	CalOptima Health: Watch

Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: February 13, 2023

2023 Federal Legislative Dates

January 3	118th Congress, 1st Session convenes
July 31–September 4	Summer recess for Senate
July 31–September 11	Summer recess for House
December 15	1st Session adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2023 State Legislative Dates

January 4	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 17	Last day for legislation to be introduced
March 30–April 10	Spring recess
April 28	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 5	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 19	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
May 30–June 2	Floor session only
June 2	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 14	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 14–August 14	Summer recess
September 1	Last day for fiscal committees to report bills in their second house to the Floor
September 5–14	Floor session only
September 8	Last day to amend bills on the Floor
September 14	Last day for each house to pass bills; final recess begins upon adjournment
October 14	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2023 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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About CalOptima Health

CalOptima Health is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to serve member health with excellence and dignity, respecting the value and needs of each person. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan) and the Program of All-Inclusive Care for the Elderly (PACE).

Board of Directors Meeting
March 2, 2023
CalOptima Health Community Outreach Summary — February and March 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
Given the current economic climate, rising cost of living and recent cold weather, the need for housing resources has significantly increased for CalOptima Health members and the community at large. In response to this growing need, CalOptima Health hosted a virtual community resource fair in January to support housing in Orange County and serve as an educational opportunity for CalOptima Health staff and community stakeholders. The four-part educational series highlighted housing resources for various target populations, including youth (age 17 and under), families (those with minor children), pregnant women, and adults. Featured organizations included but were not limited to 2-1-1 Orange County, Casa Youth Shelter, The Eli Home, Colette's Children's Home and Grandma's House of Hope. Presenters shared information for eligibility, service areas, and details about their programs and services. A total of 542 community stakeholders attended the four virtual events. Post-event evaluations from attendees indicated they had a positive experience and were pleased to learn about new resources to support their clients' housing needs.

Summary of Public Activities
As of February 9, CalOptima Health plans to participate in, organize or convene 53 public activities in February and March. In February, there will be 25 public activities, including 15 virtual community/collaborative meetings, two community-based presentations, six community events, one Health Network Forum and one Cafecito meeting. In March, there will be 28 public activities, including 21 virtual community/collaborative meetings, six community events and one Health Network Forum. 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. Letter of Support for Latino Health Access' application for the National Institute of Health's Community Partnerships to Advance Science for Society (ComPASS) Program.

2. Letter of Support for First 5 Orange County's application for the Children and Youth Behavioral Health Initiative grant with the California Department of Health Care Services (DHCS).

   For additional information or questions, contact CalOptima Health Community Relations Manager Tiffany Kaaiakamanu at 657-235-6872 or tkaaiakamanu@caloptima.org.

Updated 2023-02-09

Community events hosted by CalOptima Health and community partners in February and March 2023:

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 attended (in-person). Registration fee: $150; included 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 attended (in-person). Sponsorship fee: $5,000; included resource table, company name on event signage, materials acknowledgment, company logo on ITUP's website and communications, and two complimentary tickets.	• Conference • Open to the public
2/11 11 a.m.–1:30 p.m.	**Teen Conference hosted by Human Options†** Early College High School 2990 Mesa Verde Dr., Costa Mesa	At least one staff member attended (in-person). Sponsorship fee: $1,000; included resource table at event.	• Conference • 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 presented (in-person).	• Community-based organization presentation • Open to members/community
2/16 9–11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members attended.	• 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 attended (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; included three complimentary conference registrations; three complimentary conference webinar registrations; three guests to attend the inaugural welcome reception; resource table; social media announcement; 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
2/23 10–11 a.m.	**CalOptima Health Medi-Cal Overview Presentation in English to Laura's House** Virtual	At least one staff member presented.	• Community-based organization presentation • Open to members/community
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 attended (in-person).	• Health/resource fair • Open to the public

* CalOptima Health-hosted
† Exhibitor/Attendee

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2/28 9–10:30 a.m.	**Cafecito Meeting*** Virtual	At least six staff members attended.	• Steering committee meeting • Open to collaborative members
March 2023			
3/4 9 a.m.– 1p.m	**School Readiness Fair hosted by Pretend City†** Pretend City Children's Museum 29 Hubble, Irvine	At least one staff member to attend (in-person). Sponsorship fee: $1,000 includes; recognition as the stage sponsor, inclusion in collateral, marketing, media, social media, and e-blasts, resource table at event, recognition on Pretend City website, listing in event program and 10 complimentary tickets to Pretend City for future use.	• Health/resource fair • Open to the public
3/5-3/7 9 a.m.–1:30 p.m.	**Health Summit hosted by Family Voices of California†** Virtual	Sponsorship fee: $5,000; includes verbal recognition at the summit, logo on summit materials, inclusion on social media marketing, inclusion of 1-item in attendee packets and attendance for 2 representatives.	• Forum • Open to the public
3/16 9–11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members to attend.	• Forum • Open to health and human service providers
3/17 9 a.m.–Noon	**General Assembly Resource Fair hosted by Santa Ana Early Learning Initiative†** Delhi Center 505 E. Central Ave, Santa Ana	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
3/22 12:30–3 p.m.	**Health and Resource Fair hosted by the Wellness Center†** Wellness Center Central 401 S. Tustin St., Orange	At least two staff members to attend (in-person).	• Health/resource fair • Open to the public
3/23 1– 4 p.m.	**Children Physicals and Family Resources hosted by Homeless Intervention Services OC†** Whitten Community Center 900 S. Melrose St., Placentia	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
3/25 10 a.m.–1 p.m.	**Spring Fest hosted by the Santa Ana Collaborative†** El Salvador Center 1825 W. Civic Center Dr., Santa Ana	At least one staff to attend (in-person).	• Health/resource fair • Open to the public

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

* CalOptima Health-hosted
† Exhibitor/Attendee

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CalOptima Health Board Action Agenda Referral

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

Report Item
8. Consider Election of Officers of the CalOptima Health Board of Directors

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

Recommended Actions
Elect one member of the CalOptima Health Board of Directors (Board) to serve as Chair and one to serve as Vice Chair through June 30, 2023, or until such time as a successor(s) is elected, unless he, she, or they shall sooner resign or be removed from office.

Background/Discussion
Pursuant to Article VIII of the CalOptima Health Bylaws, the Board is to elect one Director to serve as Chair and one to serve as Vice Chair. The Chair's role is to serve as the principal officer of the Board, to preside at all meetings of the Board, and to perform other duties as may be prescribed by the Board from time to time. The Vice Chair shall perform the duties of the Chair if the Chair is absent from a meeting or otherwise unable to act.

While the Board typically holds its organizational meeting in June and conducts its annual election of officers at that time, due to the resignation of Supervisor Andrew Do at the February 2, 2023, Board meeting, staff recommends that the Board consider electing officers to serve for the remainder of the current fiscal year, through June 30, 2023.

Fiscal Impact
The recommended action has no fiscal impact.

Rationale for Recommendation
To ensure continuity in CalOptima Health's governance, staff recommends that Board members elect a Chair and Vice Chair to preside over CalOptima Health Board meetings and perform all other duties incident to the offices.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn *02/23/2023*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

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

Report Item

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

Contacts

Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Approve CalOptima Health staff recommendations to administer grant agreements and award payments to selected grant recipients (listed in Attachment 2) for each of the following funding areas, as a result of the notice of funding opportunity as follows:
   a. Infrastructure Projects that will increase housing navigation and organizational capacity to connect individuals to permanent supportive housing:
      i. Total of payments recommended for award: $5,832,314.
   b. Capital Projects to increase the current affordable and permanent housing pool:
      i. Total of payments recommended for award: $21,000,000.
   c. Equity Grants for Programs Serving Underrepresented Populations of people experiencing homelessness:
      i. Total of payments recommended for award: $3,021,311.
2. Approve reallocations to the Capital Projects priority area:
   a. $4,667,686 from Infrastructure Projects; and
   b. $1,978,689 from Equity Grants for Programs Serving Underrepresented Populations.
3. Approve allocation of up to $12.6 million in HHIP funding from the California Department of Health Care Services (DHCS) to the Capital Projects priority area.

Background/Discussion

In September 2022, CalOptima Health's Board of Directors (Board) approved staff's request to reallocate $40.1 million from the Homeless Health Initiative (HHI) reserves to fund the Housing and Homelessness Incentive Program (HHIP) Investment Plan, which was largely informed by community stakeholder input.

With consideration of the broad investment strategies presented to the Board in September and submission of the final investment plan to DHCS, staff received Board approval in December 2022 to proceed with development of a notice of funding opportunity (NOFO) whereby CalOptima Health would solicit proposals to fund $36.5 million worth of projects in Orange County with the goal of mitigating the impact of homelessness. Three funding areas were identified and allocated funding:

Funding Priority Area	Board Approved Allocation (in millions)
Priority 1: Delivery of services and member engagement	$3.6
Priority 2: Infrastructure to coordinate and meet member housing needs	

Funding Priority Area	Board Approved Allocation (in millions)
- Equity Grants for Programs Serving Underrepresented Populations - Infrastructure Projects	$5.0 $10.5
Priority 3: Partnerships and capacity to support referrals for services - **Capital Projects**	$21.0
Total	**$40.1**

The NOFO was released to the public on January 3, 2023, via distribution lists and on the CalOptima Health website. CalOptima Health staff conducted a community forum for all interested community organizations describing the grant application process, funding priority areas, applicant eligibility criteria, and responded to questions ahead of the open-portal application period, which ran from January 23, 2023, to January 31, 2023. In total, CalOptima Health received and reviewed 66 completed proposals from 45 unique organizations. This represents a very robust reach into the community to identify potential projects and partners. An internal committee of evaluators from CalOptima Health reviewed and scored the submitted proposals; 35 of the proposals received recommendations for full or partial funding, representing 32 of the 45 unique applicants.

With Board approval, staff would like to proceed with prompt development and execution of grant agreements with the organizations listed in Attachment 2. As more funding becomes available through HHIP and in an effort to use the remaining funds from this NOFO cycle (approximately $1.9 million for Equity Grants and $4.7 million for Capacity Building Grants were unallocated), staff will bring new recommendations to this Board for review and approval in the future.

Funding Priority Area	Board Approved Allocation	Proposed Award	Remainder
Priority 2: Infrastructure to coordinate and meet member housing needs			
- Equity Grants for Programs Serving Underrepresented Populations	$5.0	$3.0	$2.0
- Infrastructure Projects	$10.5	$5.8	$4.7
Priority 3: Partnerships and capacity to support referrals for services - Capital Projects	$21.0	$21.0	--
Total (in millions)	**$36.5**	**$29.8**	**$6.7**

After review of proposals and award recommendations, approximately $2.0 million within the Equity Grants for Programs Serving Underrepresented Populations priority area and approximately $4.7 million for the Infrastructure Projects priority area remain available. Staff requests that the Board reallocate those available dollars to the Capital Projects priority area. Capital project requests totaled $100M, nearly five times the allocated amount to that priority. By reallocating those funds, CalOptima Health can have a more significant impact on the creation of permanent housing units throughout the county; one of the greatest identified barriers to addressing the homelessness crisis.

Furthermore, to date, CalOptima Health has received a total of approximately $12.6 million in HHIP funding from DHCS. Specifically, approximately $4.2 million in November 2022 related to the Local Homelessness Plan submission, and approximately $8.4 million in January 2023 related to the Investment Plan submission. Staff requests the Board to allocate these funds to the Capital Projects priority area to support the development of additional permanent housing units. In addition to these amounts, staff anticipates DHCS will provide $71.2 million in HHIP funding through the remainder of the program. Staff will bring additional recommendations to the Board for review and approval in the future.

HHIP Funding from DHCS	Amount (in millions)
Funding related to Local Homelessness Plan submission (received November 2022)	$4.2
Funding related to Investment Plan submission (received January 2023)	$8.4
Estimated funding through the remainder of HHIP program*	$71.2
Total	**$83.8**

*Reflects the maximum earnable amount by CalOptima Health; final earned amount may change depending on plan performance on program measures.

Fiscal Impact

The recommended actions to award grants and reallocate funds have no additional fiscal impact. A previous Board action on September 1, 2022, reallocated up to $40.1 million within the HHI reserve to provide investment funding related to the homeless health initiatives included in the HHIP. The recommended action approves approximately $29.9 million of the total $36.5 million Board allocation for HHIP Priority 2: Infrastructure to coordinate and meet member housing needs, and Priority 3: Partnerships and capacity to support referrals for services.

The allocation of funding from DHCS has no net fiscal impact to CalOptima Health's Fiscal Year 2022-23 Operating Budget. The increased amounts attributable to HHIP will be used for HHIP Priority 3 to fund Capital Projects.

Rationale for Recommendation

Funding these programs and projects will aid CalOptima Health in meeting HHIP measures – through which CalOptima Health can receive additional funding that will enable even more investments in the community to address homelessness.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. Organizations Selected for Award and Recommended Amounts
3. Presentation of NOFO Process and Funding Recommendations

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
12/1/2022	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$36.5 million

/s/ Michael Hunn *02/23/2023*
Authorized Signature **Date**

Attachment 1 to the March 2, 2023 Board of Directors Meeting – Agenda Item 9

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Access California Services	300 W Carl Karcher Way	Anaheim	CA	92801
Alianza Translatinx	206 W. Fourth St. Suite 420	Santa Ana	CA	92701
American Family Housing	15161 Jackson Street	Midway City	CA	92655
Asian American Senior Citizens Service Center (AASCSC)	850 N. Birch Street	Santa Ana	CA	92701
City of Anaheim	201 S. Anaheim Blvd, Ste 1003	Anaheim	CA	92805
City of Anaheim/Anaheim Housing Authority	201 S. Anaheim Boulevard, Suite 1003	Anaheim	CA	92805
Colette's Children's Home	7372 Prince Dr. Suite 106	Huntington Beach	CA	92647
Community Action Partnership of Orange County	11870 Monarch Street	Garden Grove	CA	92841
Families Forward	8 Thomas	Irvine	CA	92618
Family Assistance Ministries	1030 Calle Negocio	San Clemente	CA	92673
Family Promise of Orange County	310 W. Broadway Avenue, Suite 205	Anaheim	CA	92805
Friendship Shelter	PO Box 4252	Laguna Beach	CA	92652
Grandma's House of Hope	206 N. State College Blvd.	Anaheim	CA	92806
Homeless Intervention Services of Orange County	907 Bradford Avenue	Placentia	CA	92871
Korean Community Services dba KCS Health Center	451 W Lincoln Ave Ste 100	Anaheim	CA	92805
Latino Center For Prevention And Action In Health And Welfare dba Latino Health Access	450 W. Fourth St. Suite 130	Santa Ana	CA	92701
Leading Purpose	530 Technology Drive Suite 100	Irvine	CA	92618
Lutheran Social Services of Southern California	999 Town and Country Road, Suite 100	Orange	CA	92868
Mercy House Living Centers	PO Box 1905	Santa Ana	CA	92702
Orange County Family Justice Center Foundation	150 W. Vermont Ave. Anaheim, CA 92805	Anaheim	CA	92805

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Name	Address	City	State	Zip Code
Orange County Housing Finance Trust	1 League #62335	Irvine	CA	92602
Orange County United Way	18012 Mitchell South	Irvine	CA	92614
Orange Senior Housing, Inc.	555 S. Shaffer Street	Orange	CA	92866
Orangewood Foundation	1575 East 17th Street	Santa Ana	CA	92705
PATH	340 N Madison Ave	Los Angeles	CA	90004
Pathways of Hope	PO Box 6326	Fullerton	CA	92834
Radiant Health Centers	17982 Sky Park Circle	Irvine	CA	92614
South County Outreach	7 Whatney Suite B	Irvine	CA	92618
Southland Integrated Services	9862 Chapman Ave	Garden Grove	CA	90504
StandUp for Kids	P.O. Box 14398	Irvine	CA	92623
The Eli Home, Inc.	1175 N. East Street	Anaheim	CA	92805
The Salvation Army Orange County	10200 Pioneer Road	Tustin	CA	92782
Thomas House Temporary Shelter, dba Thomas House Family Shelter	12601 Morningside Avenue, Unit 6	Garden Grove	CA	92843
WISEPlace	1411 N Broadway	Santa Ana	CA	92706

ORGANIZATIONS SELECTED FOR AWARD AND RECOMMENDED AMOUNTS

Name	Grant Type	Funding Award
Community Action Partnership of Orange	Capacity Building	$ 79,203.00
City of Anaheim	Capacity Building	$ 200,000.00
Families Forward	Capacity Building	$ 275,128.00
Family Assistance Ministries	Capacity Building	$ 350,000.00
Friendship Shelter	Capacity Building	$ 197,608.00
Grandma's House of Hope	Capacity Building	$ 50,000.00
Latino Center For Prevention And Action In Health And Welfare dba Latino Health Access	Capacity Building	$ 500,000.00
Lutheran Social Services of Southern California	Capacity Building	$ 250,000.00
Orange County United Way	Capacity Building	$ 1,588,215.00
PATH www.epath.org	Capacity Building	$ 883,637.00
Pathways of Hope	Capacity Building	$ 280,000.00
Radiant Health Centers	Capacity Building	$ 474,490.00
Southland Integrated Services	Capacity Building	$ 450,000.00
Thomas House Temporary Shelter, dba Thomas House Family Shelter	Capacity Building	$ 254,033.00
	Capacity total:	**$5,832,314**
American Family Housing	Capital Grants	$ 2,951,660.00
City of Anaheim/Anaheim Housing Authority	Capital Grants	$ 2,000,000.00
Community Action Partnership of Orange	Capital Grants	$ 98,340.00
Friendship Shelter	Capital Grants	$ 3,850,000.00
Korean Community Services dba KCS Health Center	Capital Grants	$ 2,500,000.00
Orange County Housing Finance Trust	Capital Grants	$ 4,000,000.00
Pathways of Hope	Capital Grants	$ 1,500,000.00
The Salvation Army Orange County	Capital Grants	$ 4,100,000.00
	Capital total:	**$21,000,000**
Access California Services	Equity Grants	$ 498,427.00

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Name	Grant Type	Funding Award
Alianza Translatinx	Equity Grants	$ 221,600.00
Asian American Senior Citizens Service Center	Equity Grants	$ 300,000.00
Colette's Children's Home	Equity Grants	$ 350,000.00
Family Promise of Orange County	Equity Grants	$ 300,000.00
Grandma's House of Hope	Equity Grants	$ 80,000.00
Homeless Intervention Services of Orange County	Equity Grants	$ 370,000.00
Orange County Family Justice Center Foundation	Equity Grants	$ 82,860.00
South County Outreach	Equity Grants	$ 130,000.00
StandUp for Kids	Equity Grants	$ 198,024.00
The Eli Home, Inc.	Equity Grants	$ 175,000.00
WISEPlace	Equity Grants	$ 315,400.00
	Equity total:	**$3,021,311**

Housing and Homeless Incentive Program (HHIP): Community Investment Recommendations

March 2, 2023

Board of Directors Meeting

Danielle Cameron
Director, Program Development for CalAIM

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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Within the Context of CalAIM

- One of the central goals of CalAIM is:

  Identify and manage comprehensive needs through
  whole person care approaches and social drivers of health.

- To accomplish this CalOptima Health has committed to offering all 14 community supports.
  - This requires an extensive network of community-based partners to provide those supports to our members across the county.
- Building these local partnerships, particularly contracting with smaller entities, is a process and requires an understanding of and commitment to local capacity building.
- Ultimately, CalOptima Health is integrating more deeply with the continuum of care and safety net providers in Orange County.

Purpose of Investments

- Fulfill initial commitment to Homeless Health Initiative (remainder of $100M board designation).
- Progress on DHCS metrics that will help CalOptima Health and Orange County access additional incentive dollars.
  - Quick impact on connecting members to housing (October measurement period)
- Build out additional partnership to expand network of Enhanced Care Management and Community Supports providers.
- Build local capacity to provide critical services to our members experiencing homelessness.

Solicitation and Review Process

Community Presentations on Priorities

Dec 2022 – Jan 2023

Release Notice of Funding Opportunity

January 3, 2023

Proposals due January 31, 2023

Review Proposals and Recommend-ations February 10, 2023

Present COBAR to CalOptima Health Board March 2, 2023

Project Start Dates April 1, 2023

Scoring Criteria

1. Aligns with CalOptima Health's core values for this NOFO: *Trauma-informed, inclusive, non-residency restricted, low barrier, and aligned with housing-first and harm-reduction principles* – inclusive of the voice of lived experience being considered in the proposed program or project.

2. Objectives are clearly defined, achievable, measurable, and time limited.

3. Outcomes are clear and high impact

4. Evaluation plan is feasible and clearly articulated.

5. Program or projects is sustainable beyond this funding opportunity if funding is awarded or is time-bound and does not require continuous funding.

6. Project is ready for implementation or launch soon after grant award.

7. Expertise in providing proposed services and/or implementation of similar projects in the past.

8. Demonstrate have financial and management capacity to carry out the project (reference attachments).

Scoring Criteria continued

Specific to Equity Grants:	Specific to Capacity Building/Infrastructure Grants:	Specific to Capital Grants:
9. Demonstrate expertise in working with the population of focus. **10.** Clearly articulates how it will address equity issues for the population of focus.	**9.** Demonstrate expertise with providing housing navigation or similar and have some existing capacity. **10.** Clearly articulates how funds will increase the reach or capacity of the organization’s services.	**9.** Demonstrated past experience with permanent and affordable housing. **10.** Number of units added to the County’s affordable housing pool

Proposals Received

Grant Type	Maximum Allocation	Total Funding Requested	Proposals Received
Capacity Building	$10,500,000.00	$28,965,946.00	27
Capital Grants	$21,000,000.00	$100,526,908.00	22
Equity Grants	$5,000,000.00	$10,427,071.00	17
Totals	**$36,500,000.00**	**$139,919,925.00**	**66**

Overall Funding Recommendations

Grant Type	Maximum Allocation	Proposals Received	Award Recommendation	Proposed Award	Remaining/ Unallocated
Capacity Building	$10,500,000.00	27	14	$5,832,314.00	$4,667,686.00
Capital Grants	$21,000,000.00	22	9	$21,000,000.00	$0
Equity Grants	$5,000,000.00	17	12	$3,021,311.00	$1,978,689.00
Totals	**$36,500,000.00**	***66**	**35**	**$29,853,625.00**	**$6,646,375.00**

* 66 proposals from 45 unique applicants

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Equity Grants

Organization Name	Funding Award	Service Provided; Equity Population Specified
Access California Services*	$498,427.00	Expand housing navigation and case management including financial literacy for families, immigrants and refugees
Alianza Translatinx*	$221,600.00	Expand housing navigation and case management for transgender and nonconforming individuals
Asian American Senior Citizens Service Center (AASCSC)*	$300,000.00	Expand general outreach and education in native language, some housing navigation services for older adult population
Colette's Children's Home*	$350,000.00	Expand housing navigation, case management for women and their children including employment and legal assistance
Family Promise of Orange County*	$300,000.00	Expand housing navigation and case management for families with children
Grandma's House of Hope	$80,000.00	Expand housing navigation and community engagement; hiring bi-lingual outreach and intake specialist for older adults and justice-involved

* New CalAIM partners

Equity Grants Continued

Organization Name	Funding Award	Service Provided; Equity Population Specified
Homeless Intervention Services of Orange County*	$370,000.00	Expand housing navigation and case management for families in process of reunification and TAY
Orange County Family Justice Center Foundation*	$82,860.00	Increase capacity of Victim Advocates to help survivors of domestic violence navigate to housing
South County Outreach*	$130,000.00	Expand housing navigation, tenancy sustaining services and case management for families with children
StandUp for Kids*ǂ	$198,024.00	Expand housing navigation and case management for TAY
The Eli Home, Inc.*	$175,000.00	Expand housing navigation and case management for women in recovery and their children
WISEPlace	$315,400.00	Expand several services (housing navigation, case management, as well as legal, financial lit, and employment services) to unaccompanied women

* New CalAIM partners ǂMulti-year project

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Capital Grants

Organization Name	Funding Award	Number of PSH Units Added	Site Status
American Family Housing	$2,951,660.00	111	Site identified
Orange County Housing Finance Trust*	$4,000,000.00	65	County-wide ADU project
Korean Community Services	$2,500,000.00	100	Site identified
City of Anaheim/Anaheim Housing Authority*	$2,000,000.00	87	Site identified
Pathways of Hope	$1,500,000.00	20	Site identified
The Salvation Army Orange County*	$4,100,000.00	70	Ongoing; opening this summer
Friendship Shelter	$3,850,000.00	11	Site identified
Community Action Partnership of Orange County	$98,340.00	5	Renovation

*New CalAIM partners

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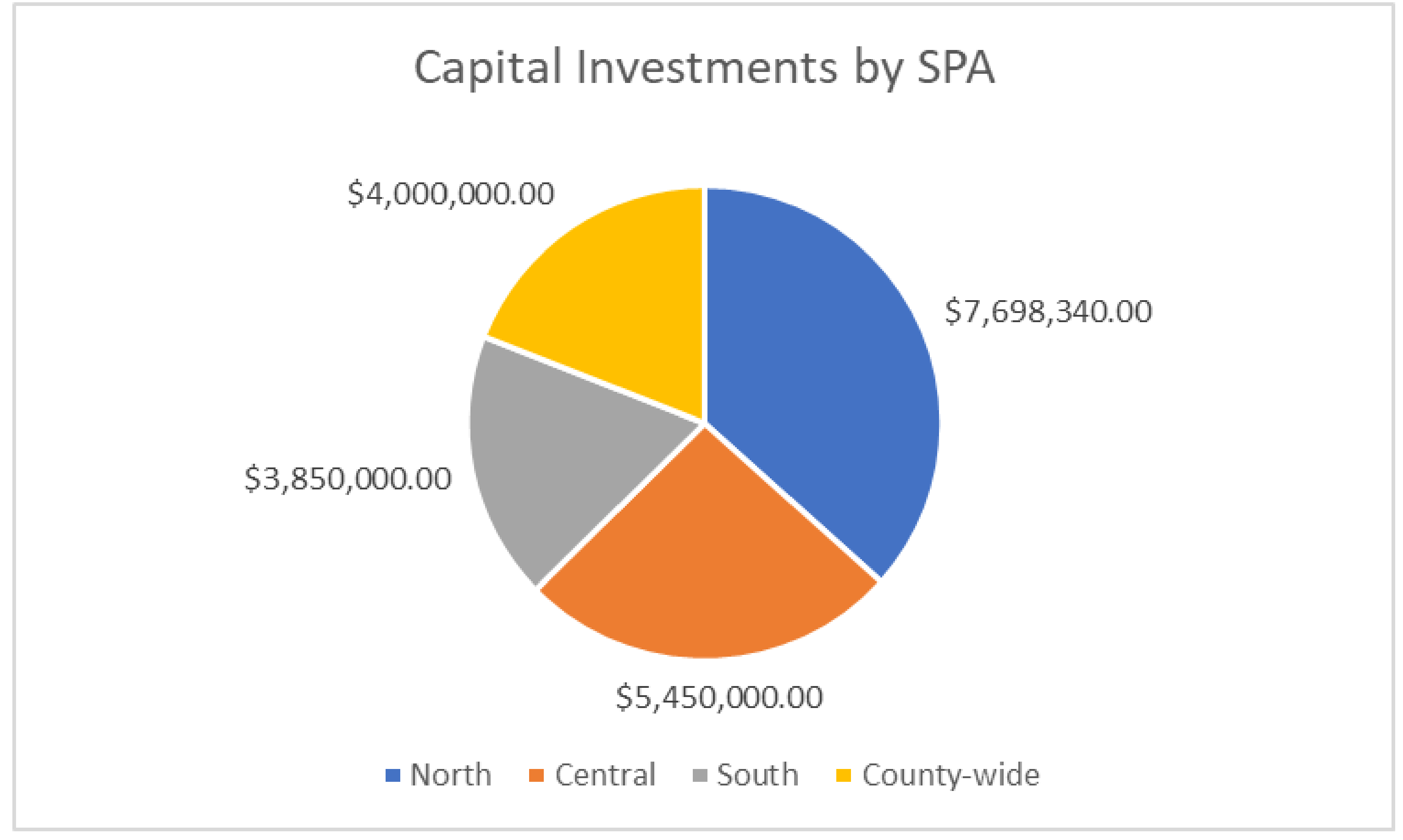
Spread of Capital Investments



Capacity Grants

Organization Name	Funding Award	Service Provided
Latino Center For Prevention And Action In Health And Welfare dba Latino Health Access	$500,000.00	Housing navigation and tenancy sustaining services
Family Assistance Ministries	$350,000.00	Expand housing navigation capacity with staff; establish South County nav center
Lutheran Social Services of Southern California	$250,000.00	Expand housing navigation and case management
Pathways of Hope	$280,000.00	Housing navigation and location services
City of Anaheim*ǂ	$200,000.00	Expansion of housing navigation for justice involved
Orange County United Way*ǂ	$1,588,215.00	County-wide landlord incentive program for all voucher holders
PATH	$883,637.00	ECM, housing navigation and tenancy sustaining services

* New CalAIM Partners ǂMulti-year project

Capacity Grants continued

Organization Name	Funding Award	Service Provided
Radiant Health Centers‡	$474,490.00	Expand housing navigation for HIV, LGBTQIA+ and BIPOC
Southland Integrated Services	$450,000.00	Expand housing navigation and case management
Families Forward*	$275,128.00	Expand housing navigation capacity with staff
Thomas House Temporary Shelter, dba Thomas House Family Shelter	$254,033.00	Expand housing navigation and career development for families w/ children
Friendship Shelter	$197,608.00	General capacity and housing location services
Community Action Partnership of Orange County	$79,203.00	Expand housing navigation capacity with staff
Grandma's House of Hope	$50,000.00	Housing navigation and tenancy sustaining services

* New CalAIM partners ‡Multi-year project

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Common Reasons for Denials

- Applicant’s project did not clearly result in significant impact
- Did not include required documentation in the proposal
- Request was out of balance with organization’s annual budget
- Budget request was heavily focused on rental subsidies; the one unallowable expense
- For capital projects; no potential site had been identified

Lessons and Next Steps

- Ungranted funds will be integrated into the next round of grantmaking (anticipated during Q3 2023)
- Host a series of technical assistance sessions on grant writing prior to that (e.g. theory of change, SMART objectives, general outlining)
- Provide more direction on our application portal and edit some questions
- Now with some funding out the door, establish a more reasonable timeline for applications and processing
- Expand our outreach to organizations not already identified or engaged

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CalOptima Health Board Action Agenda Referral

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

Report Item
10. Authorize Insurance Policy Procurements and Renewals for Policy Year 2023-24

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

Recommended Actions
1. Authorize procurement and renewal of insurance policies for policy year 2023-24 at a premium cost not to exceed $4,500,000; and
2. Delegate authority to the Chief Executive Officer to approve future policy renewals when there are no significant changes to expiring coverage terms and conditions, and no additional coverage types to consider.

Background/Discussion
CalOptima Health's business insurance coverage, except employee group health insurance and benefits, expires on April 7 of each year. Staff recommends renewing the same coverage categories included during policy year (PY) 2022-23. As reference, the following table provides brief descriptions for the proposed insurance policies included for PY 2023-24:

Coverage Type	Description
Property	Provides coverage in the event of property or personal property damage to the 505 building, the 500 building, the PACE center, and the server location not due to an earthquake. Property, general liability, and commercial auto are collectively known as commercial package coverage.
General Liability (GL)	Provides coverage to third parties for bodily injury or property damage.
Commercial Auto	Provides coverage for bodily injury and property damage caused by CalOptima Health's company-owned van, as well as collision and comprehensive coverage for the van itself. Provides excess liability for employees using personal vehicles for company business.
Workers' Compensation (WC)/ Employers Liability (EL)	Provides coverage for medical care and temporary disability benefits to employees for on-the-job injuries or illnesses.
Umbrella	Provides excess limits for general liability and commercial auto coverage over and above the respective policies.
Earthquake	Provides coverage in the event of property or personal property damage to the 505 building, the 500 building, the PACE center, and the server location only due to an earthquake.
Cyber – primary and excess	Provides coverage for claims related to or arising from cyber incidents, such as a data breach (coverage includes, but is not limited to, regulatory fines and penalties, business interruption, credit monitoring, notice requirements, etc.) or network extortion (e.g., ransomware).

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Coverage Type	Description
Directors and Officers (D&O) – primary and excess	Provides coverage for claims that are a result of an act, error, or breach of duty by a CalOptima Health employee or Board member when acting within his/her official capacity.
Employment Practices Liability (EPL) – primary and excess	Provides coverage for claims brought by any past, present, or prospective employee against CalOptima Health or a CalOptima Health employee (acting within the scope of his/her employment) alleging, for example, employment discrimination, harassment, or wrongful termination.
Crime	Provides coverage for claims related to employee theft or forgery of money, securities, or other property, and computer and funds transfer fraud.
Managed Care Errors and Omissions (E&O) – primary and excess	Provides coverage for claims that are a result of an act, error, or omission in the performance of CalOptima Health's managed care activities (e.g., provider contracting, utilization review, implementation of clinical guidelines).
Medical Malpractice (PACE)	Provides coverage for CalOptima Health employed physicians and certain other medical staff (i.e., CalOptima Health employed physician and therapists at the PACE center) in the event of a medical malpractice claim.
Pollution	Provides coverage for bodily injury, remediation expenses, and property damages to third parties and remediation expenses to CalOptima Health in the event of a pollution incident, such as stored paint leaching into the ground water supply.
Wage and Hour – primary and excess	Provides coverage for actual or alleged violations of the Fair Labor Standards Act or any similar federal, state, or local laws governing or related to the payment of wages.
Fiduciary	Provides coverage for actual or alleged mismanagement of CalOptima Health's employee benefit and retirement plans.

The following table provides information on the proposed coverage limits and deductibles for each type of insurance coverage:

Coverage	Limit	Deductible
Property	Building: $92,565,300	$10,000
	Business Personal Property: $29,117,634	$10,000
	Business Interruption & Extra Expense: $33,676.816	24 Hours
GL	GL: $1,000,000/$2,000,000 Employee Benefits Liability: $1,000,000/$2,000,000	$25,000/$1,000
Commercial Auto	Auto Liability: $1,000,000 CSL	$0 Liability $1,000/$1,000 Damage
WC/ EL	WC: Statutory	$0 (Guaranteed Cost)

Coverage	Limit	Deductible
	EL: $1,000,000/$1,000,000/$1,000,000	
Umbrella	$25,000,000	Primary limits for GL, Auto and EL
Earthquake	$130,000,000	Earthquake 5% subject to $100,000 minimum per occurrence
Cyber – primary and excess	$20,000,000	$1,000,000/Underlying limits
D&O/EPL – primary and excess	$20,000,000 (Shared Limit)	$750,000/$1,000,000 Class Action/Underlying limits
Crime	$5,000,000	$100,000
Managed Care E&O – primary and excess	$20,000,000	$1,500,000/Underlying limits
Medical Malpractice (PACE)	$1,000,000/$3,000,000	$5,000
Pollution (3-year Policy Term)	$2,000,000/$4,000,000	$25,000
Wage and Hour – primary and excess	$10,000,000	$1,000,000/Underlying limits
Fiduciary	$5,000,000	$25,000/$1,000,000 Class Action

On February 3, 2023, Woodruff Sawyer, CalOptima Health's insurance broker, provided quotations for existing coverage. Staff has reviewed and evaluated the options. Overall, CalOptima Health's insurance policy renewals for PY 2023-24 are approximately 12.5% (or $485,460) higher than the previous year. Staff recommends the following renewals at a total estimated premium not to exceed $4,500,000.

Coverage	2022-23 Premium	2023-24 Premium	$ Difference from Prior Year	% Difference from Prior Year
Renewal Premiums				
Commercial Package	$89,138	$89,368	$230	0.3%
WC/ EL	$1,165,970	$1,288,855	$122,885	10.5%
Umbrella	$35,067	$35,085	$18	0.1%
Earthquake	$289,660	$337,924	$48,264	16.7%
Cyber – primary and excess	$684,777	$966,000	$281,223	41.1%
D&O/EPL – primary and excess, Crime	$620,023 (D&O/EPL) $29,024 (Crime)	$613,561 (D&O/EPL) $29,024 (Crime)	($6,462) $0	(1.0%)
Managed Care E&O – primary and excess	$555,690	$ 609,491	$53,801	9.7%
Medical Malpractice (PACE)	$46,773	$ 44,064	($2,709)	(5.8%)
Pollution (3-year Policy Term)	$5,295	$5,878	$583	11.0%

Coverage	2022-23 Premium	2023-24 Premium	$ Difference from Prior Year	% Difference from Prior Year
Wage and Hour – primary and excess	$310,838	$295,800	($15,038)	(4.8%)
Fiduciary	$53,846	$56,510	$2,664	5.0%
Total: Renewal Premiums	**$3,886,100**	**$4,371,560**	**$485,460**	**12.5%**

Due to CalOptima Health's use of an insurance broker and the inherent competitive quotation process, negotiations may often continue up to the day before a policy expires. As of February 10, 2023, the following policy terms and premiums are still being discussed with the carriers: Cyber – primary and excess, D&O/EPL – primary and excess, Managed Care E&O – primary and excess, and Fiduciary.

Explanation of significant (i.e., at least 15.0%) cost increases:

- **Earthquake:** CalOptima Health's premium increased by 16.7% or $48,264 from the previous year. CalOptima Health continues to experience increased property values, which equate to higher premiums to insure against catastrophic events like earthquakes. Also, there is a lower threshold for risk by carriers in the market in general, particularly as carriers try to recover from losses sustained globally.

- **Cyber – primary and excess**: CalOptima Health's total Cyber premium is expected to increase by 41.1% or $281,223 from the previous year, with the deductible remaining at $1,000,000, the lowest deductible that carriers are quoting for a company CalOptima Health's size. In general, ransomware and regulatory changes continue to drive increases in the frequency and severity of claims for carriers, resulting in increased premiums, tightening terms, and very cautious underwriting, especially for healthcare-related companies.

CalOptima Health recommends the Board delegate authority to the Chief Executive Officer to approve future policy renewals when there are no significant changes to expiring coverage terms and conditions and no additional coverage types to consider. Renewal premiums and terms and conditions will be reported to the Board or the Finance and Audit Committee after policy binding, and subsequent PYs will be budgeted accordingly. However, if any changes to the existing coverage terms and conditions are recommended during the renewal process, or additional coverage is recommended, CalOptima Health will return to the Board for approval prior to policy binding.

Fiscal Impact

The recommended action to procure and renew insurance policies for PY 2023-24 for the period of April 7, 2023, through June 30, 2023, is a budgeted item under the Fiscal Year (FY) 2022-23 Operating Budget. Management plans to include funding for the remaining policy period of July 1, 2023, through April 6, 2024, and projected expenditures through fiscal year end in the CalOptima Health FY 2023-24 Operating Budget.

Rationale for Recommendation

The continued procurement of business insurance, without a lapse in coverage, ensures that CalOptima Health's risk and exposure to claims is mitigated as much as possible.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Impacted by this Recommended Board Action

/s/ Michael Hunn *02/23/2023*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Woodruff-Sawyer & Co.	50 California Street, Floor 12	San Francisco	CA	94111
CNA	151 North Franklin St	Chicago	IL	60606
QBE	55 Water Street	New York	NY	10041
AWAC	199 Water St, 25th Floor	New York	NY	10038
XL	70 Seaview Avenue	Stamford	CT	06902
TDCSU	29 Mill Street	Unionville	CT	06085
Ironshore	28 Liberty St, 5th Floor	New York	NY	10005
Argo Re	110 Pitts Bay Rd	Pembroke HM 08	Bermuda	HM 08
Hanover Insurance Group	440 Lincoln Street	Worchester	MA	01653
Resilience	55 2nd Street, Ste 1950	San Francisco	CA	94105
Beazley US /Lloyds	30 Batterson Park Rd	Farmington	CT	06032

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CalOptima Health Board Action Agenda Referral

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

Report Item
11. Authorize Implementation of a Contract with Varis LLC and Amendment to the Contract with Cotiviti, Inc.

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Actions
Authorize the Chief Executive Officer to:

1. Offer a contract to Varis LLC (Varis) at a flat per case pricing for claims overpayment forensic review for an initial term of three years, starting September 25, 2023, through September 24, 2026, with two one-year extension options, exercisable at CalOptima Health's sole discretion. Should this offer be declined by Varis, a contract with the secondary selected vendor, Cotiviti, will be proposed for the same period.
2. Effective upon Board approval, amend the contract with Cotiviti, Inc. (Cotiviti) for claims editing services to transition from a contingency fee contract to a per member per month (PMPM) service fee contract and move to the Payment Policy Management (PPM) claims editing software expected to be implemented in September 2023.

Background
Varis, a diagnosis related groupings (DRG) claims audit review vendor, provides identification and post-payment recovery services of potential overpayment of services that utilize DRG for inpatient Medicare, Medi-Cal and outpatient or ambulatory payment classification (APC) guidelines to determine the claims payment amount. To summarize the review process, Varis conducts the data and clinical analysis based on CalOptima Health's paid claims files and review of medical records, as needed, and identifies the dollar recovery amounts based on their audit findings.

CalOptima Health's contract with Varis became effective on September 25, 2017. On October 7, 2021, the Board authorized a one-year extension through September 24, 2023. The extension allowed sufficient time for CalOptima Health to invite qualified bidders that provide DRG forensic claims review services to submit proposals through the request for proposal (RFP) process.

On March 22, 2022, CalOptima Health issued a comprehensive RFP with a scope of work to include current known requirements and plan for a system with flexibility to enhance features and functionality based on regulatory and DRG coding requirements. Based on the RFP demonstrations and evaluation scores, CalOptima Health selected Varis. As part of the flat fee proposal, Varis is agreeable to conduct a bi-annual lookback review of savings performance to determine if the proposed rates require adjustment.

Cotiviti supports CalOptima Health's claims editing service solution and clinical coding validation. CalOptima Health utilizes this solution as the primary source for prepayment claims editing that identifies claims that are incorrectly coded and for which payment should be reduced, based on

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American Medical Association, National Correct Coding Initiatives (NCCI), Centers for Medicare & Medicaid Services (CMS) Benefits Manual, CMS National Physician Fee Schedule, the Federal Register, and Current Procedural Terminology code sets.

CalOptima Health's contract with Cotiviti became effective on October 8, 2018. On September 1, 2022, the Board authorized a two-year extension, with the option of two additional one-year extensions through October 7, 2027, each exercisable at CalOptima Health's sole discretion.

Staff is requesting the Board's approval to amend the contract with Cotiviti to implement a system software upgrade. This system upgrade is estimated to increase claims edits results by including additional editing features. The current system is sunsetting, and this migration is necessary to continue with Cotiviti. Additionally, staff is requesting approval of transition from a contingency service fee of 19.5% based on savings collected to a fixed fee structure as shown below.

Payment Policy Management (PPM) Service Fees	
Per Member Per Month (at execution of Scope of Work (SOW))	$0.27
Per Member Per Month (at PPM editing software Go Live Date)	$0.295

Discussion

With a new contract, the Varis pricing model will transition from a contingency service fee to a flat pricing as follows:

Service	Current Contingency Fee	New Flat Fee
Post-payment DRG forensics identification of overpaid claims	25% from recovered dollars	$225 per case reviewed
Post-payment Outpatient/APC forensic identification overpaid claims	26% from recovered dollars	$75 per case reviewed
Pre-payment DRG forensic identification of overpaid claims processing	26% from recovered dollars	$250 per case reviewed
Pre-payment Outpatient/APC forensic identification of overpaid claims processing	26% from recovered dollars	$85 per case reviewed
Non-pursuit fee for recovery of audit findings	$350	N/A

CalOptima Health's RFP stakeholders from all impacted departments reviewed the submitted vendor bids. Consistent with CalOptima Health's procurement process, review of bids, vendor demonstrations, interviews, and scoring were conducted to select a vendor. CalOptima Health received five bids from vendors on the RFP, and one elected to withdraw its proposal. The approved scoring criteria used was based on seven categories and used a weighted average as shown below:

Category	Weighted Average
Presentation overall covered the necessary topics and effectively communicated the strengths of the vendor.	10%

Category	Weighted Average
Process: Vendor has robust forensic, DRG claims, and chart review for pre- or post-inpatient and outpatient claims payment processes.	20%
Process: Vendor description of end-to-end process flow on their ability to handle any level of appeals were strong.	20%
Process: Vendor has a post-case support program, including reporting capabilities and service level guarantees.	20%
Vendor has strong California hospital relationships and excellent notification and communication processes.	10%
Medicare and Medi-Cal managed care experience.	15%
Overall ability to address CalOptima Health's requirements.	5%

Varis is recommended as a vendor to provide a comprehensive claims overpayment review process based on the RFP process. If CalOptima Health cannot reach agreeable contract terms with Varis, staff requests that the CalOptima Health Board authorize a similar contract with the secondary selected vendor, Cotiviti. If neither of these contracting efforts are successful, staff will return to the Board with further updates and recommendations.

Separately, CalOptima Health's current claims editing contract with Cotiviti is based on a contingency service fee of 19.5%. This contingency fee is based on the claims coding validation edits. CalOptima Health is seeking approval to amend the contract's pricing model to a PMPM service fee. Cotiviti will calculate its fees and invoice based on the monthly member count reported by CalOptima Health.

Cotiviti and CalOptima Health will track savings generated by Cotiviti's PPM services throughout each annual period from the execution of the SOW to the anniversary of the execution of the SOW (the "annual measurement period"). Savings for the purposes of the annual measurement period means the difference between what CalOptima Health would have paid on a given claim line before the PPM services and what CalOptima Health actually paid on such claim line after the PPM services were implemented. Base savings per annual measurement period is estimated at $18 million dollars. If savings materially change (by +/- 15%) during each annual measurement period, the PMPM rate will be adjusted in accordance with the contract. All other terms, conditions, and provisions of the Contract with Cotiviti and prior amendments shall continue in full force and effect.

Fiscal Impact

Varis: Staff anticipates that the change in payment methodology will be budget neutral assuming reviewed case volume, findings, and recovery amounts remain comparable to historical experience. Management will include expenses for the period effective September 25, 2023, through any approved contract extension periods in future CalOptima Health operating budgets.

Cotiviti: The annual fiscal impact related to migrating from a contingency fee contract to a PMPM fee is budget neutral. The annual fiscal impact related to implementing the PPM claims editing software is $240,000. Management will include updated expenses for the period effective July 1, 2023, through any approved contract extension periods in future CalOptima Health operating budgets.

Rationale for Recommendation

CalOptima Health recommends selecting and contracting with Varis to provide claims overpayments review services on a flat rate fee. Approval to implement this contract will ensure there is no disruption to the services provided by this solution and the continuation of appropriate claims payment to providers. Staff also recommends that the Board approve an amendment to the Cotiviti contract that shifts payment to Cotiviti from a contingency payment to a flat rate fee. Transitioning from a contingency based payment to a flat rate service fee will reduce any perceived bias related to service payment influencing the claims review and editing findings.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Solicitation 22-010 VARIS B Price Proposal CONFIDENTIAL Best and Final Offer 8-26-22
2. 19-10311 Verscend Agreement
3. 19-10311 Verscend Agreement No. 1 Executed
4. 19-10311 Cotiviti Amendment No. 2 Extension
5. 19-10311 Amendment No. 3 Cotiviti Extension
6. Board Action dated September 1, 2022: Authorize Contract Amendment Related to CalOptima Health Key Operational System Vendor for Claims Editing and Clinical Coding Validation
7. Contracted Entities Covered by this Recommended Board Action
8. Contract 19-10311 Cotiviti Amendment - No. 4

Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
September 1, 2022	Approved	Two-year contract extension for Cotiviti	N/A

/s/ Michael Hunn   *02/23/2023*
Authorized Signature   **Date**

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CalOptima
DRG Forensic Claims Review Services Proposal #22-010

B. Price Proposal: Services shall be provided to CalOptima based on the following pricing table:

Service	Basis	Fee %		Fee $
1. Post-payment DRG forensic identificationof overpaid claims	Overpayments collected byCalOptima	20%	or	$225 per case reviewed
2. Post-payment Outpatient/APC forensic identificationof overpaid claims	Overpayments collected byCalOptima	21%	or	$75 per case reviewed
3. Post pay Clinical Validation DRG	Overpayments collected byCalOptima	22%	or	$275 per case reviewed
4. Non-collection of identified overpaidclaims. If after 365 days from date of 60-day notification refund request letter sent by CalOptima – no receipt of refund	Overpaid claims identified by VARIS that CalOptima decides not to collect for whatever reason.	$350 per claim		
5. Ad Hoc reports, non-proprietary	Per hour with a minimum	$150 hour with a $150 minimum		
6. Pre-payment DRG forensic identificationof overpaid claims processing	Identification of a proposed overpayment prior to the completion of CalOptima's payment cycle	22%	or	$250 per case reviewed
7. Pre-payment Outpatient/APC forensic identificationof overpaid claims processing	Identification of a proposed overpayment prior to the completion of CalOptima's payment cycle	23%	or	$85 per case reviewed
8. Pre-Payment Clinical Validation DRG forensic identification of overpaid claims	Identification of a proposed overpayment prior to the completion of CalOptima's payment cycle	23%	or	$300 per case reviewed
9. VARIS will reimburse hospitals forcopying and postage.	First Class postage and the number of pages submitted in response to VARIS specific medical record sectionrequested.	Not to exceed $00.12 per pageand first class postage if applicable up to a maximum of $15. Any copycharges in excess will be reimbursed by CalOptima		

Intended only for representatives of CalOptima.

CalOptima will be responsible for collecting overpayments identified by VARIS and that CalOptima has a duty of good faith and fair dealing to make reasonable efforts to collect overpayments identified by VARIS.

Per case reviewed will be invoiced and paid net 30 from date of invoice.

VARIS does not guarantee any set amount of overpayments being identified.

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CONTRACT NO. 19-10311
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, dba ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba CALOPTIMA and VERSCEND TECHNOLOGIES, INC.
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into the date last signed below, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and VERSCEND TECHNOLOGIES, INC., a Delaware corporation, 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 CONTRACTOR to provide Clinical Editing Solution and 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) CONTRACTOR's proposal dated March 1, 2018, and (iii) CalOptima's Request for Proposal ("RFP") 18-003, if applicable, inclusive of any revisions, amendments and addenda. 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 March 1, 2018.

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 without a replacement meeting the requirements of the Contract being in place 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 $1,200,000 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

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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 is to be covered as an additional insured 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 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.

3.2.7 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.

3.2.8 Thirty (30) days prior written notice without a replacement meeting the requirements of the Contract being in place 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 the Indemnified Parties from and against any third-party 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 any third-party claim and 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.

"Indemnified Parties" refers to (i) CalOptima, (ii) it's officers and directors, and (iii) any of the following of CalOptima who work with or are involved in the services CONTRACTOR provides under Exhibit A: agents, consultants, and employees.

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 insurance limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation. 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.). The parties agree that the limitation of liability in section 4.7 survives as long as any indemnification obligation.

4.5 It is not the intent of the Parties that the provisions of this Section and the Indemnification provision(s) set forth in the Business Associate Protected Health Information Disclosure Agreement executed by the Parties shall be in conflict. In the event of any conflict, the Indemnification provision(s) in the Business Associate Protected Health Information Disclosure Agreement shall be interpreted to relate only to matters within the scope of that Agreement.

4.6 The terms of this Section shall survive the termination of this Contract.

4.7 Limitation of liability

4.7.1 Even if advised of the possibility of Losses, Verscend is not liable for any indirect damages, including any lost profits, data, business, goodwill, anticipated savings, opportunity or use or other incidental or consequential damages, which Client or any third party may suffer as a result of or in connection with this Agreement. Verscend will not be liable for any Losses due to impairments to a deliverable caused by acts of Client's representatives, subcontractors, or suppliers.

4.7.2 Even if Verscend is advised of the possibility of Losses, Verscend will not be liable for any Loss due to: (a) misuse of any data or deliverable by Client; (b) any error or omission in data results or information provided by the deliverable and not caused by Verscend; (c) any inability to use the deliverable; (d) any error or omission in data provided to Verscend; and/or (e) any failure, delay, corruption, error, inaccuracy, discrepancy, incompletion or omission in or made through the deliverable and not caused by Verscend.

4.7.3 Notwithstanding anything to the contrary, or any failure of essential purpose of any limited remedy or invalidity of this Section 4.7, regardless of the form of action, whether incurred with respect to one claim, or cumulatively incurred from multiple related or unrelated claims, Verscend's aggregate liability, if any, to Client or to any third party for claimed Loss arising under this Contract during any specific period will not exceed the lesser of five million dollars ($5,000,000) and three times the amount of fees paid by Client to Verscend for the corresponding deliverable in the twelve months prior to the date the Claim arose; provided, however, (1) the limitation in this section 4.7.3 will not apply for claimed Loss arising under this Contract in a Claim for gross negligence or willful misconduct and (2) the limitation in this section 4.7.3 is not intended to modify the limitation of liability in the BAA with respect to breaches of the BAA only. In the event that a Claim that is subject to this section 4.7.3 arises before the first twelve months of the Contract are complete, the calculation of fees paid will be made by annualizing fees paid since the Effective Date.

4.7.4 Should any Deliverables become the subject of an infringement claim of the kind described in this section, CONTRACTOR shall, at its option and expense, (a) procure for CalOptima the right to make continued use thereof, (b) replace or modify the Deliverable so that it becomes non-infringing, or (c) if such remedies are not reasonably available, request the return of the infringing Deliverable and grant CalOptima a pro-rated credit for the infringing Deliverable. CONTRACTOR shall have no liability if the alleged infringement is based on (1) combination with Third Party products if the alleged infringement relates solely to such combination, (2) modifications by parties other than CONTRACTOR (or persons or entities employed or contracted by CONTRACTOR) if the alleged infringement solely relates directly to such modification, unless such modification was approved by CONTRACTOR, (3) use for a purpose or in a manner for which the Deliverable was not designed, or (4) use of any older version of the Deliverable when use of a newer version that have been made available to CalOptima would have avoided the infringement.

4.7.5 Client hereby expressly acknowledges and agrees that in view of the amount of the fees paid or to be paid hereunder, the limitations of liability in this Section 4.7 and the

indemnities given in Section 4.1 are in all respects fair and reasonable and reflect a duly considered allocation of risk between the Parties. "Claims" shall mean all claims, requests, accusations, allegations, assertions, complaints, petitions, demands, suits, actions, proceedings, and causes of action of every kind and description.

4.7.6 "Losses" refers to any and all liabilities, costs, damages, payments, judgments, settlements, fines, penalties, and expenses (including, without limitation, reasonable attorneys' fees, disbursements and administrative or court costs) imposed pursuant to a final, unappealable judgment or settlement, as well as interest penalties (as described in Exhibit B, section E).

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 to one or more Verscend employee (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, the following is considered to be an assignment and will be addressed as described in this section 6.2: (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. CONTRACTOR shall provide CalOptima prior written notice promptly upon the public announcement of any deal giving rise to any of the events described here. If, following any of the events described in this section 6.2, CalOptima reasonably determines that CONTRACTOR can no longer meet its obligations required by CMS/DHCS regulations with respect to OIG, SAM, or other exclusion list checks required to do business with CalOptima, then CalOptima may terminate this Contract immediately without any additional cause.

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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 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 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.

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

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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

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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.

"Deliverable" means the provision of an Internet- or other data network-available application or consulting, programming, professional or other service by CONTRACTOR to CalOptima, per CalOptima's requirements as defined and agreed to per Exhibit A. Deliverable also means the right of use of any applications by CONTRACTOR to CalOptima, as defined and agreed to in Exhibit A.

CONTRACTOR expressly warrants that all Deliverables will (1) conform to applicable agreed upon specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications; (2) be performed using sound, professional practices and in a competent and professional manner by knowledgeable, trained and qualified personnel; and (3) will be of good workmanship and material. Further, CONTRACTOR expressly warrants that its Edits (as defined in Exhibit A) conform to applicable agreed upon specifications and documentation. CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects of the Deliverables, 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. Contractor does not warrant or guaranty that deliverables will be error free, or that any access to such deliverables will always be uninterrupted. CalOptima's sole and exclusive remedy for breach by Contractor of the foregoing warranty will be for: (i) Contractor to re-perform the nonconforming whole or part of the Deliverable; and (ii) if within thirty (30) business days of receiving notice from CalOptima Contractor fails to provide a specific conforming deliverable, Contractor will provide to CalOptima a proportional refund of the fees (as set forth in Statements of Work) paid by CalOptima for the nonconforming portion of the deliverable. Except as otherwise expressly provided in this section 13, or the applicable statement of work ("Contractor Warranty") Contractor makes no express or implied warranties of any kind, including, but not limited to, warranties of merchantability, fitness for a particular purpose, title, non-infringement, or warranties alleged to arise as a result of custom and usage; all deliverables are advisory and provided on an "as is" basis.

13.3 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. The disclaimer in section 13.3 is hereby agreed to.

13.4 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 The payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority, and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR agrees to abide by the terms of the CalOptima Travel Policy, attached hereto as Exhibit C, and incorporated herein by this reference.

15. Term. This Contract shall commence on October 8, 2018, (the "Effective Date") and shall continue in full force and effect for thirty-six months ("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 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.

The parties agree that, on the Effective Date of this Contract, the Amended and Restated Contract No. MC 03258 dated October 1, 2008, between the parties (the "2008 Contract") will be terminated.

16. Termination.

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16.1 Termination without Cause. CalOptima may terminate this Contract at any time after the first twelve (12) months of the Initial Term, in whole or in part, for its convenience and without cause, by giving CONTRACTOR sixty (60) days' prior 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 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 as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract ("Default") and does not cure such breach or violation within thirty (30) days after written notice by CalOptima that specifies the Default, including but not limited to the section(s) of the Contract at issue and the actions or inactions of CONTRACTOR that caused the Default, and provides reasonable and clearly defined standards for cure. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable direct and actual costs incurred by CalOptima as a result of such default, including, but not limited to, re-procurement costs of the same or similar services defaulted by CONTRACTOR under this Contract, but not including opportunity loss or lost savings or profits; provided, however, CONTRACTOR's total liability under this section 16.3 may not exceed three month's contingency fees. In the event that CalOptima makes any Claim against CONTRACTOR arising out of this Contract following a termination according to this section 16.3, any costs paid by CONTRACTOR under this section 16.3 will be counted toward any Loss arising out of any such Claim.

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:

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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.

17.1 CalOptima reserves the right to modify the Contract at any time should such modification be required by CMS or applicable law or regulation and CONTRACTOR agrees to execute the modification if both Parties reasonably agree that the proposed amendment accurately reflects the applicable law or regulation.

17.2 Modifications to this Contract that are desired by CalOptima but not required by CMS or applicable law or regulation will be freely negotiated by the parties.

17.3 All 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

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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 and was not subject to confidentiality obligations on that other party at the time it became known to the party; (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 reports, 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. CalOptima hereby grants CONTRACTOR a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce such reports. Copies may be made

for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such reports shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these reports includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all reports 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 owns and retains all right, title, and interest in and to, including without limitation all Intellectual Property rights, in all software programs (whether or not installed on a CalOptima-owned system), methodology, techniques, the identity of edits and materials, enhancements, derivatives, and modifications to all CONTRACTOR owned Intellectual Property, including without limitation all source code, object code, and documentation associated therewith, and all documentation, report formats, methodologies, algorithms, templates, logic flow, formulae, inventions, methods, systems, processes, works of authorship, and materials which have been or are in the future created, conceived, developed or acquired by CONTRACTOR and which are included in or used in providing the Deliverables, including without limitation all modifications, improvements, derivative works and compilations thereof and thereto (all the foregoing, collectively, "CONTRACTOR IP"). As between the Parties, unless otherwise expressly specified in a Statement of Work, CONTRACTOR will be the owner of all right, title and interest, including all Intellectual Property rights, in and to any code required to provide Deliverables. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the reports, 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 and for the limited purpose of fully utilizing the reports.

CalOptima agrees that all CONTRACTOR IP constitutes the Confidential Information of CONTRACTOR, and CalOptima shall not use or disclose such CONTRACTOR Confidential Information except as permitted herein. CalOptima further agrees that it will not use or disclose such CONTRACTOR IP except solely as necessary to receive the Deliverables described in this Agreement. Without limiting the foregoing, CalOptima shall not, and shall cause its employees or authorized users not to: 1) reverse engineer, decompile, reverse compile, or disassemble the CONTRACTOR IP; 2) create a derivative work or compilation of the CONTRACTOR IP, including without limitation any product or service derived or compiled from or based on, in whole or in part, any Deliverables. CalOptima may not copy, distribute, market, sell, lease, sublicense or otherwise transfer the Deliverables to third parties. Notwithstanding the above, in no way shall CalOptima be prevented from implementing changes to its systems, processes, or contracts that are done in the ordinary course of business or were otherwise arrived at independent of and without reliance on or benefit of the results of the Deliverables provided herein.

20.3 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property in the information, documents, and other materials provided to CONTRACTOR, including but not limited to Application Data, ("CalOptima IP") 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.

20.4 For purposes of this Section, the following definitions apply:

"Intellectual Property" means all inventions, patents, copyrights, trade secrets, trade names, trademarks, know-how, software, shop rights, moral rights, licenses, developments, research data, designs, processes, formulas, and other tangible or intangible proprietary or property rights, whether or not patentable (or otherwise subject to legally enforceable restrictions or protections against unauthorized third-party usage), and any and all applications for, and extensions, divisions,

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derivations, compilations, and reissuances of, any of the foregoing, and rights therein, and whether arising by statute or common law, which are brought to bear to generate a Deliverable or are inherent in the Deliverable itself.

"Application Data" includes but is not limited to individuals' personal, medical, pharmacy, disability, provider or insurance claim information provided by CalOptima or CalOptima's business partners, including without limitation, third party administrators, pharmacy benefit companies and utilization management companies, to CONTRACTOR to create an Application Service, pursuant to the Applications Agreement. Application Data includes, but is not necessarily limited to, claims and membership information for CalOptima insurance plan members.

"Application Service" means any Deliverable whereby users gain access, via an interface provided by CONTRACTOR, to information compiled by CONTRACTOR, in any Internet-available or private data network.

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. 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 and CONTRACTOR agrees to execute the modification if both Parties reasonably agree that the proposed amendment accurately reflects the applicable law or regulation.

Modifications to the Business Associate Protected Health Information Disclosure Agreement that are desired by CalOptima but not required by CMS or applicable law or regulation will be freely negotiated by the parties.

All modifications to the Business Associate Protected Health Information Disclosure Agreement shall be executed only by a written amendment, signed by CalOptima and CONTRACTOR.

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

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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. Offshore Performance.

25.1 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.

25.2 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.

25.3 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

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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.

25.4 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.

25.5 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.

25.6 The provisions of this Section apply to work performed by subcontractors at all tiers.

26. FDR Compliance. Upon execution of this Contract, CONTRACTOR agrees to execute and abide by the terms of the "FDR Compliance Attestation," which is attached hereto as Exhibit F and incorporated herein by this reference, and shall submit an executed FDR Compliance Attestation no less than annually thereafter.

27. 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.

28. Time is of the Essence. Time is of the essence in performance of this Contract.

29. 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.

30. 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.

31. 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.

32. 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.

33. 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.

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To CONTRACTOR:	To CalOptima:
Verscend Technologies, Inc.	CalOptima
201 Jones Road	505 City Parkway West
Waltham, MA 02451	Orange, CA 92868
Attention: Legal Department	Attention: Kim Marquez

34. Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall promptly notify and submit all relevant, reasonable information to CalOptima.

35. Unavoidable Delays.

35.1 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.

35.2 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.

35.3 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.

36. 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.

37. 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 arbitration, action or proceeding.

38. 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

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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.

39. Headings. The section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

40. 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.

41. 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.

42. 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.

43. Debarment and Suspension Certification.

43.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

43.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

43.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

43.2.2 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;

43.2.3 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 43.2.2 herein;

43.2.4 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;

43.2.5 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

43.2.6 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.

43.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

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

43.5 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.

44. Lobbying Restrictions and Disclosure Certification.

44.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

44.2 Certification and Disclosure Requirements.

44.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or sub grant, 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 44.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

44.2.2 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 44.3 of this provision if paid for with appropriated funds.

44.2.3 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 44.2.2herein. An event that materially affects the accuracy of the information reported includes:

44.2.3.1 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;

44.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

44.2.3.3 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.

44.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 44.2.1of this provision a contract, subcontract, grant or sub grant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

44.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 44.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

44.3 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.

45. 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.

46. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Limitation of Liability, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

47. 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.

48. 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.

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49. 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.

50. 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.

51. 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. 19-10311 on the day and year last shown below.

Verscend Technologies, Inc.	CalOptima
By: DocuSigned by: [signature] 7E43D55B04BB4E8	By: [signature]
Print Name: David Mason	Print Name: Greg Hamblin
Title: COO	Title: CFO & Treasurer
Date: 9/28/2018	Date: 9-28-18

By: DocuSigned by: Felix Morgan 47FF52BAADE34B7	By: [signature]
Print Name: Felix Morgan	Print Name: Michael Schrader
Title: CFO	Title: CEO
Date: 9/28/2018	Date: 10-01-18

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required

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Exhibit A, "Scope of Work"

CONTRACTOR shall provide to CalOptima Claim Accuracy services. These services are for CalOptima's Medi-Cal, OneCare Connect, and OneCare Medicare Advantage Special Needs Plan programs only. CalOptima will submit Claims to CONTRACTOR to edit each claim as further described in Schedule 1. CalOptima is ultimately responsible for final utilization review and maintains sole and complete authority to adjudicate claims.

CalOptima does not guarantee any volume of claims will be submitted to CONTRACTOR for review, however, CalOptima will submit, according the format and timing agreed to, Medi-Cal, OneCare Connect and OneCare claims to CONTRACTOR for processing as described herein.

1. **Solution.** The following Schedules marked with an "x" are hereby incorporated into this SOW:

   ☒ Schedule 1: Claim Accuracy

   ☒ Claims Editing: ☒ Batch | ☐ Real Time

   ☒ Clinical Validation: ☒ Batch | ☐ Real Time

   ☒ Schedule 2: Service Level Agreements

   ☒ Schedule 3: Claim Accuracy Edits Artifact

   ☒ Schedule 4: Claim Accuracy Reports

2. **Implementation**

   A. **Platform Upgrade.** The parties acknowledge and agree that they intend to upgrade CalOptima from CONTRACTOR's platform currently in production for CalOptima to the then current version of CONTRACTOR's platform.

   B. **Team.** CONTRACTOR and CalOptima will each assign a designated project manager and implementation team with appropriate business and technical expertise, and decision-making authority to fulfill their obligations in the Project Plan.

   C. **Project Plan.** The parties will develop a project plan, which will include deliverables and anticipated timelines, and that the parties will use the project plan to guide the implementation process (the "**Project Plan**"). The following table outlines the implementation phases and high-level tasks associated with each phase that are typically included in the Project Plan:

Project Plan Outline	
Phase	Key Tasks
Phase I – Planning	Joint Kick-off Meeting Product Demonstration, if applicable Solution Deep-Dive Joint Requirements definition via Workshops General Testing Discussions Joint Project Plan
Phase II – Build and Test	Project requirements finalized Environment Set-Up & Connectivity Established Development & System Configuration (including review and Configuration of Edits to CalOptima requirements

	Data Exchange & Validation User Training for Test Execution Test Plan Development & Execution using historical CalOptima data Go or No-Go Decision
Phase III – Deploy	Finalize Operational & Support models User Training Migrate to production Go-Live
Phase IV – Operate	Verscend Client account team will provide ongoing technical and business support Verscend will provide program performance metrics & Monthly/Quarterly Release Notes

D. **Go-Live.** The "**Go-Live Date**" refers to the date that CalOptima first submits Prepayment Claim Data to CONTRACTOR for production.

E. **Implementation Training.** During implementation, CONTRACTOR shall provide CalOptima up to 32 hours of training, as requested by CalOptima and subject to CONTRACTOR availability.

F. **Implementation Documentation.** During implementation, CONTRACTOR shall provide CalOptima with the following project artifacts:

(1) **Project Plan.** A document providing a work breakdown structure of all milestones and tasks, which CalOptima will have access to review or download at any time.

(2) **Technical Integration Plan.** A documented plan to address new integration requirements stemming from a review of the existing CalOptima configuration and environment.

(3) **Clinical Configuration Document.** A document outlining CalOptima-specific Edit Configurations and Edit decisions made by CalOptima based on CalOptima policies.

(4) **Joint Testing Plan.** A system and user acceptance testing (UAT) plan that includes CalOptima signoff as final step.

3. **Support Services**

A. **Help Desk and Portal.** CONTRACTOR shall make available to CalOptima help desk support during Business Hours, as well as a CalOptima portal containing additional product documentation and a means of communication with CONTRACTOR.

B. **Training.** Following implementation, CONTRACTOR shall provide CalOptima up to eight hours of training annually, as requested by CalOptima and subject to CONTRACTOR availability. CONTRACTOR shall provide training for any upgrades or new features as needed to CalOptima. Additional training may be requested through a Work Order.

C. **Standard Support.** CONTRACTOR's standard application support includes the following: one planning call each year; one quarterly status review with the account team, during which CalOptima should address concerns; calls with the CONTRACTOR account team, which may include a business analyst, on a mutually determined frequency, which may not be more frequent than weekly; and phone support during Business Hours.

D. **Additional Support.** CalOptima may request support beyond that which is described in this section by

submitting a Work Order.

4. **Performance Standards.** See Schedule 2 to Exhibit A.

5. **Fees.** See Exhibit B.

6. **Modifications and Interpretation**

   A. **Work Orders.** In order to request Additional Services, CalOptima may request work order from CONTRACTOR through its account management contact (a "**Work Order**"). The Work Order must specify the work to be performed and the fee. For work requested in a Work Order that corresponds to an Additional Service outlined in this SOW, the fees in the Additional Services Fee Table in this SOW will apply, unless CONTRACTOR AND CalOptima agree on a different fee schedule for any particular Work Order and should be indicated in the Work Order. For work requested in a Work Order that does not correspond to the Additional Services outlined in this SOW, additional fees will be proposed by CONTRACTOR and indicated in the Work Order. Work Orders are not enforceable until they have been validly executed by both parties and a CalOptima Purchase Order is issued. CONTRACTOR is not obligated to agree to each work order submitted by CalOptima. Work Orders made pursuant to this SOW are subject to the terms of this SOW. If there is any discrepancy or ambiguity in interpretation such that a term of this SOW potentially conflicts with a term or condition of a Work Order made pursuant to this SOW, the relevant term or condition of this SOW controls.

   B. **Changes to Artifacts.** Artifacts are documents that provide additional information about the Solution that are not a part of this SOW and may be modified by CONTRACTOR at any time.

   C. **Controlling Agreement.** Unless explicitly amended by a term in this SOW, the terms and conditions of the Contract remain in force. If there is any discrepancy or ambiguity in interpretation such that a term of this SOW potentially conflicts with a term or condition of the Agreement, the relevant term or condition of this SOW controls.

   D. **Time.** All references to time of day are references to the time in Eastern Time.

7. **Definitions.** In addition to the integrated definitions throughout this SOW, in this SOW, the following definitions apply:

   "**Additional Services**" refers to services that are described in this SOW as available at the request of CalOptima. Additional Services are subject to additional fees.

   "**Authorized Users**" refers to named, licensed users of the applications described in the Schedule.

   "**Business Days**" refers to CONTRACTOR's business days, which are Monday through Friday, except for CONTRACTOR Holidays.

   "**Business Hours**" refers to CONTRACTOR's business hours which are 8:00 a.m. to 8:00 p.m. ET on Business Days.

   "**Fee Table**" refers to the table in section A of Exhibit B. Each capitalized term in the description column of the Fee Table is considered a defined term, referring to the fee or rate listed for that term in the second column.

   "**Schedule**" refers to the documents attached to this SOW that describe the products or services CONTRACTOR will provide CalOptima. In this SOW, Schedule specifically refers to those schedules identified in section 1.

   "**Solution**" refers to the products and services described on the attached Schedules.

"SOW" stands for statement of work and specifically refers to this agreement, which is comprised of this statement of work and any attached Schedules.

"Term" refers to the initial term plus any renewal periods.

"CONTRACTOR Holidays" CONTRACTOR's holidays, which are New Year's Day, Martin Luther King Jr. Day, President's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving, and Christmas Day, or those CONTRACTOR reasonably notifies CalOptima of in advance.

Schedule 1, "Claim Accuracy Solution Description," to Exhibit A, "Scope of Work"

1. **Description**

   A. **Claim Accuracy.** Claim Accuracy is a CONTRACTOR-hosted software-enabled service, composed of two modules, Claims Editing and Clinical Validation. In order to provide the Solution, CONTRACTOR may use CalOptima's data to provide CONTRACTOR products and services. CalOptima is ultimately responsible for final utilization review and maintains sole and complete authority to adjudicate claims.

      (1) **Claims Editing.** CONTRACTOR's Claims Editing service reviews Prepayment Claims Data to identify Claims that are incorrectly coded or for which payment should be reduced. The Claims Editing service includes the Edits listed on the Claim Accuracy Edit Artifact, hereby attached as Exhibit A, including Medi-Cal specific Edit. CONTRACTOR returns edited Claims to CalOptima that are found to have an error that may result in improper payment as "**Recommendations.**"

      (2) **Clinical Validation.** CONTRACTOR's Clinical Validation service provides clinical assessment of Prepayment Claims Data. The Clinical Validation service includes the Edits listed on the Claim Accuracy Edit Artifact, including Medi-Cal- specific edits. CONTRACTOR returns edited claims to CalOptima that are found to have an error that may result in improper payment as Recommendations.

      (3) **Claim Accuracy Appeals Support.** CONTRACTOR's appeals support service reviews disputes by providers of ALL CONTRACTOR's Recommendations for which CalOptima provides documentation that supports services rendered (such a request, an "**Appeal**"). In response to an Appeal, CONTRACTOR's appeals support services provides an "**Appeal Response,**" containing an updated Recommendation to CalOptima that recommends either upholding or overturning the original Recommendation.

      (4) **Edit Configuration and Customization.** Edits in the Solution may be configured, and new Edits may be developed, as described in this section.

         (a) **Edit Configuration.** Edits can be activated, suppressed, or configured, changing the way an Edit applies (a "**Configuration**").

         (b) **New CONTRACTOR Edits.** CONTRACTOR's standard Edits available in Contractor's Claims Editing service are listed in the Claim Accuracy Edit Artifact. CONTRACTOR may develop new Edits from time to time. As CONTRACTOR offers new Edits or Configurations, CalOptima will have the option to deploy each new Edit or Configuration.

         (c) **Custom Edits.** CalOptima may request a Custom Edit by submitting a Work Order. "**Custom Edits**" are Edits that require development to either make changes to existing Edits or to create a new Edit specific to CalOptima's business requirements or Edits out of scope as mentioned in section (1) Claims Editing and/or (2) Clinical Validation. If an edit for a specific criterion does not function in the manner in which it is described in any written, agreed-upon specifications, then no charge will apply to the re-development of the edit. Contractor may not charge for any Custom Edits it agrees to build to allow CalOptima to comply with Medi-Cal- specific edits, National Medicare and Medicaid CCI edits, or Medicare policy manuals.

      (5) **Claims Accuracy Application.** Claims Accuracy offers the following application services (the "**Claim Accuracy Applications**"):

(a) **Claim Accuracy Application.** CONTRACTOR's SaaS-based application, which provides access to Recommendations, through Authorized User accounts.

(b) **Claim Accuracy API.** CONTRACTOR's web API that can be integrated into the CalOptima's systems and provider portal and is accessed through a single authorized user name.

(c) **Clinical Validation Dashboard or Application.** CONTRACTOR's SaaS-based application that provides a CalOptima the ability to initiate and support Clinical Validation Recommendations and Appeals.

2. **CONTRACTOR Responsibilities**

A. **Claim Accuracy Recommendations.** CONTRACTOR shall provide Claim Accuracy Recommendations to CalOptima.

(1) CalOptima shall transmit provider files and member files on a Pre-payment basis to CONTRACTOR. These two files shall be updated daily. CONTRACTOR shall utilize previously supplied data dictionaries, file layouts and comprehensive historical claims data to compare daily adjudicated claims against.

(2) CalOptima shall transfer adjudicated claims data via FTP to CONTRACTOR on a daily basis by 2:00AM PST (Pacific Standard Time). Such transfer shall occur after all updates to the CalOptima computer system have been completed. CONTRACTOR shall provide CalOptima a mutually agreed to secure file transfer protocol key to encrypt the outbound claims data. The same key will be used by CalOptima to decrypt the return inbound claims from CONTRACTOR.

(3) CONTRACTOR shall normalize CalOptima claims data and load all such data into a database table. CONTRACTOR shall perform analysis on all data to assure that it is properly formatted. Improperly formatted data will be transmitted to the CalOptima Claims department to identify errors.

(4) CONTRACTOR shall import the remaining normalized data into the CONTRACTOR system and perform cross-walking of CalOptima-defined crosswalk data. CONTRACTOR shall be responsible for updating its CONTRACTOR reference files with updated data sets monthly or as industry standards occur. Sources for changes include CPT, CPT Assist, AMA, National Correct Coding edits, Centers for Medicare and Medicaid Benefits Manual, CMS' National Physician Fee Schedule, the Federal Register, as well as other information published by various medical specialty societies concerning coding and reimbursement.

(5) CONTRACTOR shall process all claim line items through the Claim Accuracy solution to determine if each claim is processed correctly based upon applicable coverage, coding and reimbursement rules. Suspect claims that are identified are reviewed between 8AM and 12 Noon MST by CONTRACTOR RN coding specialists. Claims identified as suspicious after CONTRACTOR review are posted on CONTRACTOR website. CalOptima claims processors shall review these claims on the website. CalOptima has sole discretion to "accept", "not accept" or "request logic" for payment recommendations of CONTRACTOR claims. Claims accepted for payment will be processed during the next claims adjudication run.

(6) CONTRACTOR shall produce a monthly report identifying claims without recommendations by CalOptima (30 days prior to the 90-day window.)

(7) ONTRACTOR shall continuously monitor, record and make accessible in the system for CalOptima the

daily turnaround time for all Claim Accuracy Recommendations submitted. CONTRACTOR shall provide CalOptima with monthly reports such as turnaround time (TAT) that show daily and average turnaround times commencing within thirty (30) days of execution of this Contract

B. **Appeals Responses.** CONTRACTOR shall provide Appeals Responses to CalOptima for Appeals submitted by CalOptima, including Appeals submitted for PCI (as defined in the 2008 Contract) Recommendations under the 2008 Contract.

(1) All first-level appeals received by CalOptima shall be uploaded by CalOptima to the CONTRACTOR website along with the medical records submitted by the provider. CalOptima is responsible for determining whether the provider has submitted medical records. CONTRACTOR will not process appeals on claims/lines not reviewed by CONTRACTOR.

(2) CONTRACTOR will make adjustments and refunds to CalOptima as provided in Exhibit B based upon any changes to review findings through CONTRACTOR's resolution process, or though adjustments made by CalOptima or adjustments made by CalOptima on the CONTRACTOR website, including, but not limited to, those adjustments resulting from the appeals process, the government claims process, or litigation.

C. **Right to Access.** During the Term, CONTRACTOR shall provide CalOptima the nonexclusive, non-assignable, royalty free, worldwide, limited right to access the Claim Accuracy Applications solely for CalOptima's internal business operations and subject to the terms of the Agreement.

D. **Authorized Users.** CONTRACTOR will provide CalOptima 30 Authorized User accounts for the Claim Accuracy Applications. Additional Authorized Users may be added for an additional fee.

E. **Standard Reports.** CONTRACTOR shall provide CalOptima all then-current standard reports, which offer insight into operations and program effectiveness. See Schedule 4 to Exhibit A. CalOptima may request additional reports by submitting a Work Order.

3. **Assumptions**

A. **Integration and Environments.** The Solution will be provided in a ☒ Batch, ☒ Real-Time integration.

(1) Batch integrations include one UAT environment and one production environment.

(2) Real time integration includes one development, one UAT, and one production environment. Additional environments may be requested in a Work Order and will be subject to additional fees.

B. **Secure Transfer.** All data will be transmitted between the parties using secure means agreed to by the parties.

C. **Position.** CONTRACTOR's Claim Accuracy Solution will be the first editor in CalOptima's editing process for the Term of this SOW.

D. **Scope.** Following the Go-Live Date and throughout the Term of this SOW, CalOptima shall submit to CONTRACTOR for editing CalOptima's Professional Claims and Outpatient Facility Claims for all of CalOptima's populations, platforms, product lines, and territories. CalOptima may add additional populations or platforms to this SOW by submitting a Work Order, which may be subject to reasonable additional implementation fees and will be subject to the same shared savings rates.

E. **Acceptance.** Acceptance will be deemed to be made as of the date CONTRACTOR provides CalOptima access to the Claim Accuracy Application.

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4. **CalOptima Responsibilities**

A. **Point of Contact.** CalOptima shall appoint a dedicated project team with appropriate business and technical expertise for requirements, design, and testing.

B. **Supply Data.** CalOptima shall supply the necessary data feeds and supporting documentation for production of the service. CalOptima shall provide CONTRACTOR with CalOptima's Prepayment Claim Data, Paid Claim Data, and Utilization Data, as often as the parties agree. For each Claims submission, CalOptima shall provide CONTRACTOR with CalOptima's Professional Claims and Outpatient Facility Claims for editing. CalOptima shall provide CONTRACTOR with CalOptima's Inpatient Facility Claims and Capitated Claims to provide context for the Clinical Validation services. In each data submission, CalOptima shall include all data elements required by CONTRACTOR.

C. **Data Submission During Implementation.** For Implementation, CalOptima shall provide CONTRACTOR twelve months of all data described in Section 4.B., above, and Paid Claims Data.

D. **Edit Configuration.** CalOptima shall notify CONTRACTOR of requested Edit Configurations using CONTRACTOR's standard notification method.

E. **Production Support.** CalOptima shall comply with CONTRACTOR's escalation procedures.

F. **Format.** CalOptima shall submit Claims in CONTRACTOR's CIF file format or any agreed upon format that fulfills all data elements required by CONTRACTOR.

G. **Demand Forecasting.** CalOptima shall make good faith efforts provide CONTRACTOR its membership eligible for editing forecast at least 90 days prior to the Go-Live Date. Then, CalOptima shall provide CONTRACTOR at least 90 days prior written notice of changes to its membership eligible for editing by more than 10% of its membership.

H. **Appeals Delegation**

(1) CalOptima will delegate an Appeal to CONTRACTOR only if:

(a) It is a claim for which CONTRACTOR provided a Edit that CalOptima accepted;

(b) The provider has attached medical records, and

(c) Either,

(1) It is the provider's first appeal of the Claim Accuracy Edit; or

(2) Additional medical records have been provided since the first appeal.

(2) CalOptima will make medical record documentation available to CONTRACTOR.

I. **Post-Appeal Payment Adjustments and Response to Provider**

(1) CalOptima will review and make the final determination to adjust the Appealed claim or not and will respond to the provider.

(2) CalOptima will make a work queue available to CONTRACTOR that contains Finalized Claims Data for all Appeals.

(3) CalOptima will update the Utilization Data as applicable and provide to CONTRACTOR.

J. **Unauthorized Access.** CalOptima shall notify CONTRACTOR immediately of any unauthorized use of any

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password or Authorized User account or any other known or suspected breach of security.

K. **Hardware.** CalOptima shall provide internet access, computers, and software to its Authorized Users to allow for access to the Claims Accuracy Applications.

5. **Additional Definitions.** In addition to the definitions provided in the SOW and the integrated definitions throughout this SOW and Schedule, in this Schedule, the following definitions apply:

"**ANSI**" stands for American National Standards Institute.

"**Capitated Claims**" refers to claims for healthcare service providers for which CalOptima does not make fee for service payments.

"**Claims**" refers to CalOptima's claims submitted to CONTRACTOR for editing.

"**Dental Claims**" refers to claims billed for services by a dentist or other dental entity, typically on an American Dental Association (ADA) claim form.

"**Inpatient Facility Claims**" refers to those services that are billed by a provider of inpatient services on a UB04 Form or equivalent format that are associated with an inpatient or hospital stay.

"**Outpatient Facility Claims**" refers to those services billed by a provider of professional services on a UB04 Form or equivalent format that are not associated with an inpatient or hospital stay. Examples include, but are not limited to ambulatory care, radiology, and physical therapy services.

"**Pharmacy Claims**" refers to claims billed for prescription drugs and devices billed by a licensed pharmacy on a National Council for Prescription Drug Programs (NCPDP) form.

"**Professional Claims**" refers to claims billed for services by a provider of professional services on a CMS 1500 Form or equivalent format such as ANSI 837p.

"**CMS**" stands for Centers for Medicare and Medicaid Services.

"**Edits**" are rules or processes applied to Claims by the Solution that may correspond to an adjustment in the Claim's payment amount.

"**Paid Claim Data**" refers to Claims data after it has been finalized in CalOptima's transaction system.

"**Prepayment Claim Data**" refers to Claims data before it has been finalized in CalOptima's transaction system.

"**Utilization Data**" refers to the final outcome of the claims after processing by CONTRACTOR has been completed and the claim has been finalized in the CalOptima's transaction system.

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Schedule 2, "Service Level Agreements," to Exhibit A, "Scope of Work"

1. Contractor shall provide the Solution in accordance with the SLAs described in this Exhibit.
2. Underperformance Credits each month are subject to a cap of $3,000. To invoke an Underperformance Credit, CalOptima must, in writing, notify Contractor of the Underperformance within 30 days of the end of the month during which the Underperformance occurred and request the appropriate Underperformance Credit be applied to the next invoice. Contractor's obligation to pay Underperformance Credits is subject to the following conditions: CalOptima followed the appropriate notification procedures; the escalation procedure was followed, if applicable; CalOptima is not responsible for the failure.
3. The SLAs are as follows:

Title	Description	Target		Underperformance Credit	Credit Frequency
System Uptime	Contractor shall ensure that its systems required to provide the Solution will be available at or above the Target, measured on a monthly average basis.	98% of the time, 24-hour per day, seven days per week, with the following exceptions: Contractor Holidays; 7:00 p.m. Saturday to 6:00 a.m. Sunday (the "**Maintenance Window**"); downtime caused by CalOptima; and any other emergency or mutually agreed to maintenance scheduled as described in the Maintenance Policy described below.		$600	Monthly, based on Contractor's average performance in the previous month
Support Response Time	Contractor shall provide an initial response to CalOptima's support requests within the timeframes indicated for each severity level (as those are described below) in the Target. The parties shall use the Escalation Procedure for unresolved issues.	Severity Level 1	1 hour	$300	Per occurrence
		Severity Level 2	3 hours		
		Severity Level 3	1 Business Day		
		Severity Level 4	3 Business Days		
Claim Accuracy Turnaround Time	Contractor shall provide an initial response to all batch Claims within the Target, excluding Surges, measured on a monthly average basis. Claims response time will be measured from the Contractor gateway, and transport time and any	8 hours Business Hours		$900	Monthly, based on Contractor's average performance in

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	file queuing resulting from a previous Claim file still in process will be excluded from the claims response time calculation.			the previous month
Appeals Turnaround Time	Contractor shall return all Claim Accuracy Appeals within the Underperformance Target, measured on a monthly average basis. Contractor's turnaround time will be calculated from the time the Claim is received in Contractor's Claim Accuracy system, until the time the Claim leaves Contractor's Claim Accuracy system. Contractor will exclude Claim Accuracy Appeals from SLA Appeal Turnaround Time for appeals impacted by CalOptima system downtime.	10 Business Days	$900	Monthly, based on Contractor's average performance in the previous month
Expedited Appeals Turnaround Time	Contractor shall return all Claim Accuracy Appeals for which CalOptima requests expedited review within the Underperformance Target, measured on a monthly average basis. Contractor's turnaround time will be calculated from the time the Claim is received in Contractor's Claim Accuracy, until the time the Claim leaves Contractor's Claim Accuracy system. Contractor will exclude Claim Accuracy Appeals from SLA Appeal Turnaround Time for appeals impacted by CalOptima system downtime.	4 Business Days	$900	Monthly, based on Contractor's average performance in the previous month

4. As referenced in the table above, Contractor's "**Maintenance Policy**" is as follows:

   a. Emergency Maintenance. In the event that Contractor needs to conduct emergency maintenance resulting in a downtime outside of the Maintenance Window, Contractor will provide as much notice as is practical under the circumstance to CalOptima to allow for an orderly

shutdown of the relevant systems used by the CalOptima. Contractor will use commercially reasonable efforts to minimize emergency maintenance of the system.

b. Extended Maintenance. From time to time, Contractor may need to conduct maintenance on the system that may extend beyond the Maintenance Window. Contractor agrees not to perform extended maintenance without communicating to the CalOptima at least 15 calendar days in advance. Contractor agrees not to conduct extended maintenance during standard Business Hours.

c. Maintenance Notification. Standard maintenance will occur on a regularly scheduled basis during the Maintenance Window. Maintenance will be done on a rolling basis across the system, ensuring that the system remains available to CalOptima during the maintenance. In the event that the standard maintenance requires downtime, Contractor will provide advance notification to the CalOptima at least five business days ahead of the standard scheduled maintenance.

5. As referenced in the table above, the "**Escalation Procedure**" for this SOW is as follows: In the event a Severity Level 1 or 2 problem is escalated, the problem will be escalated to a senior Contractor support manager who will update CalOptima's senior information security personnel and authorized CalOptima technical contact twice a day until the problem is resolved. If the problem is not resolved within 48 hours, the issue will be escalated to Contractor's chief operating officer and to CalOptima's chief information officer.

6. In addition to the integrated definitions throughout this Exhibit and the SOW, in this Exhibit and SOW, the following definitions apply:

"**Severity Level 1**" exists when CalOptima's production use of the Solution is so severely impacted that CalOptima cannot reasonably continue work. Severity Level 1 problems may include catastrophic failure of the system; major data loss or data corruption; or critical functionality is not available, impacting a majority of the CalOptima's Authorized Users. If the condition is cause by CalOptima, it is not considered a Severity Level 1 issue. Severity Level 1 problems must be reported via telephone.

"**Severity Level 2**" exists when CalOptima's production use of the application is functioning with limited capabilities or is unstable with periodic interruptions. The software may be operating but is severely restricted with no acceptable workaround. If the condition is cause by CalOptima, it is not considered a Severity Level 2 issue.

"**Severity Level 3**" exists when product features are unavailable, but a workaround exists, and the majority of software functions are still useable. Severity Level 3 problems may include, error message with workaround; minimal performance degradation impacting a small subset of users at a time, typically less than five; incorrect product behavior with minor impact to less than five people; or questions on product functionality or configuration during implementation. If the condition is cause by CalOptima, it is not considered a Severity Level 3 issue.

"**Severity Level 4**" exists when CalOptima experiences a minor problem or has a question that does not affect the software function, such as "how to" questions, documentation, general questions, or enhancement requests, and there is no impact to product usage or CalOptima's operations. Severity Level 4 problems may include general requests for advice on product usage, clarification on product documentation or release notes, or product enhancement requests. If the condition is cause by CalOptima, it is not considered a Severity Level 4 issue.

"**SLA**" stands for service level agreement.

"**Surge**" refers to a continuous rolling six-hour period on a Business Day during which the claim volume Contractor receives under this agreement exceeds the peak volume received in the previous two months by 15% or more outside of any Surges in that month.

"**Target**" refers to, generally, the target metric for SLAs and, specifically, as it relates to any specific SLA, the target for that SLA.

"**Underperformance**" refers to Contractor failing to meet the target of a service level.

"**Underperformance Credit**" refers to the amount owed to CalOptima for Contractor's Underperformance, which will be applied to CalOptima's future invoices, subject to the SLA management provisions. Specific Penalty amounts for each SLA are identified below that SLA.

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Schedule 3, "Claim Accuracy Edits Artifact," to Exhibit A, "Scope of Work"

This is a list of the Edits available in the Solution at the time of the Effective Date. This list may change from time-to-time without amendment to the Agreement.

Flag	Flag Short Description	Flag Long Description
ACW	Incorrect Anesthesia Code	Provider has used a surgical procedure code to bill for anesthesia services. An anesthesia code is required for reimbursement.
ADD	Add-on Denied as Primary Code Denied	Identifies add-on codes that need to be disallowed because the primary procedure has been disallowed.
ADM	Services Within Discharge Time Frame	Under Development
AGE	Inappropriate for Age	Identifies codes billed by the provider that are incorrect, based on the code description, for the patient on the date of service.
AGM	Ancillary Ante Partum	Identifies ancillary services that are included in routine ante partum care billed either will global maternity codes or E&M codes.
ANT	Antepartum Services included in global Code	It is not appropriate to report the antepartum, delivery, and postpartum care separately when a single physician or the physicians of the same group practice provide the total obstetrical care.
AOM	Add-on Code Missing Primary Code	Identifies situations in which an add-on code has been reported without a primary procedure code(s).
ASD	Services Associated with Non-Covered Services	Identifies services rendered in conjunction with a service that is not covered.
ASM / RASM	Does Not Match Surgeon	Identifies procedure code(s) billed by an assistant surgeon that do not match the procedure code(s) billed on the same date by the provider identified as the primary surgeon. The assistant surgeon should be billing the same procedure codes as the primary surgeon. RASM (Reverse ASM edit)
ASN	Assistant Surgeon Necessary	Identifies procedures for which an assistant surgeon is only allowed with supportive documentation.
ASR	Assistant Surgeon Reductions	Identifies those situations in which a reduction in payment should apply for services provided by an assistant surgeon.
BIL	Bilateral Disallowed	Identifies procedures that cannot be billed bilaterally or already include bilateral reimbursement.
COS	Cosmetic Procedure	Identifies procedures that may be cosmetic.
CPD	Cross Provider Duplicate	Identifies services that have already been billed by another provider for the same patient and date of service.

Flag	Flag Short Description	Flag Long Description
CPR	Multiple Cardiology Procedures Reduction	Identifies situations in which a reduction in payment has been made for multiple cardiology procedures performed on the same day.
CPRC	Multiple Cardiology Procedures, Carrier Priced	Identifies procedures for which a co–surgeon is not allowed.
CSA	Co-Surgeon Inappropriate	Identifies procedures for which a co–surgeon is only allowed with supportive documentation.
CSN	Co-Surgeon Necessary	The reimbursement has been adjusted to reflect payment for co-surgeons.
CSR	Reduce, Surgical Team	Identifies procedure codes that are not valid CPT, HCPCS or state codes on the date of service.
DEL	Deleted Code	Identifies procedures that are for the same patient, provider and date of service as a previous claim.
DUP	Duplicate Billing	Reimbursement has been adjusted as multiple procedures were performed at the same time with the same instrument.
EFR	Endoscopic Family Reduction	Identifies when procedure codes have been assigned to an incorrect revenue code. RFLU (Reverse FLU edit)
FLU / RFLU	Florida Unbundling Revenue Codes	Identifies procedures that exceed the number of services allowed over a specific time period. Units under the allowance are recommended for reimbursement.
FOT	Frequency Over Time	Identifies when the number of units or lines billed on the same day by the same provider exceeds the maximum allowance.
FRE	Reimbursable Once Per day	Identifies E&M services billed in the post operation period that are included in the value of the surgical procedure.
FUD / GPA	Part of Global Service	Identifies services billed during the ante partum or post partum periods that are reimbursed in the value of another procedure code.
GDR	Ante Partum Care Included in Global Code	Identifies procedure codes that do not match the patient's gender based on the value submitted by the payer.
GEN	Incorrect Patient Gender	The GPA edit identifies E&M services that have been paid but a later claim with a surgical procedure makes the E&M not reimbursable. Recovery of the incorrectly paid code will be initiated.
GPA / FUD	Part of Global Service	Identifies outpatient services billed within the preadmission window of an inpatient admission.
HPRE / OPRE	Outpatient service within the preadmission window	Identifies reductions when multiple imaging procedures are performed on the same date of service.

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Flag	Flag Short Description	Flag Long Description
IFR	Multiple Radiological Procedure Reductions	Identifies procedure codes that are not valid CPT, HCPCS or state codes on the date of service.
INVC	Invalid CPT/HCPCS Code	Identifies revenue codes that are not valid revenue codes on the date of service.
INVR	Invalid Revenue Code	Identifies procedures that CMS requires performed at an inpatient only setting.
IOP	Inpatient Only Procedure	Identifies when the number of units or lines billed for a patient exceeds the maximum allowance for a patient's lifetime.
LIF	Service Exceeds Lifetime Patient Allowance	Identifies services that need to be reduced services as indicated by the presence of modifier 52.
M52	Modifier 52 reduction	Identifies services that need to be reduced services as indicated by the presence of modifier 53 indicating discontinued services.
M53	Modifier 53 reduction	Identifies services that need to be reduced services as indicated by the presence of modifier 73 indicating discontinued services.
M73	Modifier 73 reduction	Identifies services that need to be reduced services as indicated by the presence of modifier 74 indicating discontinued services.
M74	Modifier 74 reduction	Identifies maternity services that have been reimbursed by another procedure code.
MAT	Part of Global Service	Identifies procedures where a reduction for bilateral procedures is needed.
MAX	Exceeds Daily Limits	Identifies procedures that typically should not be billed together. RMEA (Reverse MEX)
MEX / RMEA	Mutually Exclusive Unbundled	HCI's Clinical Director has determined procedure code(s) warrant additional clinical review for medical necessity.
MNR	Review for Medical Necessity	Identifies procedure codes incorrectly billed with modifier -26 (professional component). These procedures cannot be billed with modifier -26 or the procedure does not have a professional component.
MOD	Inappropriate Use of Modifier 26	Identifies procedure codes that need to be reduced to because multiple procedures have been performed on the same date of service by the same provider.
MPR	Multiple Procedure Reduction	Identifies procedure codes incorrectly billed with modifier -TC (technical component). These procedures cannot be billed with modifier -TC or the procedure does not have a technical component.
MTC	Inappropriate Use of TC Modifier	Identifies procedure codes that need to be reduced to because multiple therapy procedures have been performed on the same date of service by the same provider.
MTR	Multiple Therapy Procedures Reduction	Identifies services that are not covered.

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Flag	Flag Short Description	Flag Long Description
NCS	Not Covered by Plan	Identifies situations in which a lab procedure has been submitted with a diagnosis code that does not support medical necessity.
NCD / NCDN	National Coverage Determination	Identifies situations in which a lab procedure has been submitted with a diagnosis code that does not support reimbursement.
NCD - ALL Dx Codes	National Coverage Determination - All Dx Codes	Identifies services, based on the presence of modifiers<>, which represent medical mistakes or errors that are not reimbursable.
NEV	Never Paid Events	Identifies E&M services billed with a new patient E&M code when the provider has billed other services which make the patient an established patient.
NPR	New E&M not allowed	Identifies the established patient procedure code that the provider should have billed because the patient is an established patient for the provider.
NPT	New E&M Not Allowed	Identifies outpatient services billed within the preadmission window of an inpatient admission.
OPR	Multiple Ophthalmology Procedures Reduction	Identifies situations in which a reduction in payment has been made for multiple ophthalmology procedures performed on the same day.
OPRE / HPRE	Outpatient service within the preadmission window.	Identifies situations in which the amount being paid is greater than the billed charges.
PAY	Paid Amount Exceeds Billed	Identifies procedure codes where the diagnosis codes preclude reimbursement for the procedure code.
PEDM	Procedure to Excluded Diagnosis Mismatch	Identifies procedure codes where the diagnosis codes required reimbursements for the procedure code are not present on the claim.
PFUD	Procedure Follow Up days	Identifies situations in which a procedure code is billed before the post-operative period is over for an earlier procedure.
PRD	PCI Reissued Duplicate	Identifies situations in which a resubmitted line has already been denied on a previous claim.
PRDM	Procedure to Required Diagnosis Mismatch	Identifies claim lines where the procedure code billed has an inappropriate modifier appended to the procedure code based on specific coding rules and guidelines.
PMM	Modifier Inappropriate	Identifies codes billed in an inappropriate place of service.
PSM	Place of Service Mismatch	Identifies procedure codes that do not match the revenue code on the claim line.
PRM	Procedure to Revenue Code Mismatch	Identifies the primary service when multiple services are reported on the same date of service.
PS	Primary Service	Identifies post partum services that are included in the global maternity codes.

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Flag	Flag Short Description	Flag Long Description
PST	Postpartum Services Included in the Global Code	Identifies claim lines billed by a provider whose claims are being flagged for review prior to payment. Only those claims with the specific condition or problem identified for the provider will be flagged.
PSUS	Fraud, Documentation Needed for Processing	The RASM edit is applied when the surgeon's bill is received after the assistant surgeon's bill. The edit then identifies that the assistant surgeon's billing does not match the surgeon's bill. Recovery will be initiated.
RASM / ASM	Does Not Match Surgeon	Identifies when all the components of a procedure are billed but the global procedure has not been billed. Each of the component codes will be identified with a REB edit.
REB / RBP	Component Codes Billed Separately	Identifies situations where a provider reports a drug toxicology CPT code(s) which CMS no longer recognizes and should be reported with a more appropriate G-code.
RBPD / REBD	Rebundled Toxicology Codes	Identifies procedures billed by more than one provider in the same procedure code range. For example, two providers from the same practice billing for an E&M service.
RDS	Duplicate Services in Same Range of Codes	Identifies revenue codes that have been billed more than once on a date of service. Provider contract exceptions have been excluded.
RFRE	Revenue Code Frequency	Identifies when a previously reimbursed procedure codes has been assigned to an incorrect revenue code. Recovery of the incorrectly paid code will be initiated.
RFLU / FLU	Florida Unbundling Revenue Codes	RMEA edits identify procedures that have been paid but a subsequent claim line identifies the procedure was paid incorrectly. Recovery of the incorrectly paid code will be initiated.
RMEA / MEX	Mutually Exclusive Unbundled	Identifies unusual situations that warrant additional review before reimbursement.
RPR	Review Prior to Reimbursement	RUPA edits identify procedure code(s) that have been already reimbursed that are should be included in the reimbursement of a more global procedure code. Recovery of the incorrectly paid code will be initiated.
RUPA / UNB	Unbundled	Identifies procedures for which an assistant surgeon is not allowed.
SAS	Assistant Surgeon Inappropriate	Identifies procedures for which a co-surgeon is not allowed.
TSA	Team Surgeon Inappropriate	Identifies procedures for which a co-surgeon is only allowed with supportive documentation.
TSN	Team Surgeon Necessary	Identifies procedure codes that are reimbursed in the value of another procedure code that was reimbursed. RUPA (Reverse UNB edit)

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Flag	Flag Short Description	Flag Long Description
UNB / RUPA	Unbundled	Identifies procedures billed with a non-specific procedure code. Medical documentation is required before reimbursement can be made.
UNL	Unlisted Code	Identifies lines where the anticipated paid amount is greater than would be expected. Additional review of the reimbursement is warranted.
UPA	Unreasonable Paid Amount	

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Schedule 4, "Claim Accuracy Reports," to Exhibit A, "Scope of Work"

This is a list of the reports available in the Solution at the time of the Effective Date. This list may change from time-to-time without amendment to the Agreement.

- Batch Summary
- Edit Acceptance
- Customization Summary
- Rolling 12 Month Edit Summary
- Appeals Summary and Detail Client User Summary
- Client Override Summary
- Client Edit Detail (Note: to include the Edit Explanation Description)
- Client Pend & Logic Claims
- Claims without CalOptima Recommendations to CONTRACTOR Edits
- 13 weeks to Date Summary
- Top Providers by Savings

Exhibit B, "Fees"

A. **Fee Table**

Fee Table	
Description	Fee or Rate
One-Time Fees	
Implementation Fee	Waived
Recurring Fees	
Claim Accuracy: Shared Savings Rate	19.5%
Additional Services Fees	
Custom Development	$250 per hour
Additional Authorized Users over 30 (see section 2.D of Schedule 1 to Exhibit A)	$600 per additional Authorized User per year
Additional Support Services	$200 per hour
Online Training	$200 per hour
Onsite Training	$3,000 per trainer per day
Ad Hoc Reporting	$375 per hour

B. **Billing.** The following billing terms describe how the fees listed in the Fee Table will be calculated and when they will be billed:

(1) **Solution Fees.** Product-specific defined terms used in this subsection may be defined in the additional definitions sections of the applicable Schedules.

(a) **Claim Accuracy.** Beginning on the Go-Live Date, each month, CONTRACTOR will bill CalOptima the product of *Final Accepted Savings × Shared Savings Rate.*

"Final Accepted Savings" refers to the difference between (i) the submitted allowed amount configured for CalOptima and (ii) the allowed amount remaining after CONTRACTOR Edits are applied and CalOptima accepts the CONTRACTOR Recommendations. For the purposes of calculating Final Accepted Savings: (i) adjustments made to Utilization Data will be accounted for only if they are made within 90 days of the date the original Recommendation was made and (ii) Recommendations that are not returned to CONTRACTOR in Utilization Data within 90 days will be considered accepted (this does not apply to Appeals). A report identifying claims without recommendations by CalOptima will be provided by the CONTRACTOR 30 days prior to the 90-day window. See CONTRACTOR responsibilities Section 2.6.

(2) **Additional Services Fees.** Each month, CONTRACTOR will bill CalOptima any applicable Additional Services fees indicated in the Fee Table for applicable services performed in the previous month. An approved CalOptima Purchase Order outlining these Additional Services must accompany any invoices for said Additional Services.

(3) **Travel.** CONTRACTOR will bill CalOptima for all CalOptima pre-approved reasonable travel expenses, per CalOptima's travel policy related to this SOW.

C. **Payment Terms.** CONTRACTOR will send invoices for the fees described in this section each month. CalOptima shall pay all invoiced fees according to the payment terms stated in the Contract.

D. **Reversals.** In the event, during the Contract, CalOptima reverses the claims payment determination that was based on CONTRACTOR's recommended action, in whole or in part, for any reason (including,

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without limitation, as a result of provider grievance or appeal, government claim or litigation), leading to an additional payment to the provider on that claim, CalOptima shall notify CONTRACTOR of such action, CONTRACTOR shall reverse the initial compensation changes (issued a credit) and re-invoice CalOptima for its payment based on the re-calculated claims payment determination amount.

E. **Interest**. If the event that CalOptima claims are delayed by the sole fault of CONTRACTOR, and CalOptima accrues and pays interest charges on said claims to providers, CalOptima shall provide CONTRACTOR with notice of such interest charges. CONTRACTOR shall issue a credit (deduct) in the amount of such interest on its next monthly invoice to CalOptima for CONTRACTOR compensation. However, this provision may not apply to any Claim that Contractor processes within the applicable SLA timeframes.

F. **Reversals Post Termination.** The Parties acknowledge that the basis (e.g., provider appeal) for CONTRACTOR payment reversals may not occur for many months following the date of CalOptima's implementation of CONTRACTOR's Recommendation. Therefore, for a twelve-month period commencing on the date this Contract is terminated for any reason, CalOptima may provide written notice to CONTRACTOR of any adjustments to CONTRACTOR'S compensation (and interest charges, if any) arising from reversals as provided herein and CONTRACTOR shall issue a refund to CalOptima within 30 days of receipt of such notice. For a Claim to be eligible for adjustment, CalOptima must provide CONTRACTOR written notice within 365 days from the date that CONTRACTOR provided the original Recommendation to CalOptima.

G. **Appeal Support Post Termination.** The parties acknowledge provider Appeals of CONTRACTOR Recommendations may not occur until after termination of the Contract. Upon termination of the Contract for any reason other than CalOptima's termination without cause pursuant to section 16.1 of the Contract, CONTRACTOR shall process provider Appeals of CONTRACTOR'S Recommendations, as described in section 2.B of Exhibit A, for a twelve-month period following the date the Contract is terminated. For an Appeal to be eligible for processing by CONTRACTOR post-termination, CalOptima must provide Contractor written notice of the Appeal within 365 days from the date that CONTRACTOR provided the original Recommendation to CalOptima.

H. 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 B.

I. 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. 19-10311; specify the services provided, the time period covered by the invoice and the amount of payment requested.

J. CONTRACTOR shall also invoice CalOptima on a monthly basis for travel-related expenses. All expenses charged to CalOptima under this Contract shall be consistent with Exhibit C, CalOptima's Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging, and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client. Travel related expenses shall not exceed $10,000 in the aggregate. CONTRACTOR shall obtain CalOptima's written approval, which shall not be unreasonably withheld or delayed, before incurring any expenses exceeding, in the aggregate, $10,000. CalOptima shall not pay CONTRACTOR for time spent traveling.

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Exhibit C

CalOptima Travel Policy

Policy #: GA.5004
Title: **Travel Policy**
Department: Finance
Section: Purchasing
CEO Approval: Michael Schrader MS
Effective Date: 8/1/12 Revised: 9/6/12, 3/1/13
Board Approval: 9/6/12

I. **PURPOSE**

To establish a process for reasonable and equitable reimbursement of approved travel and other related expenses incurred by CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants while traveling on authorized CalOptima Business.

II. **POLICY**

A. For the purpose of this policy, Individual shall mean, unless otherwise specified, all persons authorized to submit an Expense Report, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima employees, and; individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses, in accordance with CalOptima rules and regulations.

B. CalOptima shall provide an expense reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel expenses and miscellaneous expenses incurred by authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal regulations.

C. CalOptima shall reimburse employees for reasonable expenses incurred while traveling on CalOptima business. All travel must be for the benefit of CalOptima, and must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible.

1. Travel Expenses shall include the following items:

a. Transportation: including commercial carriers, rental vehicles, and mileage for use of personal vehicle;

b. Lodging;

c. Meals;

d. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

e. Insurance for rental vehicles;

f. Parking fees and tolls fees (i.e., toll roads and necessary parking);

g. Miscellaneous expenses including:

i. Authorized local and long-distance telephone calls;

ii. Baggage fees;

iii. Internet or Wi-Fi charges;

iv. Facsimiles;

v. Expenses in connection with the preparation of authorized company reports or correspondence;

vi. Taxi or public transit fares, required to conduct business; and

vii. Other unforeseen or unusual expenses that are properly justified and substantiated.

D. Board Member/Standing Committee Member Travel

1. CalOptima shall allow Board members and Standing Committee members reasonable and necessary Travel Expenses and miscellaneous expenses incurred when participating in activities as a member of their respective Board or Committee. Eligible Travel Expenses shall be governed by this policy.

a. The CEO or the Chairperson of the CalOptima Board of Directors, or his or her designee, shall review and approve all Board member and Standing Committee member non-local travel.

b. CalOptima shall limit Board member and Standing Committee member travel to the following purposes:

i. CalOptima business-related activities;

ii. Requests to represent CalOptima as a speaker at an approved meeting, seminar or conference; and

iii. Other travel deemed necessary by the CalOptima Board of Directors.

E. Travel Approval

1. Budgeted Travel: All budgeted Travel and miscellaneous expenses for CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants shall be pre-approved by the appropriate level of CalOptima Management or Board Chair, prior to travel expenses being incurred, according to the following:

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Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

2. Non-Budgeted Travel: Non-Budgeted Travel and miscellaneous expenses for authorized Individuals shall be pre-approved by the CEO, or his or her designee, prior to Travel Expenses being incurred.

F. Conferences and Seminars

1. Attendance at any given conference and/or seminar shall be:

   a. Limited to the number of Individuals deemed appropriate by the CEO for that particular conference or seminar, and

   b. Approved by Human Resources.

2. Payment of Fees

   a. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and seminar fees at the time the Travel and Training Authorization form is prepared, and submit necessary registration information to the Purchasing Department.

   b. In the event an Individual must personally pay for conference or seminar registration fees, the Individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

G. Meal Expenses

1. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

2. CalOptima shall reimburse authorized Individuals the actual cost of Travel Meals, excluding alcoholic beverages, in an amount not to exceed forty-five dollars ($45.00) per day, excluding taxes and gratuity.

   a. CalOptima shall reimburse employees and Board members for meals that exceed the forty-five dollars ($45.00) per day under the following conditions:

      i. The authorized Individual shall submit a valid receipt for such meals with a brief explanation of the expenditure. Individual meals shall be subject to the above limitations;

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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:

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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.

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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.

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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

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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

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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, Verscend Technologies, Inc., 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: Iulia Fried   Date: 9/28/2018

Print Name: Iulia Fried

Title: Compliance Officer

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 sub awards at all tiers (including subcontractors, sub grants, 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.

Verscend Technologies, Inc.
Name of Contractor

David Mason
Printed Name of Person Signing for Contractor

19-10311
Contract/Grant Number

DocuSigned by:
Signature of Person Signing for Contractor

9/28/2018
Date

COO
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

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Exhibit E

Part 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:
   - ☐a. contract ☐b. grant
   - ☐c. cooperative agreement
   - ☐d. loan
   - ☐e. loan guarantee
   - ☐f. loan insurance

2. Status of Federal Action:
   - ☐a. bid/offer/application
   - ☐b. initial award
   - ☐c. post-award

3. Report Type:
   - ☐a. initial filing
   - ☐b. material change

   For Material Change Only:
   Year _____ quarter_______
   date of last report ___________

4. Name and Address of Reporting Entity:
   ☐ Prime ☐ Subawardee
   Tier ____, *if known*:

   Congressional District, *if known*:

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

   Congressional District, *if known*:

6. Federal Department/Agency:

7. Federal Program Name/Description:

   CDFA Number, *if applicable*:

8. Federal Action Number, *if known*:

9. Award Amount, *if known*:
   $____________

10. a. Name and Address of Lobbying Entity
    (*If individual, last name, first name, MI*):

    b. Name and Address of Lobbying Entity
    (If individual, last name, first name, MI):

    (attach Continuation Sheet(s) SF-LLLA, if necessary)

11. Amount of Payment (check all that apply):
    $____________ ☐actual ☐planned

12. Form of Payment (check all that apply):
    - ☐ a. cash
    - ☐ b. in-kind, specify: Nature ____________
      Value ____________

13. Type of Payment
    - ☐ a. retainer
    - ☐ b. one-time fee
    - ☐ c. commission
    - ☐ d. contingent fee
    - ☐ e. deferred
    - ☐ f. other, specify: __________

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

    (Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature:

Print Name:

Title:

Telephone No.: Date:

Federal Use Only

Authorized for Local Reproduction
Standard Form-LLL

Back to Item

Back to Agenda

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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 sub award recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Sub awards include but are not limited to subcontracts, sub grants, 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

FDR Attestation

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via fax (714) 481-6457, email hnreporting@caloptima.org, or mail: 505 City Parkway West, Orange, CA 92868, within fifteen (15) calendar days of the notice accompanying this form.

Check which CalOptima program(s) this form pertains to:

- ☐ OneCare
- ☒ Medi-Cal
- ☐ PACE

I hereby attest that [Verscend Technologies, Inc. (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. Provide effective Fraud, Waste and Abuse Training and Compliance Training to all Organization and downstream entity Board members, officers, employees, temporary employees, and volunteers, within 90 days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use (Select all that apply):

- ☐ CMS's Fraud, Waste, and Abuse Training and Compliance Training Module.
- ☒ An internal training program that meets CMS's Fraud, Waste, and Abuse and Compliance Training Module requirements.
- ☐ Deemed to have met the Fraud, Waste and Abuse certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS).

II. Administer specialized compliance training to Organization and downstream entity Board members, employees, temporary employees, and volunteers: (i) based on their job function within the first 90 days of hire and at least annually thereafter as a condition of appointment, employment or contracting, (ii) when requirements change; (iii) when such persons work in an area previously found to be non-compliant with program requirements or implicated in past misconduct.

III. Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity Board members, officers, employees, temporary employees, and volunteers within 90 days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization. The Organization and its downstream entities currently use (Select all that apply):

☒ Our own compliance policies and procedures, standards of conduct, and compliance reference material. (Please provide to CalOptima for review).

☐ CalOptima's compliance policies and procedures, Code of Conduct, and compliance reference material.

IV. Review all Organization and downstream entity Board members, officers, potential and actual employees, temporary employees, and volunteers against the HHS OIG List of Excluded Individuals & Entities list and GSA Debarment list upon appointment, hire or contracting, as applicable,and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within 5 calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. Screen its and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima Policies upon hire and annually thereafter.

VI. Will report suspected fraud, waste, and abuse, as well as all other forms of non-compliance, as it relates to CalOptima.

VII. Understand that any violation of any laws, regulations, or CalOptima Policies is grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII Are aware that persons reporting suspected fraud, waste, and abuse, and other non-compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. Will retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

That the individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

DocuSigned by:
Iulia Fried
5DB7EB0958CA412

Signature	Date
Iulia Fried	9/28/2018

Name	Organization
Iulia Fried	Verscend Technologies, Inc.

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.

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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

Attestation Concerning the Use of Offshore Subcontractors

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via fax (714) 481-6457, email hnreporting@caloptima.org, or mail: 505 City Parkway West, Orange, CA 92868, within fifteen (15) calendar days of the notice accompanying this form.

Check which CalOptima program(s) this form pertains to:

- ☐ OneCare HMO SNP
- ☒ Medi-Cal
- ☐ PACE

Are any administrative or other functions conducted on behalf of your organization by entities located offshore? This shall include employees of your firm, subcontractors and any 3rd party subcontractors. ("X" where appropriate)

No ☐ If NO, please complete Part I:

Yes ☐ If YES, please complete Parts II–VI of this form:

Part I — Our Firm is Not Using Offshore Subcontractors and/or Employees

Offshore Subcontractors

☒ Our Organization is NOT using Offshore Subcontractors for contract 19-10311 with CalOptima

Offshore Employees

☒ Our Organization does NOT employ workers who are located Offshore for contract 19-10311 with CalOptima

Name of Organization:	Verscend Technologies, Inc.
Name of Authorized Person:	Iulia Fried
Title:	Compliance Officer
Signature:	DocuSigned by: Iulia Fried 5D87EB0958CA412
Date:	9/28/2018

Part II — Offshore Subcontractor Information

Offshore Subcontractors

☐ Our Organization IS using Offshore Subcontractors

Offshore Employees

☐ Our Organization DOES employ workers who are located Offshore

Subcontractor Name:	
Subcontractor Country:	
Subcontractor Address:	

Describe Offshore Subcontractor Functions:

State Proposed or Actual Effective Date for Offshore Subcontractor: ____________________

Part III — Precautions for Protected Health Information (PHI)

1. Describe the PHI that will be provided to the Offshore Subcontractor and/or Employee:

2. Explain why providing PHI is necessary to accomplish the Offshore Subcontractor's/Employee's objectives:

3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:

Part IV — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract

Item	Attestation	Response Yes / No
A.	Offshore Subcontractor/Employee arrangement has policies and procedures in place to ensure that Medi-Cal, Medicare and Healthy Families beneficiary protected health information (PHI) and other personal information remains secure.	
B.	Offshore Subcontractor/Employee arrangement prohibits Subcontractor/Employee access to Medi-Cal, Medicare, and Healthy Families data not associated with CalOptima's contract with the Offshore Subcontractor/Employee.	
C.	Offshore Subcontractor/Employee arrangement has policies and procedures in place that allow for immediate termination of the subcontractor/employee upon discovery of a significant security breach.	
D.	Offshore subcontractor/employee arrangement includes all required DHCS and/or CMS language as stipulated within your contract with CalOptima.	

Part V — Attestation of Audit Requirements to Ensure Protection of PHI

Item	Attestation	Response Yes / No
A.	Your organization will conduct an annual audit of the Offshore Subcontractor/Employee.	
B.	Audit results will be used by your organization to evaluate the continuation of its relationship with the Offshore Subcontractor/Employee.	

CalOptima
Better. Together.

C.	Your organization agrees to share Offshore Subcontractor's/Employee's audit results with CalOptima upon request.	

Part VI — Organization Information

Name of Organization:	
Name of Authorized Person:	
Title:	
Signature:	
Date:	

Exhibit I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: Verscend Technologies, Inc.

Business Entity Type: Delaware Corporation
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: 201 Jones Road

City: Waltham State: MA Zip: 02032

Business Phone: 718-693-3700 Email: legal@verscend.com

President: Emad Rizk, President & CEO

Contact Person: Jamie Adams, VP Account Management

Person(s) Signing Contract & Title: David Mason, COO

*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 %
Verscend Holding Corp.	100% owner

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:
[signature]
7E43D5E6848B4E9...

Authorized Signature

9/28/2018

Date

David Mason COO

Name and Title

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Exhibit J

(Optional)

Exhibit K

Not applicable for this Contract

Exhibit L

Not applicable for this Contract

AMENDMENT NO. 1 TO
CONTRACT 19-10311

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE
DBA CALOPTIMA
(CalOptima)

AND

VERSCEND TECHNOLOGIES, INC.
(VENDOR)

AMENDMENT NO. 1 TO THIS CONTRACT is entered into as of the date last signed below, with respect to the following facts:

A. CalOptima and VENDOR (hereinafter collectively referred to as "the Parties") entered into Contract 19-10311 on October 1, 2018, under which VENDOR agreed to provide Clinical Editing Solutions and Services as described in the Scope of Work; and

B. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing executed by the Parties.

C. The Parties now desire to amend the Contract to update the legal name Verscend Technologies, Inc.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. All capitalized terms used herein shall have the same meanings given them in the Agreement, unless the context specifically provides otherwise herein.

2. Any reference in the Contract or any agreement in accordance with the Contract, to "**Verscend Technologies, Inc.**," or "**Verscend,**" is hereby replaced with "**Cotiviti**" or "**Cotiviti, Inc.**"

3. **No Other Changes.** This Amendment No. 1 is by this reference made part of said Contract. Except as otherwise provided in this Amendment No. 1, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment No. 1 and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 1 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment No. 1 shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment No. 1 shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment No. 1 shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 1 on the day and year last shown below.

"CALOPTIMA"

Date: 1/9/2019

By: Mark Finch
Its: Purchasing Manager

Date: 1/9/2019

"VENDOR"

DocuSigned by:
Brett Magun
5E3B584A18324A4

By: Brett Magun
Its: SVP, Managing Counsel
[Chairman, President or Vice President]

DocuSigned by:
7E43D5E6648B4E9...

By: David Mason
Its: COO
[Secretary or CFO]

If VENDOR is a corporation, two officer signatures or Corporate Resolution or Corporate Seal is required.

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AMENDMENT NO. 2
TO CONTRACT NO. 19-10311

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
DBA ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE,
DBA CALOPTIMA
(CalOptima)

AND

COTIVITI, INC.
(CONTRACTOR)

AMENDMENT NO. 2 TO THIS CONTRACT is entered into as the date last signed below, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 19-10311 on October 1, 2018, under which CONTRACTOR agreed to Clinical Edition Solution and Services, as described in the Scope of Work (hereinafter, "Contract").

B. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing executed by the Parties.

C. The Parties now desire to amend the Contract by extending the contract term.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. All capitalized terms used herein shall have the same meanings given them in the Agreement, unless the context specifically provides otherwise herein.

2. The Parties now agree extend this contract for an additional 12 months. The new contract termination date will be 10/7/2022.

3. **No Other Changes.** This Amendment No. 2 is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 2 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

[SIGNATURES ON FOLLOWING PAGE]

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IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 2 on the day and year last shown below.

"CALOPTIMA"

DocuSigned by:

Nancy Huang

D22E3B87032946F...

Date: 08/02/2021

By: Nancy Huang

Its: Chief Financial Officer

"CALOPTIMA"

DocuSigned by:

Richard Sanchez

234AD421BDEC4D9...

Date: 08/02/2021

By: Richard Sanchez

Its: Chief Executive Officer

Date: 7/22/2021

"VENDOR"

DocuSigned by:

Matthew Hawley

24B1AD6C0296492...

By: matthew hawley

Its: EVP Operations

[Chairman, President or Vice President]

By: ____________________

Its: ____________________

[Secretary or CFO]

If VENDOR is a corporation, two officer signatures or Corporate Resolution or Corporate Seal is required.

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AMENDMENT NO. 3 TO
CONTRACT 19-10311

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE
DBA CALOPTIMA
(CalOptima)

AND

COTIVITI, INC.
(CONTRACTOR)

AMENDMENT NO. 3 TO THIS CONTRACT is entered into as of the date last signed below, with respect to the following facts:

A. CalOptima Health and Contractor (hereinafter collectively referred to as "the Parties") entered into Contract 19-10311 on October 1, 2018, under which Contractor agreed to provide Clinical Editing Solutions and Services as described in the Scope of Work; and

B. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing executed by the Parties.

C. The Parties now desire to amend the Contract to extend the contract term.

D. The Parties agree to update the software to the current updated platform offered by Contractor.

E. The parties agree to amend the Contract for CalOptima naming conventions.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. All capitalized terms used herein shall have the same meanings given them in the Agreement unless the context specifically provides otherwise herein.

2. The Parties now agree to extend the contract term. This Amendment #3 will exercise the remaining extension option and increase the term by an additional 24 months. The new termination date will be 10/7/2025. Additionally, CalOptima Health may, at its sole option, extend the contract for 2 additional 12-month extensions, unless terminated earlier, as provided in this Contract. For the avoidance of doubt, Contractor reserves the right to decline to extend the Contract beyond 10/7/2025 by providing 24 months advanced notice.

3. CalOptima agrees to accept upgrades to the software, however, will not be charged fees by Contractor related to any platform upgrades. For the avoidance of doubt, CalOptima acknowledges it will be required to perform work in support of the upgrade and shall be responsible for its internal costs. The parties agree to document a mutually agreed scope of work for the upgrade project.

4. Any reference in the Contract to "dba CalOptima" is hereby replaced with "dba CalOptima Health".

5. **No Other Changes.** This Amendment is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency

between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power, or remedy of either party in effect prior to the date hereof.

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 3 on the day and year last shown below.

"CALOPTIMA"
DocuSigned by:
Nancy Huang
By Nancy Huang
Its: CFO, CalOptima

Date: 10/07/2022

"CALOPTIMA"
DocuSigned by:
By Michael Hunn
Its: CEO

Date: 10/07/2022

"VENDOR"

matthew hawley
By: matthew hawley
Its: EVP Operations
[Chairman, President or Vice President]

Peter Csapo
By: Peter Csapo
Its: CFO, CAO, Treasurer and EVP
[Secretary or CFO]

Date: 10/07/2022

If VENDOR is a corporation, two officer signatures or Corporate Resolution or Corporate Seal is required.

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

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

Contacts

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

Recommended Action

Authorize the Chief Executive Officer to amend the current contract with Cotiviti, Inc (Cotiviti). to extend the contract term for two years beginning October 7, 2023, with the option of two additional one-year extensions, each exercisable at CalOptima Health's sole discretion.

Background

Cotiviti supports CalOptima Health's claims editing service solution and clinical coding validation. CalOptima Health utilizes this solution as the primary source for prepayment claims editing that identifies claims that are incorrectly coded and for which payment should be reduced, based on American Medical Association, National Correct Coding Initiatives (NCCI), Centers for Medicare & Medicaid Services (CMS) Benefits Manual, CMS National Physician Fee Schedule, the Federal Register, and Current Procedural Terminology code sets. Cotiviti has provided CalOptima Health with NCCI claims editing accuracy since October 8, 2018, which has resulted in an $11.8 million in cost avoidance for calendar year 2021 and $6.6 million from January 2022 through June 2022.

Discussion

Replacing this primary editing solution would require additional investment in terms of increase in fees based on current industry rates, time commitment, and impact to current savings trend based on accuracy of editing and service level.

The Cotiviti contract has one remaining one-year extension exercisable from October 7, 2022, to October 7, 2023. By extending the contract term to add two years, beginning October 7, 2023, with the option of two additional one-year extensions, CalOptima Health will be able to maintain the current contingency rate negotiated during the initial implementation.

Additionally, Cotiviti will upgrade CalOptima Health's editing engine (platform) to the most advanced technology that can provide a combination of software-as-a-service claim editing technology and pre-payment clinical claim review service. This upgrade will ensure the accuracy of claim payments, increase adjudication speed, and reduce the technical and clinical resource needs without disrupting the current adjudication workflow or delaying payment to providers. The professional and technical support needed for this upgrade will be provided and covered by Cotiviti under the existing contract terms.

If the contract is not extended past the October 7, 2023, end date of the remaining one-year extension period, CalOptima Health will be at risk for a $150,000 upgrade fee and a 2% increase to the contracted contingency percentage (i.e., 19.50% to 21.50%).

Fiscal Impact

The CalOptima Health Fiscal Year (FY) 2022-23 Operating Budget included $2.7 million in funding for the contract with Cotiviti, Inc. through June 30, 2023. Management will include expenses related to the current contract period beginning on July 1, 2023, through any approved contract extension periods in future CalOptima Health operating budgets.

Rationale for Recommendation

Extension of this contract will ensure there is no disruption to the services provided by this solution and the continuation of appropriate claims payment to our providers.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. 19-10311 Verscend Agreement
2. 19-10311 Verscend Agreement Amendment No. 1 Executed
3. 19-10311 Cotiviti Agreement Amendment No. 2 Extension
4. Entities Covered by this Recommended Action

/s/ Michael Hunn — *08/25/2022*

Authorized Signature — **Date**

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CONTRACT NO. 19-10311
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, dba ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba CALOPTIMA and VERSCEND TECHNOLOGIES, INC.
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into the date last signed below, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and VERSCEND TECHNOLOGIES, INC., a Delaware corporation, 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 CONTRACTOR to provide Clinical Editing Solution and 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) CONTRACTOR's proposal dated March 1, 2018, and (iii) CalOptima's Request for Proposal ("RFP") 18-003, if applicable, inclusive of any revisions, amendments and addenda. 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 March 1, 2018.

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 without a replacement meeting the requirements of the Contract being in place 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 $1,200,000 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

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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 is to be covered as an additional insured 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 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.

3.2.7 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.

3.2.8 Thirty (30) days prior written notice without a replacement meeting the requirements of the Contract being in place 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 the Indemnified Parties from and against any third-party 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 any third-party claim and 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.

"Indemnified Parties" refers to (i) CalOptima, (ii) it's officers and directors, and (iii) any of the following of CalOptima who work with or are involved in the services CONTRACTOR provides under Exhibit A: agents, consultants, and employees.

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 insurance limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation. 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.). The parties agree that the limitation of liability in section 4.7 survives as long as any indemnification obligation.

4.5 It is not the intent of the Parties that the provisions of this Section and the Indemnification provision(s) set forth in the Business Associate Protected Health Information Disclosure Agreement executed by the Parties shall be in conflict. In the event of any conflict, the Indemnification provision(s) in the Business Associate Protected Health Information Disclosure Agreement shall be interpreted to relate only to matters within the scope of that Agreement.

4.6 The terms of this Section shall survive the termination of this Contract.

4.7 Limitation of liability

4.7.1 Even if advised of the possibility of Losses, Verscend is not liable for any indirect damages, including any lost profits, data, business, goodwill, anticipated savings, opportunity or use or other incidental or consequential damages, which Client or any third party may suffer as a result of or in connection with this Agreement. Verscend will not be liable for any Losses due to impairments to a deliverable caused by acts of Client's representatives, subcontractors, or suppliers.

4.7.2 Even if Verscend is advised of the possibility of Losses, Verscend will not be liable for any Loss due to: (a) misuse of any data or deliverable by Client; (b) any error or omission in data results or information provided by the deliverable and not caused by Verscend; (c) any inability to use the deliverable; (d) any error or omission in data provided to Verscend; and/or (e) any failure, delay, corruption, error, inaccuracy, discrepancy, incompletion or omission in or made through the deliverable and not caused by Verscend.

4.7.3 Notwithstanding anything to the contrary, or any failure of essential purpose of any limited remedy or invalidity of this Section 4.7, regardless of the form of action, whether incurred with respect to one claim, or cumulatively incurred from multiple related or unrelated claims, Verscend's aggregate liability, if any, to Client or to any third party for claimed Loss arising under this Contract during any specific period will not exceed the lesser of five million dollars ($5,000,000) and three times the amount of fees paid by Client to Verscend for the corresponding deliverable in the twelve months prior to the date the Claim arose; provided, however, (1) the limitation in this section 4.7.3 will not apply for claimed Loss arising under this Contract in a Claim for gross negligence or willful misconduct and (2) the limitation in this section 4.7.3 is not intended to modify the limitation of liability in the BAA with respect to breaches of the BAA only. In the event that a Claim that is subject to this section 4.7.3 arises before the first twelve months of the Contract are complete, the calculation of fees paid will be made by annualizing fees paid since the Effective Date.

4.7.4 Should any Deliverables become the subject of an infringement claim of the kind described in this section, CONTRACTOR shall, at its option and expense, (a) procure for CalOptima the right to make continued use thereof, (b) replace or modify the Deliverable so that it becomes non-infringing, or (c) if such remedies are not reasonably available, request the return of the infringing Deliverable and grant CalOptima a pro-rated credit for the infringing Deliverable. CONTRACTOR shall have no liability if the alleged infringement is based on (1) combination with Third Party products if the alleged infringement relates solely to such combination, (2) modifications by parties other than CONTRACTOR (or persons or entities employed or contracted by CONTRACTOR) if the alleged infringement solely relates directly to such modification, unless such modification was approved by CONTRACTOR, (3) use for a purpose or in a manner for which the Deliverable was not designed, or (4) use of any older version of the Deliverable when use of a newer version that have been made available to CalOptima would have avoided the infringement.

4.7.5 Client hereby expressly acknowledges and agrees that in view of the amount of the fees paid or to be paid hereunder, the limitations of liability in this Section 4.7 and the

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indemnities given in Section 4.1 are in all respects fair and reasonable and reflect a duly considered allocation of risk between the Parties. "Claims" shall mean all claims, requests, accusations, allegations, assertions, complaints, petitions, demands, suits, actions, proceedings, and causes of action of every kind and description.

4.7.6 "Losses" refers to any and all liabilities, costs, damages, payments, judgments, settlements, fines, penalties, and expenses (including, without limitation, reasonable attorneys' fees, disbursements and administrative or court costs) imposed pursuant to a final, unappealable judgment or settlement, as well as interest penalties (as described in Exhibit B, section E).

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 to one or more Verscend employee (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, the following is considered to be an assignment and will be addressed as described in this section 6.2: (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. CONTRACTOR shall provide CalOptima prior written notice promptly upon the public announcement of any deal giving rise to any of the events described here. If, following any of the events described in this section 6.2, CalOptima reasonably determines that CONTRACTOR can no longer meet its obligations required by CMS/DHCS regulations with respect to OIG, SAM, or other exclusion list checks required to do business with CalOptima, then CalOptima may terminate this Contract immediately without any additional cause.

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 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 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.

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

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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

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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.

"Deliverable" means the provision of an Internet- or other data network-available application or consulting, programming, professional or other service by CONTRACTOR to CalOptima, per CalOptima's requirements as defined and agreed to per Exhibit A. Deliverable also means the right of use of any applications by CONTRACTOR to CalOptima, as defined and agreed to in Exhibit A.

CONTRACTOR expressly warrants that all Deliverables will (1) conform to applicable agreed upon specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications; (2) be performed using sound, professional practices and in a competent and professional manner by knowledgeable, trained and qualified personnel; and (3) will be of good workmanship and material. Further, CONTRACTOR expressly warrants that its Edits (as defined in Exhibit A) conform to applicable agreed upon specifications and documentation. CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects of the Deliverables, 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. Contractor does not warrant or guaranty that deliverables will be error free, or that any access to such deliverables will always be uninterrupted. CalOptima's sole and exclusive remedy for breach by Contractor of the foregoing warranty will be for: (i) Contractor to re-perform the nonconforming whole or part of the Deliverable; and (ii) if within thirty (30) business days of receiving notice from CalOptima Contractor fails to provide a specific conforming deliverable, Contractor will provide to CalOptima a proportional refund of the fees (as set forth in Statements of Work) paid by CalOptima for the nonconforming portion of the deliverable. Except as otherwise expressly provided in this section 13, or the applicable statement of work ("Contractor Warranty") Contractor makes no express or implied warranties of any kind, including, but not limited to, warranties of merchantability, fitness for a particular purpose, title, non-infringement, or warranties alleged to arise as a result of custom and usage; all deliverables are advisory and provided on an "as is" basis.

13.3 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. The disclaimer in section 13.3 is hereby agreed to.

13.4 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 The payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority, and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR agrees to abide by the terms of the CalOptima Travel Policy, attached hereto as Exhibit C, and incorporated herein by this reference.

15. Term. This Contract shall commence on October 8, 2018, (the "Effective Date") and shall continue in full force and effect for thirty-six months ("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 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.

The parties agree that, on the Effective Date of this Contract, the Amended and Restated Contract No. MC 03258 dated October 1, 2008, between the parties (the "2008 Contract") will be terminated.

16. Termination.

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16.1 Termination without Cause. CalOptima may terminate this Contract at any time after the first twelve (12) months of the Initial Term, in whole or in part, for its convenience and without cause, by giving CONTRACTOR sixty (60) days' prior 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 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 as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract ("Default") and does not cure such breach or violation within thirty (30) days after written notice by CalOptima that specifies the Default, including but not limited to the section(s) of the Contract at issue and the actions or inactions of CONTRACTOR that caused the Default, and provides reasonable and clearly defined standards for cure. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable direct and actual costs incurred by CalOptima as a result of such default, including, but not limited to, re-procurement costs of the same or similar services defaulted by CONTRACTOR under this Contract, but not including opportunity loss or lost savings or profits; provided, however, CONTRACTOR's total liability under this section 16.3 may not exceed three month's contingency fees. In the event that CalOptima makes any Claim against CONTRACTOR arising out of this Contract following a termination according to this section 16.3, any costs paid by CONTRACTOR under this section 16.3 will be counted toward any Loss arising out of any such Claim.

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.

17.1 CalOptima reserves the right to modify the Contract at any time should such modification be required by CMS or applicable law or regulation and CONTRACTOR agrees to execute the modification if both Parties reasonably agree that the proposed amendment accurately reflects the applicable law or regulation.

17.2 Modifications to this Contract that are desired by CalOptima but not required by CMS or applicable law or regulation will be freely negotiated by the parties.

17.3 All 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

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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 and was not subject to confidentiality obligations on that other party at the time it became known to the party; (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 reports, 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. CalOptima hereby grants CONTRACTOR a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce such reports. Copies may be made

for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such reports shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these reports includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all reports 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 owns and retains all right, title, and interest in and to, including without limitation all Intellectual Property rights, in all software programs (whether or not installed on a CalOptima-owned system), methodology, techniques, the identity of edits and materials, enhancements, derivatives, and modifications to all CONTRACTOR owned Intellectual Property, including without limitation all source code, object code, and documentation associated therewith, and all documentation, report formats, methodologies, algorithms, templates, logic flow, formulae, inventions, methods, systems, processes, works of authorship, and materials which have been or are in the future created, conceived, developed or acquired by CONTRACTOR and which are included in or used in providing the Deliverables, including without limitation all modifications, improvements, derivative works and compilations thereof and thereto (all the foregoing, collectively, "CONTRACTOR IP"). As between the Parties, unless otherwise expressly specified in a Statement of Work, CONTRACTOR will be the owner of all right, title and interest, including all Intellectual Property rights, in and to any code required to provide Deliverables. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the reports, 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 and for the limited purpose of fully utilizing the reports.

CalOptima agrees that all CONTRACTOR IP constitutes the Confidential Information of CONTRACTOR, and CalOptima shall not use or disclose such CONTRACTOR Confidential Information except as permitted herein. CalOptima further agrees that it will not use or disclose such CONTRACTOR IP except solely as necessary to receive the Deliverables described in this Agreement. Without limiting the foregoing, CalOptima shall not, and shall cause its employees or authorized users not to: 1) reverse engineer, decompile, reverse compile, or disassemble the CONTRACTOR IP; 2) create a derivative work or compilation of the CONTRACTOR IP, including without limitation any product or service derived or compiled from or based on, in whole or in part, any Deliverables. CalOptima may not copy, distribute, market, sell, lease, sublicense or otherwise transfer the Deliverables to third parties. Notwithstanding the above, in no way shall CalOptima be prevented from implementing changes to its systems, processes, or contracts that are done in the ordinary course of business or were otherwise arrived at independent of and without reliance on or benefit of the results of the Deliverables provided herein.

20.3 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property in the information, documents, and other materials provided to CONTRACTOR, including but not limited to Application Data, ("CalOptima IP") 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.

20.4 For purposes of this Section, the following definitions apply:

"Intellectual Property" means all inventions, patents, copyrights, trade secrets, trade names, trademarks, know-how, software, shop rights, moral rights, licenses, developments, research data, designs, processes, formulas, and other tangible or intangible proprietary or property rights, whether or not patentable (or otherwise subject to legally enforceable restrictions or protections against unauthorized third-party usage), and any and all applications for, and extensions, divisions,

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derivations, compilations, and reissuances of, any of the foregoing, and rights therein, and whether arising by statute or common law, which are brought to bear to generate a Deliverable or are inherent in the Deliverable itself.

"Application Data" includes but is not limited to individuals' personal, medical, pharmacy, disability, provider or insurance claim information provided by CalOptima or CalOptima's business partners, including without limitation, third party administrators, pharmacy benefit companies and utilization management companies, to CONTRACTOR to create an Application Service, pursuant to the Applications Agreement. Application Data includes, but is not necessarily limited to, claims and membership information for CalOptima insurance plan members.

"Application Service" means any Deliverable whereby users gain access, via an interface provided by CONTRACTOR, to information compiled by CONTRACTOR, in any Internet-available or private data network.

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. 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 and CONTRACTOR agrees to execute the modification if both Parties reasonably agree that the proposed amendment accurately reflects the applicable law or regulation.

Modifications to the Business Associate Protected Health Information Disclosure Agreement that are desired by CalOptima but not required by CMS or applicable law or regulation will be freely negotiated by the parties.

All modifications to the Business Associate Protected Health Information Disclosure Agreement shall be executed only by a written amendment, signed by CalOptima and CONTRACTOR.

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. Offshore Performance.

25.1 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.

25.2 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.

25.3 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.

25.4 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.

25.5 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.

25.6 The provisions of this Section apply to work performed by subcontractors at all tiers.

26. FDR Compliance. Upon execution of this Contract, CONTRACTOR agrees to execute and abide by the terms of the "FDR Compliance Attestation," which is attached hereto as Exhibit F and incorporated herein by this reference, and shall submit an executed FDR Compliance Attestation no less than annually thereafter.

27. 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.

28. Time is of the Essence. Time is of the essence in performance of this Contract.

29. 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.

30. 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.

31. 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.

32. 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.

33. 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:
Verscend Technologies, Inc.	CalOptima
201 Jones Road	505 City Parkway West
Waltham, MA 02451	Orange, CA 92868
Attention: Legal Department	Attention: Kim Marquez

34. Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall promptly notify and submit all relevant, reasonable information to CalOptima.

35. Unavoidable Delays.

35.1 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.

35.2 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.

35.3 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.

36. 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.

37. 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 arbitration, action or proceeding.

38. 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.

39. Headings. The section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

40. 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.

41. 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.

42. 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.

43. Debarment and Suspension Certification.

43.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

43.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

43.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

43.2.2 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;

43.2.3 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 43.2.2 herein;

43.2.4 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;

43.2.5 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

43.2.6 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.

43.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

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

43.5 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.

44. Lobbying Restrictions and Disclosure Certification.

44.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

44.2 Certification and Disclosure Requirements.

44.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or sub grant, 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 44.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

44.2.2 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 44.3 of this provision if paid for with appropriated funds.

44.2.3 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 44.2.2herein. An event that materially affects the accuracy of the information reported includes:

44.2.3.1 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;

44.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

44.2.3.3 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.

44.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 44.2.1of this provision a contract, subcontract, grant or sub grant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

44.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 44.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

44.3 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.

45. 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.

46. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Limitation of Liability, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

47. 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.

48. 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.

49. 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.

50. 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.

51. 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. 19-10311 on the day and year last shown below.

Verscend Technologies, Inc.	CalOptima
By: DocuSigned by: [signature] 7E43D55B04BB4E0	By: [signature]
Print Name: David Mason	Print Name: Greg Hamblin
Title: COO	Title: CFO & Treasurer
Date: 9/28/2018	Date: 9-28-18

By: DocuSigned by: Felix Morgan 47FF52BAADE3487	By: [signature]
Print Name: Felix Morgan	Print Name: Michael Schrader
Title: CFO	Title: CEO
Date: 9/28/2018	Date: 10-01-18

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required

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Exhibit A, "Scope of Work"

CONTRACTOR shall provide to CalOptima Claim Accuracy services. These services are for CalOptima's Medi-Cal, OneCare Connect, and OneCare Medicare Advantage Special Needs Plan programs only. CalOptima will submit Claims to CONTRACTOR to edit each claim as further described in Schedule 1. CalOptima is ultimately responsible for final utilization review and maintains sole and complete authority to adjudicate claims.

CalOptima does not guarantee any volume of claims will be submitted to CONTRACTOR for review, however, CalOptima will submit, according the format and timing agreed to, Medi-Cal, OneCare Connect and OneCare claims to CONTRACTOR for processing as described herein.

1. **Solution.** The following Schedules marked with an "x" are hereby incorporated into this SOW:

   ☒ Schedule 1: Claim Accuracy

   ☒ Claims Editing: ☒ Batch | ☐ Real Time

   ☒ Clinical Validation: ☒ Batch | ☐ Real Time

   ☒ Schedule 2: Service Level Agreements

   ☒ Schedule 3: Claim Accuracy Edits Artifact

   ☒ Schedule 4: Claim Accuracy Reports

2. **Implementation**

   A. **Platform Upgrade.** The parties acknowledge and agree that they intend to upgrade CalOptima from CONTRACTOR's platform currently in production for CalOptima to the then current version of CONTRACTOR's platform.

   B. **Team.** CONTRACTOR and CalOptima will each assign a designated project manager and implementation team with appropriate business and technical expertise, and decision-making authority to fulfill their obligations in the Project Plan.

   C. **Project Plan.** The parties will develop a project plan, which will include deliverables and anticipated timelines, and that the parties will use the project plan to guide the implementation process (the "**Project Plan**"). The following table outlines the implementation phases and high-level tasks associated with each phase that are typically included in the Project Plan:

Project Plan Outline	
Phase	Key Tasks
Phase I – Planning	Joint Kick-off Meeting Product Demonstration, if applicable Solution Deep-Dive Joint Requirements definition via Workshops General Testing Discussions Joint Project Plan
Phase II – Build and Test	Project requirements finalized Environment Set-Up & Connectivity Established Development & System Configuration (including review and Configuration of Edits to CalOptima requirements

	Data Exchange & Validation User Training for Test Execution Test Plan Development & Execution using historical CalOptima data Go or No-Go Decision
Phase III – Deploy	Finalize Operational & Support models User Training Migrate to production Go-Live
Phase IV – Operate	Verscend Client account team will provide ongoing technical and business support Verscend will provide program performance metrics & Monthly/Quarterly Release Notes

D. **Go-Live.** The "**Go-Live Date**" refers to the date that CalOptima first submits Prepayment Claim Data to CONTRACTOR for production.

E. **Implementation Training.** During implementation, CONTRACTOR shall provide CalOptima up to 32 hours of training, as requested by CalOptima and subject to CONTRACTOR availability.

F. **Implementation Documentation.** During implementation, CONTRACTOR shall provide CalOptima with the following project artifacts:

(1) **Project Plan.** A document providing a work breakdown structure of all milestones and tasks, which CalOptima will have access to review or download at any time.

(2) **Technical Integration Plan.** A documented plan to address new integration requirements stemming from a review of the existing CalOptima configuration and environment.

(3) **Clinical Configuration Document.** A document outlining CalOptima-specific Edit Configurations and Edit decisions made by CalOptima based on CalOptima policies.

(4) **Joint Testing Plan.** A system and user acceptance testing (UAT) plan that includes CalOptima signoff as final step.

3. **Support Services**

A. **Help Desk and Portal.** CONTRACTOR shall make available to CalOptima help desk support during Business Hours, as well as a CalOptima portal containing additional product documentation and a means of communication with CONTRACTOR.

B. **Training.** Following implementation, CONTRACTOR shall provide CalOptima up to eight hours of training annually, as requested by CalOptima and subject to CONTRACTOR availability. CONTRACTOR shall provide training for any upgrades or new features as needed to CalOptima. Additional training may be requested through a Work Order.

C. **Standard Support.** CONTRACTOR's standard application support includes the following: one planning call each year; one quarterly status review with the account team, during which CalOptima should address concerns; calls with the CONTRACTOR account team, which may include a business analyst, on a mutually determined frequency, which may not be more frequent than weekly; and phone support during Business Hours.

D. **Additional Support.** CalOptima may request support beyond that which is described in this section by

submitting a Work Order.

4. **Performance Standards.** See Schedule 2 to Exhibit A.

5. **Fees.** See Exhibit B.

6. **Modifications and Interpretation**

   A. **Work Orders.** In order to request Additional Services, CalOptima may request work order from CONTRACTOR through its account management contact (a "**Work Order**"). The Work Order must specify the work to be performed and the fee. For work requested in a Work Order that corresponds to an Additional Service outlined in this SOW, the fees in the Additional Services Fee Table in this SOW will apply, unless CONTRACTOR AND CalOptima agree on a different fee schedule for any particular Work Order and should be indicated in the Work Order. For work requested in a Work Order that does not correspond to the Additional Services outlined in this SOW, additional fees will be proposed by CONTRACTOR and indicated in the Work Order. Work Orders are not enforceable until they have been validly executed by both parties and a CalOptima Purchase Order is issued. CONTRACTOR is not obligated to agree to each work order submitted by CalOptima. Work Orders made pursuant to this SOW are subject to the terms of this SOW. If there is any discrepancy or ambiguity in interpretation such that a term of this SOW potentially conflicts with a term or condition of a Work Order made pursuant to this SOW, the relevant term or condition of this SOW controls.

   B. **Changes to Artifacts.** Artifacts are documents that provide additional information about the Solution that are not a part of this SOW and may be modified by CONTRACTOR at any time.

   C. **Controlling Agreement.** Unless explicitly amended by a term in this SOW, the terms and conditions of the Contract remain in force. If there is any discrepancy or ambiguity in interpretation such that a term of this SOW potentially conflicts with a term or condition of the Agreement, the relevant term or condition of this SOW controls.

   D. **Time.** All references to time of day are references to the time in Eastern Time.

7. **Definitions.** In addition to the integrated definitions throughout this SOW, in this SOW, the following definitions apply:

   "**Additional Services**" refers to services that are described in this SOW as available at the request of CalOptima. Additional Services are subject to additional fees.

   "**Authorized Users**" refers to named, licensed users of the applications described in the Schedule.

   "**Business Days**" refers to CONTRACTOR's business days, which are Monday through Friday, except for CONTRACTOR Holidays.

   "**Business Hours**" refers to CONTRACTOR's business hours which are 8:00 a.m. to 8:00 p.m. ET on Business Days.

   "**Fee Table**" refers to the table in section A of Exhibit B. Each capitalized term in the description column of the Fee Table is considered a defined term, referring to the fee or rate listed for that term in the second column.

   "**Schedule**" refers to the documents attached to this SOW that describe the products or services CONTRACTOR will provide CalOptima. In this SOW, Schedule specifically refers to those schedules identified in section 1.

   "**Solution**" refers to the products and services described on the attached Schedules.

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"SOW" stands for statement of work and specifically refers to this agreement, which is comprised of this statement of work and any attached Schedules.

"Term" refers to the initial term plus any renewal periods.

"CONTRACTOR Holidays" CONTRACTOR's holidays, which are New Year's Day, Martin Luther King Jr. Day, President's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving, and Christmas Day, or those CONTRACTOR reasonably notifies CalOptima of in advance.

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Schedule 1, "Claim Accuracy Solution Description," to Exhibit A, "Scope of Work"

1. **Description**

A. **Claim Accuracy.** Claim Accuracy is a CONTRACTOR-hosted software-enabled service, composed of two modules, Claims Editing and Clinical Validation. In order to provide the Solution, CONTRACTOR may use CalOptima's data to provide CONTRACTOR products and services. CalOptima is ultimately responsible for final utilization review and maintains sole and complete authority to adjudicate claims.

(1) **Claims Editing.** CONTRACTOR's Claims Editing service reviews Prepayment Claims Data to identify Claims that are incorrectly coded or for which payment should be reduced. The Claims Editing service includes the Edits listed on the Claim Accuracy Edit Artifact, hereby attached as Exhibit A, including Medi-Cal specific Edit. CONTRACTOR returns edited Claims to CalOptima that are found to have an error that may result in improper payment as "**Recommendations.**"

(2) **Clinical Validation.** CONTRACTOR's Clinical Validation service provides clinical assessment of Prepayment Claims Data. The Clinical Validation service includes the Edits listed on the Claim Accuracy Edit Artifact, including Medi-Cal- specific edits. CONTRACTOR returns edited claims to CalOptima that are found to have an error that may result in improper payment as Recommendations.

(3) **Claim Accuracy Appeals Support.** CONTRACTOR's appeals support service reviews disputes by providers of ALL CONTRACTOR's Recommendations for which CalOptima provides documentation that supports services rendered (such a request, an "**Appeal**"). In response to an Appeal, CONTRACTOR's appeals support services provides an "**Appeal Response,**" containing an updated Recommendation to CalOptima that recommends either upholding or overturning the original Recommendation.

(4) **Edit Configuration and Customization.** Edits in the Solution may be configured, and new Edits may be developed, as described in this section.

(a) **Edit Configuration.** Edits can be activated, suppressed, or configured, changing the way an Edit applies (a "**Configuration**").

(b) **New CONTRACTOR Edits.** CONTRACTOR's standard Edits available in Contractor's Claims Editing service are listed in the Claim Accuracy Edit Artifact. CONTRACTOR may develop new Edits from time to time. As CONTRACTOR offers new Edits or Configurations, CalOptima will have the option to deploy each new Edit or Configuration.

(c) **Custom Edits.** CalOptima may request a Custom Edit by submitting a Work Order. "**Custom Edits**" are Edits that require development to either make changes to existing Edits or to create a new Edit specific to CalOptima's business requirements or Edits out of scope as mentioned in section (1) Claims Editing and/or (2) Clinical Validation. If an edit for a specific criterion does not function in the manner in which it is described in any written, agreed-upon specifications, then no charge will apply to the re-development of the edit. Contractor may not charge for any Custom Edits it agrees to build to allow CalOptima to comply with Medi-Cal- specific edits, National Medicare and Medicaid CCI edits, or Medicare policy manuals.

(5) **Claims Accuracy Application.** Claims Accuracy offers the following application services (the "**Claim Accuracy Applications**"):

(a) **Claim Accuracy Application.** CONTRACTOR's SaaS-based application, which provides access to Recommendations, through Authorized User accounts.

(b) **Claim Accuracy API.** CONTRACTOR's web API that can be integrated into the CalOptima's systems and provider portal and is accessed through a single authorized user name.

(c) **Clinical Validation Dashboard or Application.** CONTRACTOR's SaaS-based application that provides a CalOptima the ability to initiate and support Clinical Validation Recommendations and Appeals.

2. **CONTRACTOR Responsibilities**

A. **Claim Accuracy Recommendations.** CONTRACTOR shall provide Claim Accuracy Recommendations to CalOptima.

(1) CalOptima shall transmit provider files and member files on a Pre-payment basis to CONTRACTOR. These two files shall be updated daily. CONTRACTOR shall utilize previously supplied data dictionaries, file layouts and comprehensive historical claims data to compare daily adjudicated claims against.

(2) CalOptima shall transfer adjudicated claims data via FTP to CONTRACTOR on a daily basis by 2:00AM PST (Pacific Standard Time). Such transfer shall occur after all updates to the CalOptima computer system have been completed. CONTRACTOR shall provide CalOptima a mutually agreed to secure file transfer protocol key to encrypt the outbound claims data. The same key will be used by CalOptima to decrypt the return inbound claims from CONTRACTOR.

(3) CONTRACTOR shall normalize CalOptima claims data and load all such data into a database table. CONTRACTOR shall perform analysis on all data to assure that it is properly formatted. Improperly formatted data will be transmitted to the CalOptima Claims department to identify errors.

(4) CONTRACTOR shall import the remaining normalized data into the CONTRACTOR system and perform cross-walking of CalOptima-defined crosswalk data. CONTRACTOR shall be responsible for updating its CONTRACTOR reference files with updated data sets monthly or as industry standards occur. Sources for changes include CPT, CPT Assist, AMA, National Correct Coding edits, Centers for Medicare and Medicaid Benefits Manual, CMS' National Physician Fee Schedule, the Federal Register, as well as other information published by various medical specialty societies concerning coding and reimbursement.

(5) CONTRACTOR shall process all claim line items through the Claim Accuracy solution to determine if each claim is processed correctly based upon applicable coverage, coding and reimbursement rules. Suspect claims that are identified are reviewed between 8AM and 12 Noon MST by CONTRACTOR RN coding specialists. Claims identified as suspicious after CONTRACTOR review are posted on CONTRACTOR website. CalOptima claims processors shall review these claims on the website. CalOptima has sole discretion to "accept", "not accept" or "request logic" for payment recommendations of CONTRACTOR claims. Claims accepted for payment will be processed during the next claims adjudication run.

(6) CONTRACTOR shall produce a monthly report identifying claims without recommendations by CalOptima (30 days prior to the 90-day window.)

(7) ONTRACTOR shall continuously monitor, record and make accessible in the system for CalOptima the

daily turnaround time for all Claim Accuracy Recommendations submitted. CONTRACTOR shall provide CalOptima with monthly reports such as turnaround time (TAT) that show daily and average turnaround times commencing within thirty (30) days of execution of this Contract

B. **Appeals Responses.** CONTRACTOR shall provide Appeals Responses to CalOptima for Appeals submitted by CalOptima, including Appeals submitted for PCI (as defined in the 2008 Contract) Recommendations under the 2008 Contract.

(1) All first-level appeals received by CalOptima shall be uploaded by CalOptima to the CONTRACTOR website along with the medical records submitted by the provider. CalOptima is responsible for determining whether the provider has submitted medical records. CONTRACTOR will not process appeals on claims/lines not reviewed by CONTRACTOR.

(2) CONTRACTOR will make adjustments and refunds to CalOptima as provided in Exhibit B based upon any changes to review findings through CONTRACTOR's resolution process, or though adjustments made by CalOptima or adjustments made by CalOptima on the CONTRACTOR website, including, but not limited to, those adjustments resulting from the appeals process, the government claims process, or litigation.

C. **Right to Access.** During the Term, CONTRACTOR shall provide CalOptima the nonexclusive, non-assignable, royalty free, worldwide, limited right to access the Claim Accuracy Applications solely for CalOptima's internal business operations and subject to the terms of the Agreement.

D. **Authorized Users.** CONTRACTOR will provide CalOptima 30 Authorized User accounts for the Claim Accuracy Applications. Additional Authorized Users may be added for an additional fee.

E. **Standard Reports.** CONTRACTOR shall provide CalOptima all then-current standard reports, which offer insight into operations and program effectiveness. See Schedule 4 to Exhibit A. CalOptima may request additional reports by submitting a Work Order.

3. **Assumptions**

A. **Integration and Environments.** The Solution will be provided in a ☒ Batch, ☒ Real-Time integration.

(1) Batch integrations include one UAT environment and one production environment.

(2) Real time integration includes one development, one UAT, and one production environment. Additional environments may be requested in a Work Order and will be subject to additional fees.

B. **Secure Transfer.** All data will be transmitted between the parties using secure means agreed to by the parties.

C. **Position.** CONTRACTOR's Claim Accuracy Solution will be the first editor in CalOptima's editing process for the Term of this SOW.

D. **Scope.** Following the Go-Live Date and throughout the Term of this SOW, CalOptima shall submit to CONTRACTOR for editing CalOptima's Professional Claims and Outpatient Facility Claims for all of CalOptima's populations, platforms, product lines, and territories. CalOptima may add additional populations or platforms to this SOW by submitting a Work Order, which may be subject to reasonable additional implementation fees and will be subject to the same shared savings rates.

E. **Acceptance.** Acceptance will be deemed to be made as of the date CONTRACTOR provides CalOptima access to the Claim Accuracy Application.

4. **CalOptima Responsibilities**

   A. **Point of Contact.** CalOptima shall appoint a dedicated project team with appropriate business and technical expertise for requirements, design, and testing.

   B. **Supply Data.** CalOptima shall supply the necessary data feeds and supporting documentation for production of the service. CalOptima shall provide CONTRACTOR with CalOptima's Prepayment Claim Data, Paid Claim Data, and Utilization Data, as often as the parties agree. For each Claims submission, CalOptima shall provide CONTRACTOR with CalOptima's Professional Claims and Outpatient Facility Claims for editing. CalOptima shall provide CONTRACTOR with CalOptima's Inpatient Facility Claims and Capitated Claims to provide context for the Clinical Validation services. In each data submission, CalOptima shall include all data elements required by CONTRACTOR.

   C. **Data Submission During Implementation.** For Implementation, CalOptima shall provide CONTRACTOR twelve months of all data described in Section 4.B., above, and Paid Claims Data.

   D. **Edit Configuration.** CalOptima shall notify CONTRACTOR of requested Edit Configurations using CONTRACTOR's standard notification method.

   E. **Production Support.** CalOptima shall comply with CONTRACTOR's escalation procedures.

   F. **Format.** CalOptima shall submit Claims in CONTRACTOR's CIF file format or any agreed upon format that fulfills all data elements required by CONTRACTOR.

   G. **Demand Forecasting.** CalOptima shall make good faith efforts provide CONTRACTOR its membership eligible for editing forecast at least 90 days prior to the Go-Live Date. Then, CalOptima shall provide CONTRACTOR at least 90 days prior written notice of changes to its membership eligible for editing by more than 10% of its membership.

   H. **Appeals Delegation**

      (1) CalOptima will delegate an Appeal to CONTRACTOR only if:

         (a) It is a claim for which CONTRACTOR provided a Edit that CalOptima accepted;

         (b) The provider has attached medical records, and

         (c) Either,

            (1) It is the provider's first appeal of the Claim Accuracy Edit; or

            (2) Additional medical records have been provided since the first appeal.

      (2) CalOptima will make medical record documentation available to CONTRACTOR.

   I. **Post-Appeal Payment Adjustments and Response to Provider**

      (1) CalOptima will review and make the final determination to adjust the Appealed claim or not and will respond to the provider.

      (2) CalOptima will make a work queue available to CONTRACTOR that contains Finalized Claims Data for all Appeals.

      (3) CalOptima will update the Utilization Data as applicable and provide to CONTRACTOR.

   J. **Unauthorized Access.** CalOptima shall notify CONTRACTOR immediately of any unauthorized use of any

password or Authorized User account or any other known or suspected breach of security.

K. **Hardware.** CalOptima shall provide internet access, computers, and software to its Authorized Users to allow for access to the Claims Accuracy Applications.

5. **Additional Definitions.** In addition to the definitions provided in the SOW and the integrated definitions throughout this SOW and Schedule, in this Schedule, the following definitions apply:

"**ANSI**" stands for American National Standards Institute.

"**Capitated Claims**" refers to claims for healthcare service providers for which CalOptima does not make fee for service payments.

"**Claims**" refers to CalOptima's claims submitted to CONTRACTOR for editing.

"**Dental Claims**" refers to claims billed for services by a dentist or other dental entity, typically on an American Dental Association (ADA) claim form.

"**Inpatient Facility Claims**" refers to those services that are billed by a provider of inpatient services on a UB04 Form or equivalent format that are associated with an inpatient or hospital stay.

"**Outpatient Facility Claims**" refers to those services billed by a provider of professional services on a UB04 Form or equivalent format that are not associated with an inpatient or hospital stay. Examples include, but are not limited to ambulatory care, radiology, and physical therapy services.

"**Pharmacy Claims**" refers to claims billed for prescription drugs and devices billed by a licensed pharmacy on a National Council for Prescription Drug Programs (NCPDP) form.

"**Professional Claims**" refers to claims billed for services by a provider of professional services on a CMS 1500 Form or equivalent format such as ANSI 837p.

"**CMS**" stands for Centers for Medicare and Medicaid Services.

"**Edits**" are rules or processes applied to Claims by the Solution that may correspond to an adjustment in the Claim's payment amount.

"**Paid Claim Data**" refers to Claims data after it has been finalized in CalOptima's transaction system.

"**Prepayment Claim Data**" refers to Claims data before it has been finalized in CalOptima's transaction system.

"**Utilization Data**" refers to the final outcome of the claims after processing by CONTRACTOR has been completed and the claim has been finalized in the CalOptima's transaction system.

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Schedule 2, "Service Level Agreements," to Exhibit A, "Scope of Work"

1. Contractor shall provide the Solution in accordance with the SLAs described in this Exhibit.

2. Underperformance Credits each month are subject to a cap of $3,000. To invoke an Underperformance Credit, CalOptima must, in writing, notify Contractor of the Underperformance within 30 days of the end of the month during which the Underperformance occurred and request the appropriate Underperformance Credit be applied to the next invoice. Contractor's obligation to pay Underperformance Credits is subject to the following conditions: CalOptima followed the appropriate notification procedures; the escalation procedure was followed, if applicable; CalOptima is not responsible for the failure.

3. The SLAs are as follows:

Title	Description	Target		Underperformance Credit	Credit Frequency
System Uptime	Contractor shall ensure that its systems required to provide the Solution will be available at or above the Target, measured on a monthly average basis.	98% of the time, 24-hour per day, seven days per week, with the following exceptions: Contractor Holidays; 7:00 p.m. Saturday to 6:00 a.m. Sunday (the "**Maintenance Window**"); downtime caused by CalOptima; and any other emergency or mutually agreed to maintenance scheduled as described in the Maintenance Policy described below.		$600	Monthly, based on Contractor's average performance in the previous month
Support Response Time	Contractor shall provide an initial response to CalOptima's support requests within the timeframes indicated for each severity level (as those are described below) in the Target. The parties shall use the Escalation Procedure for unresolved issues.	Severity Level 1	1 hour	$300	Per occurrence
		Severity Level 2	3 hours		
		Severity Level 3	1 Business Day		
		Severity Level 4	3 Business Days		
Claim Accuracy Turnaround Time	Contractor shall provide an initial response to all batch Claims within the Target, excluding Surges, measured on a monthly average basis. Claims response time will be measured from the Contractor gateway, and transport time and any	8 hours Business Hours		$900	Monthly, based on Contractor's average performance in

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	file queuing resulting from a previous Claim file still in process will be excluded from the claims response time calculation.			the previous month
Appeals Turnaround Time	Contractor shall return all Claim Accuracy Appeals within the Underperformance Target, measured on a monthly average basis. Contractor's turnaround time will be calculated from the time the Claim is received in Contractor's Claim Accuracy system, until the time the Claim leaves Contractor's Claim Accuracy system. Contractor will exclude Claim Accuracy Appeals from SLA Appeal Turnaround Time for appeals impacted by CalOptima system downtime.	10 Business Days	$900	Monthly, based on Contractor's average performance in the previous month
Expedited Appeals Turnaround Time	Contractor shall return all Claim Accuracy Appeals for which CalOptima requests expedited review within the Underperformance Target, measured on a monthly average basis. Contractor's turnaround time will be calculated from the time the Claim is received in Contractor's Claim Accuracy, until the time the Claim leaves Contractor's Claim Accuracy system. Contractor will exclude Claim Accuracy Appeals from SLA Appeal Turnaround Time for appeals impacted by CalOptima system downtime.	4 Business Days	$900	Monthly, based on Contractor's average performance in the previous month

4. As referenced in the table above, Contractor's "**Maintenance Policy**" is as follows:

   a. Emergency Maintenance. In the event that Contractor needs to conduct emergency maintenance resulting in a downtime outside of the Maintenance Window, Contractor will provide as much notice as is practical under the circumstance to CalOptima to allow for an orderly

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shutdown of the relevant systems used by the CalOptima. Contractor will use commercially reasonable efforts to minimize emergency maintenance of the system.

b. Extended Maintenance. From time to time, Contractor may need to conduct maintenance on the system that may extend beyond the Maintenance Window. Contractor agrees not to perform extended maintenance without communicating to the CalOptima at least 15 calendar days in advance. Contractor agrees not to conduct extended maintenance during standard Business Hours.

c. Maintenance Notification. Standard maintenance will occur on a regularly scheduled basis during the Maintenance Window. Maintenance will be done on a rolling basis across the system, ensuring that the system remains available to CalOptima during the maintenance. In the event that the standard maintenance requires downtime, Contractor will provide advance notification to the CalOptima at least five business days ahead of the standard scheduled maintenance.

5. As referenced in the table above, the "**Escalation Procedure**" for this SOW is as follows: In the event a Severity Level 1 or 2 problem is escalated, the problem will be escalated to a senior Contractor support manager who will update CalOptima's senior information security personnel and authorized CalOptima technical contact twice a day until the problem is resolved. If the problem is not resolved within 48 hours, the issue will be escalated to Contractor's chief operating officer and to CalOptima's chief information officer.

6. In addition to the integrated definitions throughout this Exhibit and the SOW, in this Exhibit and SOW, the following definitions apply:

"**Severity Level 1**" exists when CalOptima's production use of the Solution is so severely impacted that CalOptima cannot reasonably continue work. Severity Level 1 problems may include catastrophic failure of the system; major data loss or data corruption; or critical functionality is not available, impacting a majority of the CalOptima's Authorized Users. If the condition is cause by CalOptima, it is not considered a Severity Level 1 issue. Severity Level 1 problems must be reported via telephone.

"**Severity Level 2**" exists when CalOptima's production use of the application is functioning with limited capabilities or is unstable with periodic interruptions. The software may be operating but is severely restricted with no acceptable workaround. If the condition is cause by CalOptima, it is not considered a Severity Level 2 issue.

"**Severity Level 3**" exists when product features are unavailable, but a workaround exists, and the majority of software functions are still useable. Severity Level 3 problems may include, error message with workaround; minimal performance degradation impacting a small subset of users at a time, typically less than five; incorrect product behavior with minor impact to less than five people; or questions on product functionality or configuration during implementation. If the condition is cause by CalOptima, it is not considered a Severity Level 3 issue.

"**Severity Level 4**" exists when CalOptima experiences a minor problem or has a question that does not affect the software function, such as "how to" questions, documentation, general questions, or enhancement requests, and there is no impact to product usage or CalOptima's operations. Severity Level 4 problems may include general requests for advice on product usage, clarification on product documentation or release notes, or product enhancement requests. If the condition is cause by CalOptima, it is not considered a Severity Level 4 issue.

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"**SLA**" stands for service level agreement.

"**Surge**" refers to a continuous rolling six-hour period on a Business Day during which the claim volume Contractor receives under this agreement exceeds the peak volume received in the previous two months by 15% or more outside of any Surges in that month.

"**Target**" refers to, generally, the target metric for SLAs and, specifically, as it relates to any specific SLA, the target for that SLA.

"**Underperformance**" refers to Contractor failing to meet the target of a service level.

"**Underperformance Credit**" refers to the amount owed to CalOptima for Contractor's Underperformance, which will be applied to CalOptima's future invoices, subject to the SLA management provisions. Specific Penalty amounts for each SLA are identified below that SLA.

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Schedule 3, "Claim Accuracy Edits Artifact," to Exhibit A, "Scope of Work"

This is a list of the Edits available in the Solution at the time of the Effective Date. This list may change from time-to-time without amendment to the Agreement.

Flag	Flag Short Description	Flag Long Description
ACW	Incorrect Anesthesia Code	Provider has used a surgical procedure code to bill for anesthesia services. An anesthesia code is required for reimbursement.
ADD	Add-on Denied as Primary Code Denied	Identifies add-on codes that need to be disallowed because the primary procedure has been disallowed.
ADM	Services Within Discharge Time Frame	Under Development
AGE	Inappropriate for Age	Identifies codes billed by the provider that are incorrect, based on the code description, for the patient on the date of service.
AGM	Ancillary Ante Partum	Identifies ancillary services that are included in routine ante partum care billed either will global maternity codes or E&M codes.
ANT	Antepartum Services included in global Code	It is not appropriate to report the antepartum, delivery, and postpartum care separately when a single physician or the physicians of the same group practice provide the total obstetrical care.
AOM	Add-on Code Missing Primary Code	Identifies situations in which an add-on code has been reported without a primary procedure code(s).
ASD	Services Associated with Non-Covered Services	Identifies services rendered in conjunction with a service that is not covered.
ASM / RASM	Does Not Match Surgeon	Identifies procedure code(s) billed by an assistant surgeon that do not match the procedure code(s) billed on the same date by the provider identified as the primary surgeon. The assistant surgeon should be billing the same procedure codes as the primary surgeon. RASM (Reverse ASM edit)
ASN	Assistant Surgeon Necessary	Identifies procedures for which an assistant surgeon is only allowed with supportive documentation.
ASR	Assistant Surgeon Reductions	Identifies those situations in which a reduction in payment should apply for services provided by an assistant surgeon.
BIL	Bilateral Disallowed	Identifies procedures that cannot be billed bilaterally or already include bilateral reimbursement.
COS	Cosmetic Procedure	Identifies procedures that may be cosmetic.
CPD	Cross Provider Duplicate	Identifies services that have already been billed by another provider for the same patient and date of service.

Flag	Flag Short Description	Flag Long Description
CPR	Multiple Cardiology Procedures Reduction	Identifies situations in which a reduction in payment has been made for multiple cardiology procedures performed on the same day.
CPRC	Multiple Cardiology Procedures, Carrier Priced	Identifies procedures for which a co–surgeon is not allowed.
CSA	Co-Surgeon Inappropriate	Identifies procedures for which a co–surgeon is only allowed with supportive documentation.
CSN	Co-Surgeon Necessary	The reimbursement has been adjusted to reflect payment for co-surgeons.
CSR	Reduce, Surgical Team	Identifies procedure codes that are not valid CPT, HCPCS or state codes on the date of service.
DEL	Deleted Code	Identifies procedures that are for the same patient, provider and date of service as a previous claim.
DUP	Duplicate Billing	Reimbursement has been adjusted as multiple procedures were performed at the same time with the same instrument.
EFR	Endoscopic Family Reduction	Identifies when procedure codes have been assigned to an incorrect revenue code. RFLU (Reverse FLU edit)
FLU / RFLU	Florida Unbundling Revenue Codes	Identifies procedures that exceed the number of services allowed over a specific time period. Units under the allowance are recommended for reimbursement.
FOT	Frequency Over Time	Identifies when the number of units or lines billed on the same day by the same provider exceeds the maximum allowance.
FRE	Reimbursable Once Per day	Identifies E&M services billed in the post operation period that are included in the value of the surgical procedure.
FUD / GPA	Part of Global Service	Identifies services billed during the ante partum or post partum periods that are reimbursed in the value of another procedure code.
GDR	Ante Partum Care Included in Global Code	Identifies procedure codes that do not match the patient's gender based on the value submitted by the payer.
GEN	Incorrect Patient Gender	The GPA edit identifies E&M services that have been paid but a later claim with a surgical procedure makes the E&M not reimbursable. Recovery of the incorrectly paid code will be initiated.
GPA / FUD	Part of Global Service	Identifies outpatient services billed within the preadmission window of an inpatient admission.
HPRE / OPRE	Outpatient service within the preadmission window	Identifies reductions when multiple imaging procedures are performed on the same date of service.

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Flag	Flag Short Description	Flag Long Description
IFR	Multiple Radiological Procedure Reductions	Identifies procedure codes that are not valid CPT, HCPCS or state codes on the date of service.
INVC	Invalid CPT/HCPCS Code	Identifies revenue codes that are not valid revenue codes on the date of service.
INVR	Invalid Revenue Code	Identifies procedures that CMS requires performed at an inpatient only setting.
IOP	Inpatient Only Procedure	Identifies when the number of units or lines billed for a patient exceeds the maximum allowance for a patient's lifetime.
LIF	Service Exceeds Lifetime Patient Allowance	Identifies services that need to be reduced services as indicated by the presence of modifier 52.
M52	Modifier 52 reduction	Identifies services that need to be reduced services as indicated by the presence of modifier 53 indicating discontinued services.
M53	Modifier 53 reduction	Identifies services that need to be reduced services as indicated by the presence of modifier 73 indicating discontinued services.
M73	Modifier 73 reduction	Identifies services that need to be reduced services as indicated by the presence of modifier 74 indicating discontinued services.
M74	Modifier 74 reduction	Identifies maternity services that have been reimbursed by another procedure code.
MAT	Part of Global Service	Identifies procedures where a reduction for bilateral procedures is needed.
MAX	Exceeds Daily Limits	Identifies procedures that typically should not be billed together. RMEA (Reverse MEX)
MEX / RMEA	Mutually Exclusive Unbundled	HCI's Clinical Director has determined procedure code(s) warrant additional clinical review for medical necessity.
MNR	Review for Medical Necessity	Identifies procedure codes incorrectly billed with modifier -26 (professional component). These procedures cannot be billed with modifier -26 or the procedure does not have a professional component.
MOD	Inappropriate Use of Modifier 26	Identifies procedure codes that need to be reduced to because multiple procedures have been performed on the same date of service by the same provider.
MPR	Multiple Procedure Reduction	Identifies procedure codes incorrectly billed with modifier -TC (technical component). These procedures cannot be billed with modifier -TC or the procedure does not have a technical component.
MTC	Inappropriate Use of TC Modifier	Identifies procedure codes that need to be reduced to because multiple therapy procedures have been performed on the same date of service by the same provider.
MTR	Multiple Therapy Procedures Reduction	Identifies services that are not covered.

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Flag	Flag Short Description	Flag Long Description
NCS	Not Covered by Plan	Identifies situations in which a lab procedure has been submitted with a diagnosis code that does not support medical necessity.
NCD / NCDN	National Coverage Determination	Identifies situations in which a lab procedure has been submitted with a diagnosis code that does not support reimbursement.
NCD - ALL Dx Codes	National Coverage Determination - All Dx Codes	Identifies services, based on the presence of modifiers<>, which represent medical mistakes or errors that are not reimbursable.
NEV	Never Paid Events	Identifies E&M services billed with a new patient E&M code when the provider has billed other services which make the patient an established patient.
NPR	New E&M not allowed	Identifies the established patient procedure code that the provider should have billed because the patient is an established patient for the provider.
NPT	New E&M Not Allowed	Identifies outpatient services billed within the preadmission window of an inpatient admission.
OPR	Multiple Ophthalmology Procedures Reduction	Identifies situations in which a reduction in payment has been made for multiple ophthalmology procedures performed on the same day.
OPRE / HPRE	Outpatient service within the preadmission window.	Identifies situations in which the amount being paid is greater than the billed charges.
PAY	Paid Amount Exceeds Billed	Identifies procedure codes where the diagnosis codes preclude reimbursement for the procedure code.
PEDM	Procedure to Excluded Diagnosis Mismatch	Identifies procedure codes where the diagnosis codes required reimbursements for the procedure code are not present on the claim.
PFUD	Procedure Follow Up days	Identifies situations in which a procedure code is billed before the post-operative period is over for an earlier procedure.
PRD	PCI Reissued Duplicate	Identifies situations in which a resubmitted line has already been denied on a previous claim.
PRDM	Procedure to Required Diagnosis Mismatch	Identifies claim lines where the procedure code billed has an inappropriate modifier appended to the procedure code based on specific coding rules and guidelines.
PMM	Modifier Inappropriate	Identifies codes billed in an inappropriate place of service.
PSM	Place of Service Mismatch	Identifies procedure codes that do not match the revenue code on the claim line.
PRM	Procedure to Revenue Code Mismatch	Identifies the primary service when multiple services are reported on the same date of service.
PS	Primary Service	Identifies post partum services that are included in the global maternity codes.

Flag	Flag Short Description	Flag Long Description
PST	Postpartum Services Included in the Global Code	Identifies claim lines billed by a provider whose claims are being flagged for review prior to payment. Only those claims with the specific condition or problem identified for the provider will be flagged.
PSUS	Fraud, Documentation Needed for Processing	The RASM edit is applied when the surgeon's bill is received after the assistant surgeon's bill. The edit then identifies that the assistant surgeon's billing does not match the surgeon's bill. Recovery will be initiated.
RASM / ASM	Does Not Match Surgeon	Identifies when all the components of a procedure are billed but the global procedure has not been billed. Each of the component codes will be identified with a REB edit.
REB / RBP	Component Codes Billed Separately	Identifies situations where a provider reports a drug toxicology CPT code(s) which CMS no longer recognizes and should be reported with a more appropriate G-code.
RBPD / REBD	Rebundled Toxicology Codes	Identifies procedures billed by more than one provider in the same procedure code range. For example, two providers from the same practice billing for an E&M service.
RDS	Duplicate Services in Same Range of Codes	Identifies revenue codes that have been billed more than once on a date of service. Provider contract exceptions have been excluded.
RFRE	Revenue Code Frequency	Identifies when a previously reimbursed procedure codes has been assigned to an incorrect revenue code. Recovery of the incorrectly paid code will be initiated.
RFLU / FLU	Florida Unbundling Revenue Codes	RMEA edits identify procedures that have been paid but a subsequent claim line identifies the procedure was paid incorrectly. Recovery of the incorrectly paid code will be initiated.
RMEA / MEX	Mutually Exclusive Unbundled	Identifies unusual situations that warrant additional review before reimbursement.
RPR	Review Prior to Reimbursement	RUPA edits identify procedure code(s) that have been already reimbursed that are should be included in the reimbursement of a more global procedure code. Recovery of the incorrectly paid code will be initiated.
RUPA / UNB	Unbundled	Identifies procedures for which an assistant surgeon is not allowed.
SAS	Assistant Surgeon Inappropriate	Identifies procedures for which a co-surgeon is not allowed.
TSA	Team Surgeon Inappropriate	Identifies procedures for which a co-surgeon is only allowed with supportive documentation.
TSN	Team Surgeon Necessary	Identifies procedure codes that are reimbursed in the value of another procedure code that was reimbursed. RUPA (Reverse UNB edit)

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Flag	Flag Short Description	Flag Long Description
UNB / RUPA	Unbundled	Identifies procedures billed with a non-specific procedure code. Medical documentation is required before reimbursement can be made.
UNL	Unlisted Code	Identifies lines where the anticipated paid amount is greater than would be expected. Additional review of the reimbursement is warranted.
UPA	Unreasonable Paid Amount	

Schedule 4, "Claim Accuracy Reports," to Exhibit A, "Scope of Work"

This is a list of the reports available in the Solution at the time of the Effective Date. This list may change from time-to-time without amendment to the Agreement.

- Batch Summary
- Edit Acceptance
- Customization Summary
- Rolling 12 Month Edit Summary
- Appeals Summary and Detail Client User Summary
- Client Override Summary
- Client Edit Detail (Note: to include the Edit Explanation Description)
- Client Pend & Logic Claims
- Claims without CalOptima Recommendations to CONTRACTOR Edits
- 13 weeks to Date Summary
- Top Providers by Savings

Exhibit B, "Fees"

A. **Fee Table**

Fee Table	
Description	Fee or Rate
One-Time Fees	
Implementation Fee	Waived
Recurring Fees	
Claim Accuracy: Shared Savings Rate	19.5%
Additional Services Fees	
Custom Development	$250 per hour
Additional Authorized Users over 30 (see section 2.D of Schedule 1 to Exhibit A)	$600 per additional Authorized User per year
Additional Support Services	$200 per hour
Online Training	$200 per hour
Onsite Training	$3,000 per trainer per day
Ad Hoc Reporting	$375 per hour

B. **Billing.** The following billing terms describe how the fees listed in the Fee Table will be calculated and when they will be billed:

(1) **Solution Fees.** Product-specific defined terms used in this subsection may be defined in the additional definitions sections of the applicable Schedules.

(a) **Claim Accuracy.** Beginning on the Go-Live Date, each month, CONTRACTOR will bill CalOptima the product of *Final Accepted Savings* × *Shared Savings Rate.*

"Final Accepted Savings" refers to the difference between (i) the submitted allowed amount configured for CalOptima and (ii) the allowed amount remaining after CONTRACTOR Edits are applied and CalOptima accepts the CONTRACTOR Recommendations. For the purposes of calculating Final Accepted Savings: (i) adjustments made to Utilization Data will be accounted for only if they are made within 90 days of the date the original Recommendation was made and (ii) Recommendations that are not returned to CONTRACTOR in Utilization Data within 90 days will be considered accepted (this does not apply to Appeals). A report identifying claims without recommendations by CalOptima will be provided by the CONTRACTOR 30 days prior to the 90-day window. See CONTRACTOR responsibilities Section 2.6.

(2) **Additional Services Fees.** Each month, CONTRACTOR will bill CalOptima any applicable Additional Services fees indicated in the Fee Table for applicable services performed in the previous month. An approved CalOptima Purchase Order outlining these Additional Services must accompany any invoices for said Additional Services.

(3) **Travel.** CONTRACTOR will bill CalOptima for all CalOptima pre-approved reasonable travel expenses, per CalOptima's travel policy related to this SOW.

C. **Payment Terms.** CONTRACTOR will send invoices for the fees described in this section each month. CalOptima shall pay all invoiced fees according to the payment terms stated in the Contract.

D. **Reversals.** In the event, during the Contract, CalOptima reverses the claims payment determination that was based on CONTRACTOR's recommended action, in whole or in part, for any reason (including,

without limitation, as a result of provider grievance or appeal, government claim or litigation), leading to an additional payment to the provider on that claim, CalOptima shall notify CONTRACTOR of such action, CONTRACTOR shall reverse the initial compensation changes (issued a credit) and re-invoice CalOptima for its payment based on the re-calculated claims payment determination amount.

E. **Interest**. If the event that CalOptima claims are delayed by the sole fault of CONTRACTOR, and CalOptima accrues and pays interest charges on said claims to providers, CalOptima shall provide CONTRACTOR with notice of such interest charges. CONTRACTOR shall issue a credit (deduct) in the amount of such interest on its next monthly invoice to CalOptima for CONTRACTOR compensation. However, this provision may not apply to any Claim that Contractor processes within the applicable SLA timeframes.

F. **Reversals Post Termination.** The Parties acknowledge that the basis (e.g., provider appeal) for CONTRACTOR payment reversals may not occur for many months following the date of CalOptima's implementation of CONTRACTOR's Recommendation. Therefore, for a twelve-month period commencing on the date this Contract is terminated for any reason, CalOptima may provide written notice to CONTRACTOR of any adjustments to CONTRACTOR'S compensation (and interest charges, if any) arising from reversals as provided herein and CONTRACTOR shall issue a refund to CalOptima within 30 days of receipt of such notice. For a Claim to be eligible for adjustment, CalOptima must provide CONTRACTOR written notice within 365 days from the date that CONTRACTOR provided the original Recommendation to CalOptima.

G. **Appeal Support Post Termination.** The parties acknowledge provider Appeals of CONTRACTOR Recommendations may not occur until after termination of the Contract. Upon termination of the Contract for any reason other than CalOptima's termination without cause pursuant to section 16.1 of the Contract, CONTRACTOR shall process provider Appeals of CONTRACTOR'S Recommendations, as described in section 2.B of Exhibit A, for a twelve-month period following the date the Contract is terminated. For an Appeal to be eligible for processing by CONTRACTOR post-termination, CalOptima must provide Contractor written notice of the Appeal within 365 days from the date that CONTRACTOR provided the original Recommendation to CalOptima.

H. 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 B.

I. 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. 19-10311; specify the services provided, the time period covered by the invoice and the amount of payment requested.

J. CONTRACTOR shall also invoice CalOptima on a monthly basis for travel-related expenses. All expenses charged to CalOptima under this Contract shall be consistent with Exhibit C, CalOptima's Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging, and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client. Travel related expenses shall not exceed $10,000 in the aggregate. CONTRACTOR shall obtain CalOptima's written approval, which shall not be unreasonably withheld or delayed, before incurring any expenses exceeding, in the aggregate, $10,000. CalOptima shall not pay CONTRACTOR for time spent traveling.

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Exhibit C

CalOptima Travel Policy

Policy #:	GA.5004
Title:	**Travel Policy**
Department:	Finance
Section:	Purchasing
CEO Approval:	Michael Schrader MS
Effective Date: 8/1/12	Revised: 9/6/12, 3/1/13
Board Approval: 9/6/12	

I. PURPOSE

To establish a process for reasonable and equitable reimbursement of approved travel and other related expenses incurred by CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants while traveling on authorized CalOptima Business.

II. POLICY

A. For the purpose of this policy, Individual shall mean, unless otherwise specified, all persons authorized to submit an Expense Report, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima employees, and; individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses, in accordance with CalOptima rules and regulations.

B. CalOptima shall provide an expense reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel expenses and miscellaneous expenses incurred by authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal regulations.

C. CalOptima shall reimburse employees for reasonable expenses incurred while traveling on CalOptima business. All travel must be for the benefit of CalOptima, and must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible.

1. Travel Expenses shall include the following items:

    a. Transportation: including commercial carriers, rental vehicles, and mileage for use of personal vehicle;

    b. Lodging;

    c. Meals;

    d. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

    e. Insurance for rental vehicles;

    f. Parking fees and tolls fees (i.e., toll roads and necessary parking);

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g. Miscellaneous expenses including:

   i. Authorized local and long-distance telephone calls;

   ii. Baggage fees;

   iii. Internet or Wi-Fi charges;

   iv. Facsimiles;

   v. Expenses in connection with the preparation of authorized company reports or correspondence;

   vi. Taxi or public transit fares, required to conduct business; and

   vii. Other unforeseen or unusual expenses that are properly justified and substantiated.

D. Board Member/Standing Committee Member Travel

1. CalOptima shall allow Board members and Standing Committee members reasonable and necessary Travel Expenses and miscellaneous expenses incurred when participating in activities as a member of their respective Board or Committee. Eligible Travel Expenses shall be governed by this policy.

   a. The CEO or the Chairperson of the CalOptima Board of Directors, or his or her designee, shall review and approve all Board member and Standing Committee member non-local travel.

   b. CalOptima shall limit Board member and Standing Committee member travel to the following purposes:

      i. CalOptima business-related activities;

      ii. Requests to represent CalOptima as a speaker at an approved meeting, seminar or conference; and

      iii. Other travel deemed necessary by the CalOptima Board of Directors.

E. Travel Approval

1. Budgeted Travel: All budgeted Travel and miscellaneous expenses for CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants shall be pre-approved by the appropriate level of CalOptima Management or Board Chair, prior to travel expenses being incurred, according to the following:

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Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

2. Non-Budgeted Travel: Non-Budgeted Travel and miscellaneous expenses for authorized Individuals shall be pre-approved by the CEO, or his or her designee, prior to Travel Expenses being incurred.

F. Conferences and Seminars

1. Attendance at any given conference and/or seminar shall be:

   a. Limited to the number of Individuals deemed appropriate by the CEO for that particular conference or seminar, and

   b. Approved by Human Resources.

2. Payment of Fees

   a. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and seminar fees at the time the Travel and Training Authorization form is prepared, and submit necessary registration information to the Purchasing Department.

   b. In the event an Individual must personally pay for conference or seminar registration fees, the Individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

G. Meal Expenses

1. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

2. CalOptima shall reimburse authorized Individuals the actual cost of Travel Meals, excluding alcoholic beverages, in an amount not to exceed forty-five dollars ($45.00) per day, excluding taxes and gratuity.

   a. CalOptima shall reimburse employees and Board members for meals that exceed the forty-five dollars ($45.00) per day under the following conditions:

      i. The authorized Individual shall submit a valid receipt for such meals with a brief explanation of the expenditure. Individual meals shall be subject to the above limitations;

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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:

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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.

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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.

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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.

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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

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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;

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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

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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

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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, Verscend Technologies, Inc., 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: DocuSigned by: Iulia Fried   Date: 9/28/2018

Print Name: Iulia Fried

Title: Compliance Officer

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 sub awards at all tiers (including subcontractors, sub grants, 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.

Verscend Technologies, Inc.	David Mason
Name of Contractor	Printed Name of Person Signing for Contractor
19-10311	DocuSigned by: [signature] 7E43D4E064...
Contract/Grant Number	Signature of Person Signing for Contractor
9/28/2018	COO
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*):	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):

(attach Continuation Sheet(s) SF-LLLA, if necessary)

11. Amount of Payment (check all that apply): $______________ ☐actual ☐planned 12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature ___________ Value___________	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _________

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

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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 sub award recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Sub awards include but are not limited to subcontracts, sub grants, 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

FDR Attestation

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via fax (714) 481-6457, email hnreporting@caloptima.org, or mail: 505 City Parkway West, Orange, CA 92868, within fifteen (15) calendar days of the notice accompanying this form.

Check which CalOptima program(s) this form pertains to:

- ☐ OneCare
- ☒ Medi-Cal
- ☐ PACE

I hereby attest that [Verscend Technologies, Inc. (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. Provide effective Fraud, Waste and Abuse Training and Compliance Training to all Organization and downstream entity Board members, officers, employees, temporary employees, and volunteers, within 90 days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use (Select all that apply):

- ☐ CMS's Fraud, Waste, and Abuse Training and Compliance Training Module.
- ☒ An internal training program that meets CMS's Fraud, Waste, and Abuse and Compliance Training Module requirements.
- ☐ Deemed to have met the Fraud, Waste and Abuse certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS).

II. Administer specialized compliance training to Organization and downstream entity Board members, employees, temporary employees, and volunteers: (i) based on their job function within the first 90 days of hire and at least annually thereafter as a condition of appointment, employment or contracting, (ii) when requirements change; (iii) when such persons work in an area previously found to be non-compliant with program requirements or implicated in past misconduct.

III. Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity Board members, officers, employees, temporary employees, and volunteers within 90 days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization. The Organization and its downstream entities currently use (Select all that apply):

☒ Our own compliance policies and procedures, standards of conduct, and compliance reference material. (Please provide to CalOptima for review).

☐ CalOptima's compliance policies and procedures, Code of Conduct, and compliance reference material.

IV. Review all Organization and downstream entity Board members, officers, potential and actual employees, temporary employees, and volunteers against the HHS OIG List of Excluded Individuals & Entities list and GSA Debarment list upon appointment, hire or contracting, as applicable,and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within 5 calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. Screen its and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima Policies upon hire and annually thereafter.

VI. Will report suspected fraud, waste, and abuse, as well as all other forms of non-compliance, as it relates to CalOptima.

VII. Understand that any violation of any laws, regulations, or CalOptima Policies is grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII Are aware that persons reporting suspected fraud, waste, and abuse, and other non-compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. Will retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

That the individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

DocuSigned by:
Iulia Fried
5DB7EB0958CA412

Signature	Date
Iulia Fried (signed)	9/28/2018

Name	Organization
Iulia Fried	Verscend Technologies, Inc.

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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.

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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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Exhibit H

Attestation Concerning the Use of Offshore Subcontractors

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via fax (714) 481-6457, email hnreporting@caloptima.org, or mail: 505 City Parkway West, Orange, CA 92868, within fifteen (15) calendar days of the notice accompanying this form.

Check which CalOptima program(s) this form pertains to:

- ☐ OneCare HMO SNP
- ☒ Medi-Cal
- ☐ PACE

Are any administrative or other functions conducted on behalf of your organization by entities located offshore? This shall include employees of your firm, subcontractors and any 3rd party subcontractors. ("X" where appropriate)

No ☐ If NO, please complete Part I:

Yes ☐ If YES, please complete Parts II–VI of this form:

Part I — Our Firm is Not Using Offshore Subcontractors and/or Employees

Offshore Subcontractors

☒ Our Organization is NOT using Offshore Subcontractors for contract 19-10311 with CalOptima

Offshore Employees

☒ Our Organization does NOT employ workers who are located Offshore for contract 19-10311 with CalOptima

Name of Organization:	Verscend Technologies, Inc.
Name of Authorized Person:	Iulia Fried
Title:	Compliance Officer
Signature:	DocuSigned by: Iulia Fried 5DB7EB0058CA412...
Date:	9/28/2018

Part II — Offshore Subcontractor Information

Offshore Subcontractors

☐ Our Organization IS using Offshore Subcontractors

Offshore Employees

☐ Our Organization DOES employ workers who are located Offshore

Subcontractor Name:	
Subcontractor Country:	
Subcontractor Address:	

Describe Offshore Subcontractor Functions:

State Proposed or Actual Effective Date for Offshore Subcontractor: ____________________

Part III — Precautions for Protected Health Information (PHI)

1. Describe the PHI that will be provided to the Offshore Subcontractor and/or Employee:

2. Explain why providing PHI is necessary to accomplish the Offshore Subcontractor's/Employee's objectives:

3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:

Part IV — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract

Item	Attestation	Response Yes / No
A.	Offshore Subcontractor/Employee arrangement has policies and procedures in place to ensure that Medi-Cal, Medicare and Healthy Families beneficiary protected health information (PHI) and other personal information remains secure.	
B.	Offshore Subcontractor/Employee arrangement prohibits Subcontractor/Employee access to Medi-Cal, Medicare, and Healthy Families data not associated with CalOptima's contract with the Offshore Subcontractor/Employee.	
C.	Offshore Subcontractor/Employee arrangement has policies and procedures in place that allow for immediate termination of the subcontractor/employee upon discovery of a significant security breach.	
D.	Offshore subcontractor/employee arrangement includes all required DHCS and/or CMS language as stipulated within your contract with CalOptima.	

Part V — Attestation of Audit Requirements to Ensure Protection of PHI

Item	Attestation	Response Yes / No
A.	Your organization will conduct an annual audit of the Offshore Subcontractor/Employee.	
B.	Audit results will be used by your organization to evaluate the continuation of its relationship with the Offshore Subcontractor/Employee.	

CalOptima
Better. Together.

C.	Your organization agrees to share Offshore Subcontractor's/Employee's audit results with CalOptima upon request.	

Part VI — Organization Information

Name of Organization:	
Name of Authorized Person:	
Title:	
Signature:	
Date:	

Exhibit I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: Verscend Technologies, Inc.

Business Entity Type: Delaware Corporation
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: 201 Jones Road

City: Waltham State: MA Zip: 02032

Business Phone: 718-693-3700 Email: legal@verscend.com

President: Emad Rizk, President & CEO
Contact Person: Jamie Adams, VP Account Management

Person(s) Signing Contract & Title: David Mason, COO

*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 %
Verscend Holding Corp.	100% owner

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:
[signature]
7E43D5E6848B4E9...

Authorized Signature 9/28/2018
Date

David Mason COO
Name and Title

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Exhibit J

(Optional)

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Exhibit K

Not applicable for this Contract

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Exhibit L

Not applicable for this Contract

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AMENDMENT NO. 1 TO
CONTRACT 19-10311

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE
DBA CALOPTIMA
(CalOptima)

AND

VERSCEND TECHNOLOGIES, INC.
(VENDOR)

AMENDMENT NO. 1 TO THIS CONTRACT is entered into as of the date last signed below, with respect to the following facts:

A. CalOptima and VENDOR (hereinafter collectively referred to as "the Parties") entered into Contract 19-10311 on October 1, 2018, under which VENDOR agreed to provide Clinical Editing Solutions and Services as described in the Scope of Work; and

B. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing executed by the Parties.

C. The Parties now desire to amend the Contract to update the legal name Verscend Technologies, Inc.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. All capitalized terms used herein shall have the same meanings given them in the Agreement, unless the context specifically provides otherwise herein.

2. Any reference in the Contract or any agreement in accordance with the Contract, to "**Verscend Technologies, Inc.**," or "**Verscend,**" is hereby replaced with "**Cotiviti**" or "**Cotiviti, Inc.**"

3. **No Other Changes.** This Amendment No. 1 is by this reference made part of said Contract. Except as otherwise provided in this Amendment No. 1, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment No. 1 and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 1 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment No. 1 shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment No. 1 shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment No. 1 shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

[SIGNATURES ON FOLLOWING PAGE]

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IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 1 on the day and year last shown below.

Date: 1/9/2019

"CALOPTIMA"

By: Mark Finch
Its: Purchasing Manager

Date: 1/9/2019

"VENDOR"

DocuSigned by:
Brett Magun
5E3B584A18324A4

By: Brett Magun
Its: SVP, Managing Counsel
[Chairman, President or Vice President]

DocuSigned by:
David Mason
7E43D5E6648B4E9...

By: David Mason
Its: COO
[Secretary or CFO]

If VENDOR is a corporation, two officer signatures or Corporate Resolution or Corporate Seal is required.

DocuSign Envelope ID: A629503D-54D1-4BC5-8066-0FF4D69FD89F

AMENDMENT NO. 2
TO CONTRACT NO. 19-10311

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
DBA ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE,
DBA CALOPTIMA
(CalOptima)

AND

COTIVITI, INC.
(CONTRACTOR)

AMENDMENT NO. 2 TO THIS CONTRACT is entered into as the date last signed below, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 19-10311 on October 1, 2018, under which CONTRACTOR agreed to Clinical Edition Solution and Services, as described in the Scope of Work (hereinafter, "Contract").

B. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing executed by the Parties.

C. The Parties now desire to amend the Contract by extending the contract term.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. All capitalized terms used herein shall have the same meanings given them in the Agreement, unless the context specifically provides otherwise herein.

2. The Parties now agree extend this contract for an additional 12 months. The new contract termination date will be 10/7/2022.

3. **No Other Changes.** This Amendment No. 2 is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 2 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

[SIGNATURES ON FOLLOWING PAGE]

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IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 2 on the day and year last shown below.

"CALOPTIMA"
DocuSigned by:
Nancy Huang
D22E3B87032946F...

Date: 08/02/2021

By: Nancy Huang
Its: Chief Financial Officer

"CALOPTIMA"
DocuSigned by:
Richard Sanchez
234AD421BDEC4D9...

Date: 08/02/2021

By: Richard Sanchez
Its: Chief Executive Officer

Date: 7/22/2021

"VENDOR"
DocuSigned by:
Matthew Hawley
24B1AD6C0296492...

By: matthew hawley
Its: EVP Operations
[Chairman, President or Vice President]

By: __________
Its: __________
[Secretary or CFO]

If VENDOR is a corporation, two officer signatures or Corporate Resolution or Corporate Seal is required.

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Verscend Corp.	1 Glenlake Pkwy NE #1400	Atlanta	GA	30328
Cotiviti	10701 S. River Front Pkwy, #200	South Jordan	UT	84095

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Cotiviti	10701 S. River Front Pkwy, #200	South Jordan	UT	84095
Varis	9245 Sierra College Blvd, #100	Roseville	CA	95661

AMENDMENT NO. 4 TO
CONTRACT 19-10311

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE
DBA CALOPTIMA
(CalOptima)

AND

COTIVITI, INC.
(CONTRACTOR)

AMENDMENT NO. 4 TO THIS CONTRACT ("Amendment") is entered into as of the date last signed below, with respect to the following facts:

A. CalOptima and Contractor (hereinafter collectively referred to as "the Parties") entered into Contract 19-10311 on October 1, 2018, under which Contractor agreed to provide Clinical Editing Solutions and Services as described in the Scope of Work; and

B. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing executed by the Parties.

C. The Parties now desire to amend the Contract to update the Term and Claims Editing Services.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. All capitalized terms used herein shall have the same meanings given them in the Agreement, unless the context specifically provides otherwise herein.

2. **Implementation.** Contractor and CalOptima acknowledge that Claims Editing Services are performed under the Contract as of the Effective Date of this Amendment, and further agree to transition the current Claims Editing Services to a different Contractor platform. The new platform and claims editing service offerings are hereinafter referred to as the "PPM Services".

   a. Scope. Following implementation of the PPM Services, the types of claims edited by Contractor will remain the same. That is, CalOptima shall submit for editing all Professional and Facility claims for their Commercial, Medicaid and Medicare lines of business for all markets subject to reasonable exclusions as outlined in the section below (the "**Scope**"). Future lines of business can be added via additional work order

   b. Integration Method. The PPM Services will be provided in Batch integration. Integration consists of one production environment and one model test environment. PPM Services consist of Contractor's standard reporting package. Custom reporting can be requested by CalOptima but is subject to additional fees.

   c. **Team.** Contractor and CalOptima will each assign a designated project manager and implementation team with appropriate business and technical expertise, and decision-making authority to fulfill their obligations in the Project Plan.

   d. **Project Plan.** The parties will develop a project plan that will be used to guide the implementation process (the "**Project Plan**") and that will, among other things, within two weeks of the Effective

Date of this Amendment schedule a work together to schedule a kick-off meeting, and the first steering committee will meet within thirty days of the Effective Date and every thirty days thereafter.

e. **Interface**. CalOptima will dedicate the appropriate business and technical resources to design, build, test, operationalize and upgrade the current Interface and file format to be compatible with the application of PPM Services.

Within defined parameters, Contractor will provide technical development resources who will utilize best practice Facets integration experience to assist the CalOptima in the design, build, test and operationalization of the data interface. CalOptima will provide the Contractor technical resources remote access to necessary technical development environments to support this development work.

The upgraded electronic Interface will enable Contractor and CalOptima to:

1. Generate and Transmit Claim extracts from CalOptima' claim system into the enhanced standard Contractor Global Data Format batch file layout

2. Parse batch received from CalOptima into the Contractor claim editing engine and apply the additional CalOptima PPM Service policies.

3. Generate and Transmit batch claim extracts from Contractor claim editing engine to real-time transactions

4. Auto Apply of PPM Services Recommendations into CalOptima' claim system

5. Send Claim History extract (initial load and ongoing incremental) to Contractor

6. Load Claim history into the Contractor claim editing engine for contextual PPM Services editing and invoicing

Upon completion of the Interface and during the Term, CalOptima will be responsible for ongoing maintenance and support of those Interface components within its control, including connectivity to its then current claims system.

f. **Final Filter and No Additional Editors.** CalOptima agrees that Contractor's position within the CalOptima claims adjudication system will be the final editing position, immediately after the claims have been finalized and are in a ready to pay status. CalOptima further agrees that during the Term of the Contract, CalOptima will not place any additional editing vendors or capabilities before Contractor, or after Contractor.

g. **Implementation Fee.** Contractor will reduce the implementation fee of $150,000 to $0 if CalOptima completes the upgrade to the PPM Services on or before December 30, 2023; provided, that, if the Implementation is delayed through no fault of CalOptima, the December 30, 2023 date will be extended by an amount agreed upon by both parties.

h. **Policy Selection.** Contractor will provide information from Contractor's PPM Services payment policy library and edit artifacts to CalOptima in order for CalOptima to select the payment policy rules, edits and content which shall be configured for the PPM Services (the "Selected Policies"). CalOptima shall be solely responsible for and have sole authority over the selection of those payment policy rules, edits and content that together constitute the Selected Policies. On no less than a quarterly basis, CalOptima agrees to meet with Contractor to discuss adoption of additional Selected Policies and to review the recommended policies that CalOptima elects not to adopt. Customizations to PPM Policies may be requested by CalOptima but may be subject to additional fees.

3. **PPM Services.** No changes will take place to the process or workflow of the Claims Editing Services by virtue of the PPM Services upgrade, except as follows:

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a. **Policy Selection.** Contractor will provide information from Contractor's PPM Services payment policy library and edit artifacts to CalOptima in order for CalOptima to select the payment policy rules, edits and content which shall be configured for the PPM Services (the "Selected Policies"). CalOptima shall be solely responsible for and have sole authority over the selection of those payment policy rules, edits and content that together constitute the Selected Policies. On no less than a quarterly basis, CalOptima agrees to meet with Contractor to discuss adoption of additional Selected Policies and to review the recommended policies that CalOptima elects not to adopt. Customizations to PPM Services Selected Policies may be made for additional fees. The parties acknowledge that the Selected Policies may be different than those contained in Schedule 3, "Claim Accuracy Edits Artifact".

b. **Claims Inquiry Tool ("CIT").** The Claim Inquiry Tool is a web-based vehicle available to CalOptima, which will include information on all claim lines affected by Contractor's PPM Services and information that CalOptima can use for claim inquiries by Providers. CalOptima will access the Claim Inquiry Tool through Authorized User accounts. The Claims Inquiry Tool may include customizations reflecting Selected Policies and scripts and rationales for use via telephonic Provider services.

c. **Services Level Agreements.** For the avoidance of doubt, all Service Level Agreements contained in Schedule 2 will remain the same.

4. **Term.** The Term of the Contract is governed by Amendment No. 3.
5. **Fees.** Except for the Implementation Fee described above, the Fees contained in Exhibit B are modified as follows:

PPM Service Fees	
Per Member Per Month (at execution of SOW)	$0.27
Per Member Per Month (at PPM Services Go Live Date)	$0.295
Total CalOptima Membership	903,784
Total Monthly Fees (at execution of SOW)	$244,021.68

a. A "Member" for purposes of the Fee Table above is a covered life in CalOptima's in Scope health plans. CalOptima agrees to report in an excel format the total current Members each month, by the fifth day of the month, so that Contractor can calculate its fees and invoice.

b. The "PPM Services Go Live Date" means the first date CalOptima provides claims to the PPM Services claims engine for processing.

c. The PMPM rate is based on an effective contingency rate of 19.5%. If Member count is not correct (includes non-capitated Members or Member that are excluded from the Scope), then Contractor may change the PMPM rate so that the PMPM rate reflects a contingency rate of 19.5%.

d. Contractor and CalOptima will track savings generated by Contractor's PPM Services throughout each annual period from the execution of this SOW to the anniversary of the execution of this SOW (the "Annual Measurement Period"). Savings for this purpose means the difference between what CalOptima would have paid on a given claim line before the PPM Services, and what CalOptima actually paid on such claim line after the PPM Services were rendered. Base Savings per Annual Measurement Period is $18 million dollars. If Savings materially change (+/- 15%) during each Annual Measurement Period, the parties agree to allow Contractor to modify the PMPM fee during the Annual Measurement Period such that it remains consistent with a 19.5% contingency rate across all months within the Annual Measurement Period.

e. Contractor will provide CalOptima a reconciliation report within thirty business days from the end of each Annual Measurement Period. The Reconciliation report will include: a summary of the Net Savings achieved and the calculation of the new monthly PMPM fee.

f. CalOptima agrees to select and deploy PPM Services Selected Policies that cover 80% or more of the value presented in the Opportunity Analysis.

g. CalOptima will accept 85% of Recommendations, excluding Reversals; provided, however, that since the Contractor fees are based on a Per Member Per Month model, Contractor will not reimburse or credit CalOptima for Reversals.

h. Contractor will process at least $439 million dollars of annualized final paid claims subject to the PPM Services at the end of the first Annual Measurement Period and thereafter throughout the Term of the Contract.

i. Should any of the requirements in subsections f., g or h prove false during any Annual Measurement Period, then Contractor and CalOptima agree to enter into negotiations on an equitable price modification.

j. If CalOptima does not return the final paid state of the claim in the Utilization Data or other files after 180 days from Contractor returning the Claim Recommendation, then Contractor will assume the Recommendation was not accepted for purposes of calculating ongoing Savings totals.

6. **No Other Changes**. This Amendment is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 3 on the day and year last shown below.

“CALOPTIMA”

____
By:
Its: Purchasing Manager

Date: ___________________________

“VENDOR”

____

By: _______________________________

Its: _______________________________ [Chairman, President or Vice President]

Date: _____________________________

____

By: _______________________________

Its: _______________________________
[Secretary or CFO]

Date: _____________________________

If VENDOR is a corporation, two officer signatures or Corporate Resolution or Corporate Seal is required.

CalOptima Health Board Action Agenda Referral

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

Report Item
12. Approve Actions Related to the Procurement of a Modern Customer Contact Center Solution

Contacts
Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
Ladan Khamseh, Executive Director, Operations Management, (714) 246-8866

Recommended Actions
1. Authorize reallocation of budgeted but unused funds up to $2.25 million to a new project "Modern Customer Contact Center Solution" under the "Infrastructure" category in the CalOptima Health Fiscal Year 2022-2023 Digital Transformation Year One Capital Budget. The reallocated funds will come from the following capital projects under "Applications Development" category:
   a. $1.8 million from "Digital Transformation Strategy Planning and Execution Support"; and
   b. $450,000 from "Migrate Data Warehouse Analytics to the Cloud."
2. Approve the scope of work (SOW) for the Modern Customer Contact Center Solution.
3. Authorize the Chief Executive Officer to release the approved SOW through a request for proposal (RFP) and to negotiate and contract with the selected vendor.

Background
As part of CalOptima Health's Workplace Modernization and Digital Transformation Strategy, Information Technology Services will be evaluating and deploying multiple solutions. These solutions coincide with CalOptima Health's Cloud First strategy and take regulatory compliance and security measures into consideration. These initiatives will assist CalOptima Health in achieving its vision statement of removing barriers to achieve real-time claims payments and 24-hour treatment authorizations and coordinating 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

The SOW and RFP will allow CalOptima Health to procure a vendor solution with functionality to deliver a customer-centered, multi-channel solution (e.g., voice, chat, email, text, social messaging) that is capable of scaling and is flexible enough to meet the current and future needs of its customers. The goal is to improve the member and provider experience with a tightly integrated solution capable of automation, member assisted services, proactive outbound communication, that provides additional internal workflow improvements.

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CalOptima Health currently deploys and supports several separate solutions that are not integrated and therefore seeks to consolidate to a single platform that enables easier integrations and supports the needs of employees, providers, and members. This proposed solution, as part of CalOptima Health's ongoing digital transformation, will drive innovation to the contact center and will enhance current and future operations. CalOptima Health will leverage modern technologies to improve the overall member and provider experiences and evolve its interactions as technologies and requirements change.

Staff is requesting reallocation of budgeted funds within the "Cloud Migration Strategy" and "Migrate Data Warehouse Analytics to the Cloud" to procure a comprehensive customer contact center solution. Staff will defer the Migrate Data Warehouse/Analytics to the Cloud project until FY 2024 as part of this reallocation. Staff recommends aligning this new capital project to coincide with the implementation of the Customer Relationship Management (CRM) system currently in progress. These budgeted funds are available due to the shifting of this project to coincide with the CRM system implementation, as well as utilizing a different approach to migrate the Data Warehouse to the cloud. The proposed funding is available for reallocation as it has not yet been spent on other projects.

If approved, the RFP will be issued consistent with CalOptima Health's procurement process. Review of bids by a committee with a representation of stakeholders from multiple departments will take place to ensure collaboration and selection integrity by CalOptima Health staff. Based on the scoring from the bid review, CalOptima Health will request that vendors provide a demonstration for evaluation and functionality scoring to select a vendor.

Fiscal Impact

The fiscal impact for the recommended action is budget neutral. As proposed, unspent funds in an amount up to $2.25 million that were approved as part of the CalOptima Health Fiscal Year 2022-23 Digital Transformation Year One Capital Budget on June 2, 2022, will fund the expenses for the new capital project, "Modern Customer Contact Center Solution."

Rationale for Recommendation

Implementing a Modern Customer Contact Center Solution will greatly improve the customer experience, as well as internal workflow attributed to all forms of member and provider processing. These improvements will support CalOptima Health's ability to execute on its strategic vision and goals while enhancing the member and provider experience.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

SOW - Modern Customer Contact Center Solution.

/s/ Michael Hunn *02/23/2023*
Authorized Signature **Date**

C. Scope of Work

I. Project Objective

CalOptima intends to replace its existing legacy, on-premise contact center solution with a native cloud contact center solution The proposed solution needs to be a proven product in the marketplace with a track record of research, inventions and enhancing the solution to exceed future functionality demands. Our ideal solution is one that will ensure we are best poised to handle requests from our customers with the highest level of efficiency, as well as a solution that can provide us with an exceptional and differentiated customer experience from pre to post sale and support.

In this Scope of Work, we are asking you to present the "game changing" innovations that you will bring to our contact center that will enhance our operations both now and in the future. As you respond, where appropriate, please elaborate on any additional technology innovations, process enhancements, product functionality, or service and support that you offer that will help streamline deployment and ongoing maintenance of the customer experience platform.

The new solution is expected to deliver capabilities supporting the following initiatives:

1) Improve Member Experience
    - Deliver customer centric, omni-channel experience
    - Unify member and provider experiences across all modes of conversation / interaction (omni-channel)
    - Proactively anticipate and communicate with members and providers
    - Deliver personalized and context aware experiences during self-, assisted-, and agent-serviced interactions
2) Cloud Strategy – Move Contact Center to Cloud-based solution
    - Fully integrate solution with CRM (Customer Relationship Management), ERP (Enterprise Resource Planning), BI (Business Intelligence), back-office collaboration and Unified Communications (UC) platforms, etc.
    - Reduce setup, support, and training costs of new, and newly modified, customer experiences and use cases
    - Improve analytics
    - Avoid complex day-to-day interactions
    - Scalable solution to meet growing requirements
    - Flexible to meet customer demands
    - Capable to meet future business needs
3) Improve Operational Efficiencies
    - Enables frictionless integrations
    - Leverage digital employees for self- and assisted service
    - Increase automation before, during, and after the interactions
    - Include modern, engaging screen-pops as standard functionality
    - Improve quality and workforce engagement and management
    - Increase productivity & reduce duplication of effort for customer facing employees / agents
    - Reduce training time for new employees
    - Better equip field staff to support customer inquiries

- Supports the needs of employees, agents, and customers in having a unified and context aware experience.

4) Achieve full compliance with PCI/HIPAA/TCPA

SCOPE OF SERVICES

The numbered & bolded items below represent the capabilities we are looking for in this platform. All are required with the exception of the following numbers which are optional (nice to have) and informative:

- Numbers 5, 9, 14, 22, & 32 are optional.
- Numbers 10, 12, 15, 16, 18, 19, 23, 24, 25, 26, 27, 28, 30, 31, 33, 34 are informative only.

To help us better understand your solutions, for every items, please describe how it will help our business reimagine and improve the customer's experience.

Requirement	Vendor response
1. DELIVER UNIFIED CUSTOMER EXPERIENCES CalOptima wants to implement a solution that will deliver a unified and intelligent customer experience across chat, email, SMS, social messaging, voice, video, and self- and assisted-service applications – including Intelligent Virtual Assistants and other Digital Employee use cases. Describe how your solution supports this requirement.	
2. CHAT INTEGRATION CAPABILITY CalOptima is in the process of selecting an industry leading enterprise chat software. Please describe how your solution integrates with a 3rd party chat software.	
3. EMAIL CAPABILITY CalOptima volume of customer email communication is increasing to the point where we need to integrate it into the normal agent workflow. Describe how your solution supports the following features. • Describe how email features are supported. • Do you have integration and support for M365 email? • Does your solution have support for standard email templates? • Are email interactions handled using the same user interface as voice interactions? • Is the maximum number of emails defined on a per-agent basis? • How is email configured to route into the contact center? • Can agents initiate outbound email communication to end-users? • Does the system support response templates for email messages? • Does the email system support attachments?	

4. SMS CAPABILITY Currently CalOptima does not offer SMS channel to our customers. Describe how your solution supports the following features. • Describe how SMS or mobile texting features are supported. • Are SMS interactions handled using the same user interface as voice interactions? • How is SMS routing into the contact center configured? • Does your system support short or long codes for routing inbound text messages?	
5. SOCIAL MESSAGING Currently CalOptima does not offer Social Messaging channel to our customers. Describe how your solution supports the following features. • Describe how you support social messaging conversations. • Are social messages handled using the same user interface as voice interactions? • How are social messages routed into the contact center? • What social media messenger applications do you support? • How will your solution accommodate integration with messaging applications not currently supported?	
6. PROACTIVELY COMMUNICATE WITH CUSTOMERS AND PROSPECTS More and more our customers demand proactive follow-up to inquiries. Our inability to fulfill this need causes repeat inquiries into the contact center. CalOptima wants to implement a solution that will reduce the need for repeat calls by allowing us to proactively communicate with customers without requiring human intervention across communication types. Please describe how your solution supports this requirement.	
7. DIALER A key component of our contact center solution is the outbound dialer. The dialer is used for everything from courtesy follow up calls to telemarketing. Our current solution, while integrated into our ACD, is a separate system that doesn't support call-by-call blending with inbound queues. We desire a fully integrated solution that enables higher agent productivity through advanced dialing options and blending while lowering administrative overhead. CalOptima wants to implement a solution which supports following features. Please describe how your solution supports the following requirements. • Dialer to be included as a standard module of the solution. If it is required to be purchased separately, then specify.	

• Dialer provided to be built and maintained by you. If not, then specify who supports that.
• Ability for the system to support call by call blending of outbound and inbound to the same agents.
• Solution to offer configurable dialing modes.
• Change the dial mode "on-the-fly"
• Run multiple campaigns simultaneously with different dialing modes
• Ability for a single campaign to leverage multiple lists with configurable virtual sorting and dialing ratios
• Ability for multiple campaigns to leverage the same lists by using filters to segregate contacts
• Support for fully predictive dialing
  o Detail the capacities and speed of your predictive dialing pacing algorithm.
• Support for preview dialing and support configurable timers
• Ability for an inbound call to override an outbound preview prior to the dial being initiated
• Dialer to support automated, outbound IVR campaigns (e.g., reminders, robo-calls)
• Configure outbound IVR campaigns that will allow called parties to speak to a live agent
• Screen pop support to CRM or other systems used for automated outbound calls
• Ability for the dialer to track all details, including result, for all outbound calls, including incomplete and dropped calls
  o What options exist for bulk loading record lists into the dialer?
• Ability to import lists to scheduled
• Automatic load of records from a CRM system
• Ability to add individual records directly from web pages
  o Specify can these records be added with a priority flag for immediate dial?
• Dialer to comply with FTC directives regarding display of Caller ID
• Dialer to track dropped calls and prevent dialing in a manner that results in dropped calls exceeding 3%
• Ability to set rules to ensure that contacts are not dialed too frequently
  o Specify if the rules be varied based on the result of previous dial attempts
• Ability to support actions for dropped calls
• Dialer to provide answering machine detection
  o Specify What actions are supported on detection of an answering machine
• Dialer support for an internal DNC list
  o Specify Can customers add themselves to the DNC list through the IVR
• TCPA-compliant solution for telemarketing to cell phones
• Ability to include multiple levels of skill-based routing and options/alternatives for after-call work (ACW) tracking, routing, and reporting.
• Support for call-back assist natively and if not, API's for external solutions
• Support integration with conversational AI
• Access to log logs and report.	

○ Please explain the level of access you provide for call logs and reports.	
8. NON-VOICE OUTBOUND COMMUNICATION CHANNELS In addition to voice, we would like to communicate with customers proactively via other channels. Describe how your solution supports the following features. • Ability to facilitate agentless outbound communication on non-voice channels ○ Elaborate how this will be achieved by your solution and what channels, specifically, are available for outbound communication. • Ability to trigger communications. ○ Elaborate How are communications triggered by your application or by using 3rd party applications • Ability to process messages (response from customers). ○ Elaborate how your system will process If customers respond to messages (SMS, social messaging, etc.)	
9. DELIVER PERSONALIZED EXPERIENCES As we reimagine our customers' experiences, we would like to treat them more as individuals and therefore would like to deliver a more personalized, consistent experience throughout the interaction. In the sections that follow, please describe how your solution personalizes the experience for customers during self-service (fully contained), assisted-service (pre-qualifying), and live-agent serviced interactions. INTELLIGENT VIRTUAL AGENTS (IVAS/CHATBOTS) / VOICE-ENABLED CALL-STEERING AND SELF-SERVICE / IVRS As part of inbound call handling, the new solution needs to improve the customer experience pre-agent engagement. The ability to mature beyond traditional IVR applications is critical to our customer engagement strategy and we intend to further develop this capability both to provide superior service to our customers and to offload calls to less costly channels. Describe your solution's pre-agent interaction experience. • Ability to configure call flows and/or IVR applications without professional services? ○ What technical skills are required for your solution? • Graphical, drag-and-drop interface to define customer experiences • Support for dynamic customer call paths • Feature to collect input from callers (account numbers, case numbers, etc.) via various channels • Describe how your solution meets this requirement by: ○ DTMF? ○ A voice-enabled application?	

▪ Directed Speech?
▪ Word spotting?
▪ Natural Language Understanding?
• Integration to CRM and other systems to retrieve caller information
• Mechanism to query external systems
• Ability to use collected data to enhance ACD call routing
  ○ Elaborate if your solution leverages collected data be used to provide self-service applications
• Feature for Text-To-Speech for speaking back variable data
• Ability to use dynamic phrases be used to create a more variegated, human-like experience
  ○ Elaborate What text-to-speech engines do you support?
  ○ If your speech engine is self-developed, describe how it is maintained and updated.
• Ability to feed collected data to agents via screen pop
• Ability to administer and create voice asset libraries without professional services
• System to log all interactions in detail records to support reporting and tuning of applications
• Ability to develop self-service applications offline and then put into production after testing with live calls
• Support for native Virtual Agent/IVA solution
• Multi-language support.
  ○ Elaborate what languages does your IVA support? Is it available globally?
• IVA to have sentiment analysis capabilities
• IVA to have capabilities to handle misspellings, synonyms, etc.
• IVA able to group multiple intents
• IVA support for switching to a live agent and support the agent during the conversation
 	
OMNICHANNEL CUSTOMER EXPERIENCES AND VISUAL IVR
 	
CalOptima currently does not use intelligent routing or visual IVR to create personalized experiences for text-based channels but intends to add this capability to our contact center to improve customer satisfaction and automate additional interactions.
 	
• Ability to deliver a more personalized experience specifically via non-voice channels.
  ○ Describe in detail if and how your solution supports this capability
• Visual IVR capability – If your solution supports this feature then answer the following related questions in detail.
  ○ Does the solution require that users download an application on their mobile device or is it HTML-driven?
  ○ Does the solution enable mobile, visual access to IVR prompts?	

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- Does the solution enable mobile visual access to self-service applications?
    - Does the Visual IVR solution provide contact center agent access via phone, chat, and email? And do agents receive customer context?
    - Does the solution provide estimated callback delay time?
    - Does the solution require a separate administrative interface?
    - Can the solution be embedded in our corporate website?
    - What other ways can customers be directed to visual IVR applications?
- Bot-like capabilities for text-based interactions. If your solution supports this feature, then answer the following questions in detail.
    - Are the interactions available on all text channels?
    - Does each different channel require a separate bot?
- Ability to enable IVAs for text interactions by repurposing the same set-up done previously. If your solution supports this feature, then answer the following questions in detail.
    - Must they be re-configured, or can the same set-up effort be repurposed?
    - Describe the set-up process for adding a new channel to an existing experience.

CALLBACK ASSIST

CalOptima currently uses a Callback assists solution to assist our members and providers efficiently; increase first-contact resolution rate and decrease call abandonment rate. We would like the new solution to have a callback assist feature built in it. We would like the following capabilities in our callback assist solution:

- Ability to call our member and providers back to avoid them staying in our queue.
- Provide estimated wait time in the queue.
    - Inform them on where they are in the queue (queue position).
        - Keep members/providers posted with text updates including exactly how many people are in front of them and approximate time on callback.
    - Send them multiple reminders especially as they get closer to being called back.
- Ability to have our members get in queue from a QR code, mobile app, via our web, or text to join etc.
- Ability to confirm and cancel callback services over text.
- Ability to streamline the customer experience and only offer available callback times to customers.

• Ability to integrate with CRM to be able to detect members/providers phone numbers automatically and obtain our Members ID, Name, Last name, etc.). • Ability to offer SMS messages in 7 threshold languages (English, Spanish, Vietnamese, Farsi, Korean, Arabic and Chinese).	
10. VENDOR SOLUTION INFRASTRUCTURE DATA CENTERS Since your solution is hosted in the Cloud, the following questions must be answered by each vendor in detail so CalOptima can assess the Service Availability, Security and Disaster Recovery of your solution. • What is the location(s) of the data centers that your solution uses? • Are the data centers operated by a third party? What vendor? • What physical security controls are in place at your production data center(s)? • Describe your call center scalability, such as how many call center agents can be supported on your system? • How can you expand capacity to support growth? • Provide network architecture diagrams on the proposed solution that depict key elements (hardware, software, and network connectivity, etc.) • What is your availability SLA / guarantees? TELECOM & DATA INFRASTRUCTURE • Does the solution require premises-based servers? • Describe LAN/WAN load considerations and connectivity recommendations between our data center and your cloud-based data center. • Describe what voice connectivity methods are supported for both receiving incoming calls, for voice connectivity to agents, and for outbound customer calling, including considerations for MPLS, VPN, and SIP trunks. • Provide call flow diagrams on how the calls are routed between the proposed solution and agents' phones. • How does your solution integrate with IP and non-IP PBX? • How does your solution integrate with cloud-based UC systems? • Are there any hardware or software elements required for PBX integration? SERVICE AVAILABILITY/DISASTER RECOVERY Describe the level of redundancy or resiliency your contact center infrastructure can provide. • How is your system architecture designed to deliver 99.99% or better availability?	

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What is capability to fail over to an alternative, geographically separated facility?
What is your approach backup and recovery, including secure back-ups of our data?
What is the frequency of upgrades and maintenance?
What is the standard lead-time you provide before maintenance or mandatory upgrades/patches?
What is the expected amount of time our service will be impacted during maintenance or upgrade windows?
What notice is provided of pending maintenance and upgrades?
Are all your customers upgraded at the same time? Can we elect to upgrade later?
Do you have teams and/or systems dedicated to monitoring system availability and alarms?
Describe how your solution will enable us to minimize the impact of any disaster affecting one or all our contact center locations?

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<h2>11. FULLY INTEGRATED SOLUTION</h2>
Due to a complex IT eco-system at CalOptima, having a solution that integrates seamlessly with CRM, ERP, BI, and back-office collaboration suites will allow us to fully utilize the information set available to our business. It’s important for us not to silo information within the contact center. Please provide the following information for CalOptima to assess your solution integration capabilities.

Please describe how your application interfaces with our other business applications to PULL (retrieve) information and where it’s used within the customer experience and contact center. Then describe your solution’s ability to PUSH (send) information to 3rd party applications; please provide example use cases

<h3>INTEGRATION/APIS</h3>
As we continue to implement our cloud strategy, the systems we use to support our business will change rapidly. We must only invest in solutions that will remain flexible in the integration endpoints they support and the applications they offer productized integrations to.

Currently we have Microsoft Teams in our technology stack. Describe how you integrate with each and provide reference to a resource where we might review what other applications your solution has productized integrations to.
Ability to screen pop to CRM or other Backoffice systems. Answer the following questions that articulate how this feature is implemented by your solution.

Is screen pop to CRM or other application supported for both inbound and outbound calls?

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○ Is screen pop to CRM or other application supported for text-based channels? Which channels? ○ What mechanisms are used to integrate for screen pops? ○ What mechanisms does the IVR/IVA use to query external systems? ○ Does your solution provide click-to-dial from CRM or other applications? ○ Can inbound and outbound calls be automatically logged in the CRM? ○ Is there a productized adapter available for the CRM? If yes, Does the adapter "follow" the agents around as they navigate the CRM to ensure memorialization occurs on the more appropriate record? Also Can the adapter be modified to add or remove buttons as necessary? • If your solution does not offer productized adapter, then answer the following questions to define how your solution can provide screen pop solution: ○ Can solutions be implemented without requiring custom code? ○ Does the integration utilize standard SDKs (software development toolkits)? • Define where does your application sit relative to the CRM desktop ADDITIONAL REQUIREMENTS • 3-way calling feature. Describe how your solution support 3-way calling. • Access to Call records/Data Retention & Retrieval – Describe how you treat access to call records, the retention of records, and the CalOptima's costs to archive and retrieve recordings MICROSOFT TEAMS AND LUMEN INTEGRATIONS CalOptima Health is requesting the new contact center solution be able to integrate with Microsoft Teams. As a company, we appreciate the power of collaboration between contact center and knowledge workers and would like to remove the barriers currently exist between these two sides of the organization. We intend to migrate to the cloud for UC as well with Microsoft Teams and Lumen, and it is important to us that this migration does not disrupt our contact center operations. • Please describe how your solution helps contact center workers collaborate with employees in the back office.	
12. REDUCE SETUP, SUPPORT, AND TRAINING COSTS Currently CalOptima spends too much time and money on the design and implementation of customer experiences and use cases. This has hindered our ability to innovate. Any new application should support more rapid deployment of new and modified interaction flows,	

regularly deliver new features, and partner with us for support and guidance. Please describe how you enable your customers to remain agile in the face of rapidly changing business requirements. Provide an example use case of an implementation where your customer was able to make rapid changes to meet changing business demands. From initial setup to support and renewals to new projects, we are seeking a partner who will provide exquisite service every step of the way. **Please describe how your approach to service and support would qualify as "white glove."** PROFESSIONAL SERVICES • Provide an overview of the project management methodology used. Specifically, describe the discovery process to finalize a statement of work. Indicate the duration, resources, typical steps, and the information you require from our organization during the process. • What is the Net Promoter Score of your implementation team? PROJECT MANAGEMENT • Describe the implementation process including design, planning, development, training, testing, etc. • Will your resources setup and configure the new contact center solution or is that the customer's responsibility? • Indicate which tasks are required to be performed with your representatives on-site and which you can conduct remotely. • Indicate if a dedicated project manager and a dedicated technical resource will be assigned to this project. This technical consultant cannot hold a pre-sales function in your organization. • Is the project manager accountable for creating a detailed project plan mapping out the project in full detail, through service enablement? • Throughout the project implementation phase will there be weekly project status calls? • How long does it take to implement your cloud-based contact center solution? • What customer resources are required to support the implementation of the solution? • Please provide a sample project plan. TRAINING • Do you provide training and workshops to teach customers how to implement and use your contact center solution? • Describe the training courses that are provided with a standard implementation. • Is training on-line or in person?	

• Do you provide customized training specific to the customer's configuration? • Do you provide certification programs? If yes, please describe what certifications are available and their associated cost. • Do you offer post-implementation training and workshops for optimization and new hires? DOCUMENTATION • Provide an overview of the documentation provided with the solution. • Do you offer system manuals for administrators, supervisors, and agents? • Are there online tutorials? • Is online, searchable help provided? • Are technical requirements documented? SUPPORT • The selected supplier will be expected to meet or exceed certain service level requirements, which will be specified in the agreement. • Please describe your approach to maintenance and support as well as your standard support options. • Do you provide toll free, web and email support options? Is the support in-house or outsourced? • What is your response time commitment based on severity? • What is the NPS score for your Support team? • Is emergency access to technical support personnel available 24 hours per day, seven (7) days per week? • Provide details of your escalation procedures. • Can you provide a designated contact person to be accountable for customer problem resolution and escalation when necessary? • Are dedicated or shared, but assigned, resources available for support? • Do you provide adds-moves-changes services? INNOVATION We seek a supplier that is not simply meeting market requirements today but is also looking toward the future at problems that are yet unknown to businesses. To remain competitive, we must partner with a vendor who will consistently deliver state-of-the-art products and services. Please describe how your solution continually innovates. • How frequently are updates and upgrades to the software applied? • When are system upgrades typically performed? • List any mergers and acquisitions your company has made in the last 4 years.	

• How long did it take for you to fully incorporate the solutions? (If not yet incorporated, when is the projected completion date of the assimilation?) • Describe your new-feature release development cycle. • Do you offer an app store or marketplace?	
13. IMPROVE OPERATIONAL EFFICIENCY With this investment, CalOptima expects to realize considerable improvements in operational efficiency. Please describe results you've delivered to companies like ours and how you achieved them. Be as specific as possible; link to any relevant case studies or press releases.	
14. DIGITAL EMPLOYEES To effectively scale our business to keep up with demand we must consider the addition of a digital workforce of AI-driven bots and automation. These digital employees should both reduce the need for human labor by providing self-service applications and augment the human workforce by pre-qualifying calls and supporting agents while on live calls. **Please describe your digital workforce strategy and how you use Artificial Intelligence and Machine Learning to improve client experience.** • What tools are available for creating engaging self-service applications? • What tools does your solution provide to deliver assisted-service applications? • Can interactions be escalated to a human agent without the customer disengaging with the bot? • Describe other ways your solution delivers hybrid human/bot assisted-service experiences? • How does your solution augment live agent interactions? • What real-time assistances are available during live interactions? • Are these available for voice? • Chat/SMS/Social Messaging? • How are these configured? • Describe your solution's automated agent call flow support, e.g., guided assist, guided flow, etc. • What Artificial Intelligence systems are compatible with your solution? • Who do you partner with/recommend for advanced AI capabilities? • Is there machine learning behind the solution? • Is the same AI "brain" used for all the interaction flows above? • How is training managed?	

• Can training data be used across the board or will each interaction type/use case require separate training data?	
15. INCREASE AUTOMATION To further improve efficiencies, we want our new solution to provide more automation points. The solution should deliver robust capabilities for listening for triggers from 3rd party applications as well as initiating business process workflows from the application itself. **Please describe how your solution will increase our automation before, during, and after live- and bot-based interactions.** • We are interested in Robotic Process Automation (RPA) to reduce manual effort. What RPA tools should we consider? • What are your recommendations on how to leverage RPA?	
16. BLENDING Our existing solution requires agents to log in and out of queues when they are manually instructed to shift between inbound and outbound work. This negatively impacts our service levels and results in too much idle time for agents. **Please discuss how your solution helps keep our agents busy and minimizes, or eliminates, the need for manual intervention then transitioning between inbound and outbound interactions.** • Is your dialer on the same ACD as your inbound voice traffic? • How does your ACD toggle between inbound and outbound? • What types of interactions take precedence? • Can the dialer run without causing the inbound queue to back up?	
17. REPORTING AND DASHBOARDS You can only improve what you can understand, so as we strive to create better efficiency, it's crucial we can measure all aspects of our process. Our current contact center reporting capability is limited and disjointed. We desire a system that provides easy access to non-technical users to a consolidated view of all contact center operations (agents, queues, IVR, dialer, etc.) **Please describe your reporting solution and provide example reports.** Standard Reports • Describe how historical reports are generated. • Does the solution provide unified reporting across sites? • Can supervisors and administrators access standard reports? • Are standard reports configurable? • Can business data variables be included? • Can reports be filtered to show specific agents, queues, etc.? What filters are available? • How far back can historical data be accessed?	

• Can historical data be archived? • What is the length of reports that can be archived? • Do standard reports include all interaction channels? • Does the solution support cradle-to-grave call tracking? **Custom Reports** • Can reports be customized easily without vendor intervention? • Describe how ad-hoc reports can be customized. • Can custom reports be generated without requiring a specialized application or Professional Services? • What technical skills are required to customize reports? • Can report data be exported? What formats are supported? • How is access to reports managed? • Can restricted reporting access be given to users? **Report Distribution** • Can reports be manually downloaded? • What report formats are supported? • Can reports be automatically distributed by email? • Can CSV files be automatically sent via secure FTP to external systems (data warehouse, etc.)? **Dashboards and Wallboards** • Does your solution have a dashboard that allows supervisors/managers to view the status of their agents in real time? • Are the dashboards configurable? • Can non-administrators customize dashboards? • Do the dashboards provide graphical and tabular data? • Can dashboards be displayed on wallboard or large screen monitor? • Are all interaction channels included in dashboards? • What key performance indicators (KPIs) can be displayed? • Can visual alerts be configured with thresholds for KPIs?	
18. WORKFORCE OPTIMIZATION (WFO) We see great opportunity for improving operational efficiency by investing in a workforce engagement management solution. We expect such a solution to be fully integrated into and delivered by the core solution provider. **Please describe your WFO strategy and solution.**	
19. QUALITY MANAGEMENT/OPTIMIZATION	

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To ensure we provide the best quality interaction with our customers, our company regularly monitors and scores agent interactions. Today these processes are manual, and we desire to take it to the next level. Minimally the solution should provide configurable scoresheets and reporting, but we are also interested in more advanced options such as business rule-driven quality optimization. Describe the capabilities of the Quality Management/Quality Optimization solution. • Does your solution provide integrated call recording? • Does the solution support 100% recording of calls? • Does your solution provide an integrated QA application? • Does the solution support 100% recording of voice and digital interaction screens? • Can screen and voice interactions be captured from any agent client? • Please describe the screen capture capability. How does it work? • Does your QA solution allow users to store and retrieve calls based on pre-defined business rules including queue, agent and KPIs? • Can on-demand recordings be initiated by agents? • Can on-demand recordings be initiated by supervisors? • Please explain how your recording solution helps users be PCI-DSS compliant. • What encryption methods are used for recordings? • What media formats are used for recordings? • Does the solution require servers on the customer premises or are recordings stored in the cloud? • What are your standard recording storage time frames? • Does role-based access control access to recordings? • From the time a call is recorded, how long does it take before it can be accessed? • Can users create a "snippet" of a best-practice call, annotate it, and share it? • Describe the capabilities of your QA form development environment. • Describe calibration capabilities that your QA solution provides. • Can reps challenge/question an evaluation, add comments, and send it back to the reviewer? • What reporting/dashboard visualization capabilities come standard with your QA solution?	
20. WORKFORCE MANAGEMENT We are interested in a more robust and integrated solution that provides forecasting, advanced scheduling features, transcription, audio sentiment, evaluation tools, etc. WFM metadata from Calabrio will need to be migrated going back two years. Describe your solution's WFM solution and capabilities.	

- Does your WFM solution provide accurate forecasting and the ability to plan the staffing levels?
- Can your system forecast outbound, inbound, and blended call center environments?
- Is "what if" forecasting to project the impact of increased call volume or the impact of changes in headcount provided?
- Does the forecast system properly account for multi-skilled agents?
- Does the WFM solution provide both short- and long-term forecasts?
- Does your system have real-time monitoring of Intra-day performance?
- Does your system provide graphical view of agent schedule adherence both historically and real-time?
- Does the WFM provide variable work rules? (i.e., Minimum/Maximum Shift lengths, Minimum/Maximum Hours length, Minimum/Maximum Days Off)
- Are both manual and automated shift creation supported?
- Does your system have an agent interface allowing the agents to submit vacation requests, trade shifts, shift bid, etc.?
- Does your system provide dashboard (real-time & historical) functionality for agents to monitor their performance?
- Is the WFM pre-integrated into the ACD and Dialer for historical and real-time data?
- If required, can you integrate with third party hosted and/or premise WFM solutions?

21. AGENT GUIDANCE, ENABLEMENT, AND SCRIPTING

- When can scripts be delivered?
- Does your solution provide customizable agent scripts?
- Does it support dynamic feeds based on information happening during the call?
- Does the system support unique scripts per inbound and outbound campaign?
- Can the scripts display optional content or logical flows based on available data? (i.e., dialed number, data collected by the IVR)
- Does the solution dynamically insert available customer information into the script?
- Do the scripts support both text and graphics?
- Can data entered by agents into the agent script be written back to the system internal database?
- Can data entered by agents into the agent script be provided to external systems?
- Does your solution provide the ability for guided worksheets that capture reportable data in a guided agent flow?
- Can guidance include information from 3rd party applications like CRM?

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22. GAMIFICATION

Describe your solution's gamification capabilities.

Describe three (3) ways your gamification solution has positively impacted employee engagement at companies in your client base.

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23. COMPLIANCE, SYSTEM ACCESS, AND SECURITY

Security and privacy of customer data are extremely important and an essential element of our client relationships. Your platform must be secured to industry leading standards, including daily security scans and code reviews and multiple layers of security that meet and exceed the industry's security and compliance requirements.

- Do you have a separate group within your company dedicated to Information security and compliance?
- Do you have written security and compliance policies?
- Do you have a SOC 2 attestation of compliance?
- Do you have a PCI-DSS attestation of compliance?
- Is your solution HIPAA compliant?
- Will you sign a Business Associate Agreement?
- How does your solution help us maintain TCPA Compliance?
- Is your solution complaint with STIR/SHAKEN?
- Do you deliver E911 capabilities?
- How do you stay abreast of the changing regulatory landscape?

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24. ACCESS CONTROLS

Describe how the applications for agents, supervisors and administrators are deployed and accessed.

- Does the system provide configurable, role-based access?
- Describe how many levels of access your system can provide, such as manager, supervisor, agents, etc. and provide what the capabilities of each level are in detail.
- Describe how your system supports single sign on (SSO) capability if capable.
- Does the solution provide configurable username/password policies like password complexity, retries, etc. Please describe the options available.
- Does your solution support Multifactor Authentication (MFA)?
- Are remote/at-home agents, supervisors and administrators supported?
- Are there any system limits? What is the maximum number of:
  - Agents
  - Supervisors
  - Administrators
  - Queues
  - Routing steps

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○ Announcements • What is the process to increase licensing if we need to expand capacity beyond what is purchased or contracted?	
25. SECURITY POLICY AND PROCEDURES **Describe your organization's Security Policy and Procedures.** Please include provisions to protect customer data from any unauthorized access by implementing access controls and employing encryption. • Data Retention – As noted earlier in this document, we are looking for a solution that supports our Data Retention requirements (currently, up to 10 years). This includes reporting as well as recordings. What options do you provide for storage of archival data, and what are the costs? • Are all employees required to review and certify a full understanding of your company's Policy and Procedures? • Does your Policy and Procedures cover the following topics:	

Policies	Yes/No
Data Retention Policy	
Privacy and Data Protection Policy	
Employee Security Awareness training and management	
Data Storage and Transmission	
Vulnerability Management program	
Employee Security Policy	
Physical Security Policy	
Acceptable Use Policy	
Password Policy	
Legal Regulatory and Compliance policy	
Corporate Code of Conduct	
Global Anti-Bribery/Anti-Corruption Policy	
Third Party Remote Access Policy	

• Are background checks performed on all staff with access to customer data?	
26. SECURITY VULNERABILITY ASSESSMENTS • Does your Information Security Department conduct internal and external network vulnerability scans? • Are potential vulnerabilities identified and communicated to appropriate personnel for prompt remediation? • Are all high-level vulnerabilities corrected within 10 days and medium-level vulnerabilities corrected and subject to a Change Control Policy? • Are follow-up scans performed to confirm compliance with your security standards?	
27. INTRUSION DETECTION • Are intrusion detection systems installed in your environment to alert network operations personnel of any attempt to penetrate the system and its data?	

• Are intrusion sensors and file integrity checking systems configured to automatically notify the network operations personnel of any potential compromises or attacks? • Does your Information Security Department conduct internal and external penetration scans?	
28. ACD Handling of inbound customer interactions in a timely and rules-driven way is critical to the success of our business. Describe the capabilities of your solution's ACD. • Can the ACD routing be defined by non-technical users? • Does the solution provide a graphical, drag-and-drop interface for defining ACD routing? • Does your ACD provide skills-based routing? • Can the solution conditionally overflow calls to secondary queues? • Can agents belong to multiple groups/queues at the same time? • Does your ACD provide multichannel routing? • Is data-directed routing supported based on data obtained in the IVR? • Is screen pop to CRM or other systems supported for inbound calls? • How can calls be routed to specific announcements and/or queues: • Is auto-answer available and configurable on a per agent basis? • If an agent does not have auto-answer configured and doesn't answer a call, what happens to the caller and the agent? How is it reported? • Is music on hold available? Is it configurable? • Can the caller be provided an estimated wait time? • Can calls be prioritized? Based on what? • Can calls be conditionally routed to group voicemail? If yes, how are group voicemails retrieved by agents? • Does the ACD provide a virtual hold capability allowing callers to hang up and still maintain their place in queue? • Does the ACD support alternate routing for after hours, weekends and holidays? • How are alternate routing rules activated? • Can calls be forwarded to external numbers (partner, answering service, etc.)? • Can an agent on an ACD call receive a second call to his/her specific extension? • Can maximum thresholds be set for wrap time? • Can administrators define custom not-ready codes? • Can administrators define custom logout codes?	
29. AGENT APPLICATION Describe the agent application provided by your system with specific attention to streamlined workflows and ease of use.	

• Can agents be configured to handle concurrent mixed interactions (handle an email and multiple chat sessions)? • What are the limits for concurrent interactions? Is it configurable by interaction type? By Agent? • Can agents perform warm and cold transfers to other agents, other queues and non-ACD destinations? • Does the solution provide speed dials? • Can agents see queue statistics? • Can agents see their current talk and not ready times? • Can agents schedule personal and group callbacks? • Can the agent easily request assistance from a supervisor? • Does the system support internal chat with supervisors? • Do agents get placed in a not ready state if they do not answer an inbound interaction? • Can agents enter a wrap up state following an interaction? Can a maximum wrap up time be set by the administrator? • Do remote/at-home agents have all the same capabilities as office-based agents? • Do you have a productized adapter for <this> CRM? • What happens if the CRM is unavailable? Can agent log in elsewhere?	
30. SUPERVISOR APPLICATION • Describe your system's supervisor application and capabilities to monitor interaction activity, agent status, etc. • Does the application display real-time agent interaction, queue, and dialer metrics for all agents (including remote/at-home)? • Can supervisors create alerts on KPIs? • Can supervisor alerts include visual, audible and email alerts? • Can views be locked down, so supervisors see only their team and applications? • Does the interface provide an alert when agents request assistance? • Can supervisors broadcast messages to groups? • Can supervisors send messages to individuals? • Can supervisors remotely log out agents? • Do agents have "chat room" capability to ask for supervisor assistance? Is this feature licensed or require any additional hardware/software? • Does the supervisor application support silent monitor? Whisper coach? Barge in? • Can supervisors be given access to activate/deactivate campaigns from the supervisor application? • Do you provide a mobile application for supervisors? • What capabilities does the mobile supervisor application provide?	
31. ADMINISTRATOR APPLICATION Describe your system's administrator application with specific attention to ease of use and time required to implement changes. • Can the ACD routing be defined by non-technical users?	

- Does the solution provide an intuitive administrative interface for ACD, IVR/IVA, Visual-IVR, dialer, and CTI?

Can our administrator configure:	Yes/No
Password Policies	
Local ANIs	
Dialing rules	
Users	
Queues	
Outbound Campaigns	
IVR/ACD scripts	
Prompt/announcement messages	
Reason codes	
integrations	

- Does the application provide an intuitive, drag-and-drop environment for defining IVR/IVA/ACD applications?
- Can agents be assigned to multiple queues?
- Can agents be assigned to multiple channels with concurrent limits set by channel?

32. CUSTOMER SURVEYS

In addition to our internal quality monitoring, we regularly survey our customers for feedback on our services and agent interactions. Today this process is informal. We desire a capability that will enable us to automatically survey customers immediately following their interaction with us. Please describe your survey capabilities.

- Does your solution support automated, post-call surveys? Please describe.
- Does your solution support automated, post-call surveys using IVR?
- Does your solution support text-based post-chat surveys? Please describe.
- Does your solution support follow up email surveys? Please describe.
- Describe reporting capability for survey results.

33. DESKTOP COMPUTER REQUIREMENTS

Describe minimum agent desktop requirements.

- Does voice recording add additional requirements on the agents' computer? Are there are any drivers, applications, etc. that need to be installed?
- Does screen recording add additional requirements on the agents' computer? Are there are any drivers, applications, etc. that need to be installed?
- Describe minimum supervisor desktop requirements.

• Does your solution support desktop virtualization? Which environments are supported? • Does the solution include a softphone, or does it need to be purchased? How is the softphone installed? • Describe your global presence including the countries supported today.	

34. GENERAL REQUIREMENTS
 	
Please provide two detail levels of the cost structures to include licensing structure, hardware, software, professional services, supporting pricing, tariff plans, etc. Please include details on all available pricing options e.g., per seat, monthly, bundles and add-ons and or pay per use.
 	
• How is the system licensed for:
    o Agents?
    o Supervisors?
    o Administrators?
    o IVR Ports?	

ASSUMPTIONS

In this section, please clearly state and define all assumptions used to generate offered pricing. Reasons for limitations on the applicability of offered pricing must be fully explained and justified.

PRICES ALL INCLUSIVE

Unless expressly stated otherwise, prices quoted in this proposal are all inclusive; that is, all functions and services proposed shall be delivered for the prices and costs proposed in this section.

TOTAL COST OF OWNERSHIP

To provide a complete cost comparison, please clearly state and define all costs above and beyond monthly recurring charges for, but not limited to, maintenance, support, upgrades, licenses, training, professional services etc. for 5 years.

LABOR RATES FOR OUT-OF-SCOPE WORK

Provide hourly labor rates for any additional out of scope work or for project-oriented work support, based upon the overall scope of work presented in the RFP.

SUPPLIER INFORMATION

The following sub-sections define requirements related specifically to Supplier viability. Suppliers must provide information for the following as components of the Scope of Work Response. CalOptima agrees that all information will be used solely in its evaluation and will not be disclosed to 3rd parties without express written consent from Supplier.

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Supplier Profile

- Provide the legal name and address of your company, including State of Incorporation.
- When was your company founded?
- Is the Supplier a private or publicly held company?
- How are you financed?
- Where are your company's offices for sales and support located?
- How many employees does your company employ?

Solution Description

Briefly summarize the solution you provide.

Company Overview

Give a brief overview of your company history.

Client/Project Case Studies

The Supplier is to provide three client case studies of a comparable size and configuration that demonstrate measurable improvement in contact center operations. If down selected, Supplier should be prepared to provide live customer references.

Supplier Account Team

Provide the name, address, and phone number of individuals with direct responsibility and authority to execute the elements of this RFP response.

Supplier Mission, Vision, and Objectives

What is your company's mission/vision? What are your goals and objectives as a company?

CalOptima Health Board Action Agenda Referral

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

Report Item
13. Approve Actions Related to the Procurement for the Member Mobile App

Contacts
Ladan Khamseh, Executive Director, Operations, (714) 246-8866
Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154

Recommended Actions
1. Authorize reallocation of budgeted but unused funds up to $800,000 from the "Digital Transformation Strategy Planning and Execution Support" capital project to a new project "Member Mobile App" under the "Applications Development" category in the CalOptima Health Fiscal Year 2022-2023 Digital Transformation Year One Capital Budget.
2. Approve the scope of work for a vendor to develop and support the Member Mobile App.
3. Authorize the Chief Executive Officer to release the request for proposal, 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 Operations staff are seeking approval for the attached SOW for the development and support of a CalOptima Health Member Mobile App and request approval to release the RFP to select and contract with a vendor to provide the solution. *See* Attachment 1.

Developing a modern mobile application will result in improved engagement with members regarding CalOptima Health's programs and services, particularly among those who are difficult to reach during crucial enrollment periods and associated events. The mobile application's push notification feature can be utilized for: proactive status updates, notifications for annual wellness visits and health risk assessments, and promoting cancer screenings. The mobile application will allow delivery of high-quality health and wellness content, including preventive health screenings and information on fitness, nutrition, exercise, and more. The introduction of a mobile application will enhance the prominence of CalOptima Health's brand in the marketplace and foster member loyalty. The mobile application will also facilitate the delivery of digital member rewards and provide self-service options for members.

The ITS and Operations 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 one year at an estimated annual cost of no more than $800,000.

Fiscal Impact

The fiscal impact for the recommended action is budget neutral. As proposed, unspent funds in an amount up to $800,000 that were approved as part of the CalOptima Health Fiscal Year 2022-23 Digital Transformation Year One Capital Budget on June 2, 2022, will fund the expenses for the new capital project, Member Mobile App.

Rationale for Recommendation

CalOptima Health recognizes the importance of providing members with easy access to their services and programs to drive better health outcomes. By implementing a mobile application, CalOptima Health will be able to deliver content and services to members wherever they are located, in a format that is commonly used in today's market and familiar to members. This will contribute to increased member satisfaction through adding an additional channel of communication with members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Scope of Work for the Member Mobile App.

/s/ Michael Hunn *02/23/2023*
Authorized Signature **Date**

A. OBJECTIVE

The objective of the current initiative is for CalOptima to identify and select the most appropriate software vendor for its Member Mobile Application Platform requirements.

The Mobile App should provide all the services outlined in the Scope of Work (SOW).

The solution must be able to support CalOptima's current requirements, as well as, new or changing requirements mandated by federal and state regulators.

Key objectives of this platform include:

a. Deliver better member experience.
b. Member engagement with key information, news and to convey timely and important information. Reach hard-to-reach members during critical times of enrollments and related events.
c. Elevate CalOptima Health brand in the market.
d. Deliver easy access to mobile wellness resources, member covered services, future connectivity to telemedicine.
e. Deliver curated content for quality health and wellness including preventative health screenings and fitness, diet, exercise, and tips.

The following are a few examples of how the Mobile Platform will be used:

- Member communications
- Member services announcements
- Member profile updates
- Proactive status notifications
- Notifications of annual wellness visits and health risk assessment
- Promote cancer screenings
- Membership cards requests
- Member gift cards programs

- CalOptima Health anticipates securing a contract with a vendor and implementing the solution by the first quarter of Fiscal Year 2023-24.
- Vendor can propose a phased release approach with MVP (Minimal Viable Product) being delivered as part of initial implementation and schedule for rest of the product features thereafter.

B. SCOPE OF WORK

CalOptima Health is seeking to implement a best-in-class, fast, secure mobile application for its Members and Member's Personal Representatives with the following capabilities:

B1. Technology Requirements

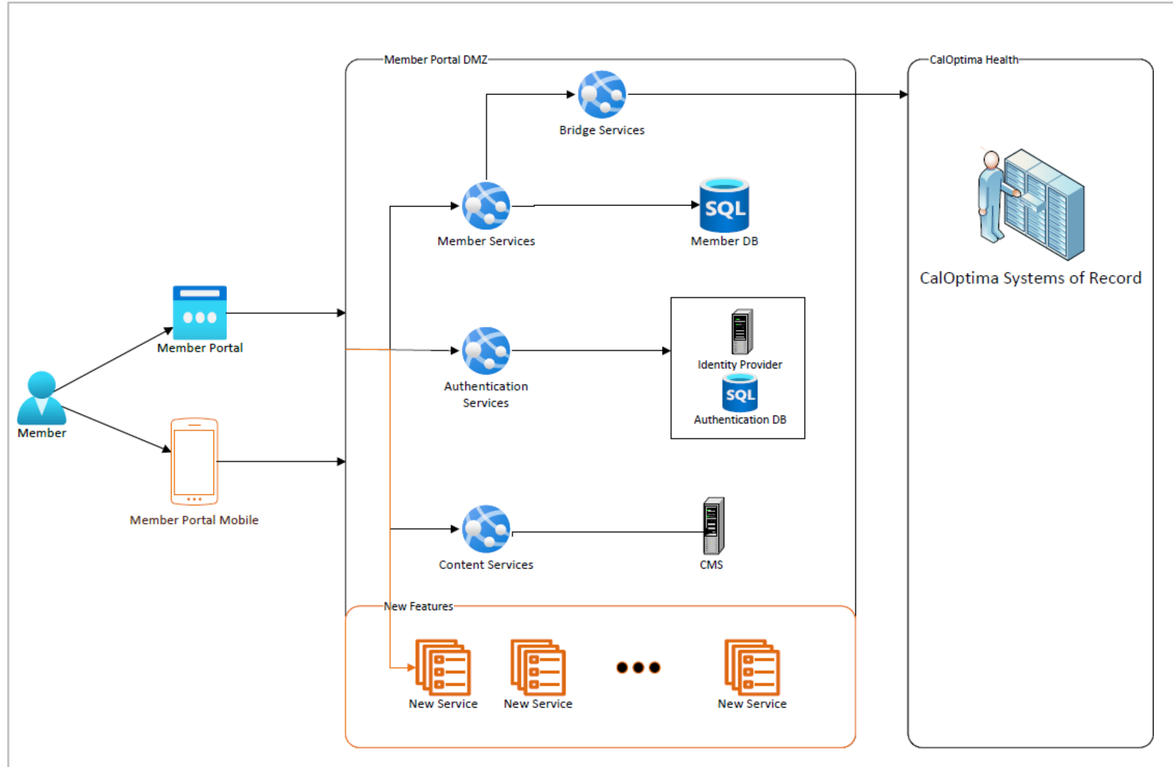
1. Member Portal Web Platform Integration Requirements

   CalOptima Member Portal is a secure online web application where Members or Member's Personal Representatives have 24-hour access to CalOptima from anywhere with an internet connection. The Member Portal content is available in English, Spanish, and Vietnamese. The Member Portal platform is implemented on .NET Core stack and fully architected using SOA model. The Portal is running on SQL backend and currently hosted on CalOptima's internal infrastructure.

   There is a separate project in-flight to migrate the Member Portal to Microsoft Azure cloud platform by June 2023 ("Lift and Shift" strategy). It is expected that the Member Mobile App code will get deployed in the Azure Cloud along with the Member Portal code.

   Existing Member Poral services need to be leveraged to integrate the Mobile App with CalOptima IT ecosystem. New Microservices or wrapper to the existing services can be built. This approach needs to be finalized during the design phase in collaboration with CalOptima Member Portal development team and Enterprise Architecture team.

   Context diagram of the existing Member Portal integrations and proposed Mobile App is depicted in the diagram below.



2. Member Mobile App Technology Requirements

    a. Mobile App to be built using the latest version of React Native.
    b. Member portal presentation layer code related to data manipulation, 508 compliance and language support will need to be assessed and potentially rewritten for Mobile app. Same applies to the Member portal code related to client-side validations.
    c. Mobile App code to co-exist with Member Portal codebase.
    d. Mobile App code to be developed by vendor resources in close collaboration with Member Portal Team and based on the standards set forth by Enterprise Architecture.
    e. Member Portal team to actively participate during design, UAT and implementation to support successful implementation of this project.
    f. Mobile App to be built using CalOptima style guides and will conform to 508 Compliance, Threshold Language Support, Screen reader capabilities, readability requirements.

3. Member Mobile App UI/UX Design Requirements

    Vendor to onboard a UI/UX experience designer to build the UI/UX for the Mobile App in collaboration with CalOptima IT and business stakeholders. UI/UX must conform to CalOptima standards and stakeholder approvals are mandatory. Following steps are expected to be followed during this process.

    a. Creation of user-journey map
    b. Building UX wireframes.
    c. Building prototype.
    d. Graphic design.
    e. Usability testing.

4. Member Mobile App Security Requirements

    a. The Mobile App needs to 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. Vendor developers should be familiar with OWASP coding standards.
    c. All code must conform to OWASP security standards. The code should not be vulnerable to SQL injection, XML injection or similar vulnerability.
    d. All code must protect the confidentiality and integrity of transmitted information.
    e. The Mobile App must not include source code, unreferenced code or subroutines that are never invoked during operation, except for software components and libraries from approved third-party products, which are approved by CalOptima Information Security department.
    f. The Mobile App must not call functions vulnerable to buffer overflows. The code must be inspected to remove identified or likely sources of buffer overflow vulnerabilities to include the following:

- Use static analysis tools that are known to find this class of vulnerability with few false positives.
- Validate all input before use, allowing only known-good input through.
- Recheck all calculations to ensure buffer sizes are calculated correctly.
- Recheck all array access and flow control calculations.
- Use compile-time options that add compiler buffer overrun defenses.

g. The Mobile App must remove temporary files when it terminates. Configure or code the mobile app to remove all temporary files before the application exits.

h. The Mobile App code must not contain hardcoded references to resources external to the app. Vendor needs to ensure that all hardcoded external resource references from the mobile app code are removed.

i. The Mobile App code must not contain adware or known malware.

j. Source Code Encryption – The usage of White-Box Cryptography together with other protection techniques such as obfuscation at different levels (e.g. function names or control flow obfuscation) is required.

k. Secure the Data-in-transit using SSL/TLS.

l. Limit storing confidential data on the mobile device or the device memory. For required use cases, work with Information security on how the data should be encrypted.

m. CalOptima will engage with a third party security vendor to perform penetration/application security testing on the Mobile App code. All defects and vulnerabilities discovered during the testing will need to be fixed by the vendor development team.

5. KPI Requirements

Following KPI's need to be captured as part of initial launch of the application. Additional KPIs may be defined as deemed necessary, during the operational support period.

a. User engagement KPI metrics
    - Adoption
    - Session length and depth
    - Average number of screens per visit
    - Daily, weekly, and monthly active users

b. Device related metrics
    - Devices & OS used by users
    - App performance & Crash reports

6. Vendor Resources Allocation post go-live implementation

Mobile App needs to be maintained and enhanced with new features by vendor resources (onshore/offshore) for one year post go-live. Vendor needs to propose retaining optimal number of technical resources for this activity, and include the cost of these resources, as part of this proposal as a separate line item. The exact number of resource needs can be discussed and finalized with CalOptima IT team during contracting phase.

7. App Store Deployment Requirements

    a. Mobile App need to be deployed in Apple App Store and Google Play

    b. Vendor needs to deliver Mobile App requirements document which should include all technical assets and information required for Apple's App Store submission and Google Play submission.

    c. Details like iTunes Connect Account access/Google Play Developer access, Company/Entity Name, App Store/Google Store app listing name and relevant details will be finalized by CalOptima and provided to the vendor after the project kick-off.

B2. Functional Requirements

The requirements below are functional requirements that have been already implemented in the Member Portal. The goal of this project is to implement the same features on a Mobile App and additional features specific to mobile technology.

Vendor needs to articulate which of the following features can be developed as part of MVP (Minimal Viable Product) and propose the one-year roadmap for remaining features. Vendor must get written approval on the MVP and future roadmap from the CalOptima IT team and business stakeholders before the work can begin.

1. Account Registration (CalOptima Member)

    a. Existing Members: Allow existing (Registered members) to seamlessly login on the Mobile App.

    b. Allow registration for New Members

    c. Capture Member ID and Member Birthdate, desired username and password, email address and mobile number.

    d. Capture security questions

    e. Validate the following conditions to complete the registration
        - The Member ID (CIN) exists in CalOptima's system of record (Facets).
        - The Member Date of Birth matches the system of record for the corresponding Member ID (CIN).
        - The member is currently eligible.
        - No other active or pending user accounts exists for the corresponding Member ID (CIN).
        - The username must be unique and must contain at least (6) characters.
        - The password must contain at least (7) characters and must contain at least three (2) of the following:
            i) Number
            ii) Symbol
            iii) Uppercase English letter
            iv) Lowercase English letter

2. Account Registration (Member Personal Representatives)

    a. Existing Member Personal Representatives: Allow existing (Registered members) to seamlessly login on the Mobile App.

    b. Allow registration for New Member Personal Representatives

c. Select account type: I am a personal representative of a CalOptima member

d. Capture Member's First Name, Last Name, Zip Code, Member Phone Number, Member ID (CIN), and Date of Birth

e. Capture Personal Representative's First Name, Last Name, and optionally capture Middle Initial. Capture Relationship to the Member, Date of Birth, Address, City, State, Zip Code, and Primary Phone Number.

f. Capture desired username, password, mobile phone and email address.

g. Capture security questions

h. Display "Declaration Message" and capture acknowledgement.

i. Validate the following conditions to complete the registration
    - The Member ID (CIN) exists in CalOptima's system of record (Facets).
    - The member is currently eligible.
    - The registrant is over the age of 18.
    - The following values supplied by the registrant matches the corresponding Member ID (CIN) in Facets:
        i) Member Date of Birth
        ii) Member Last Name
        iii) Member Zip Code
        iv) Member Primary Phone

j. For members under the age of 18, the system checks the corresponding member record for the existence of restricted warning flags, specifically:
    - User Warning Message 14, which denotes that access to the member record is revoked for specific individuals (e.g., parents who have lost legal authority of a minor member).
    - User Warning Message 11 which denotes that an active PHI authorization is on file and must be manually cross-checked against the registrant's information

k. For members over the age of 18, the system checks the corresponding member record for the existence of user warning flag, specifically:

    - User Warning Message 131 which denotes that the member has a designated lifetime care giver.

l. No other Member Portal account exists for the corresponding Member ID (CIN).

m. The username must be unique and must contain at least (6) characters.

n. The password must contain at least (7) characters and must contain at least three (2) of the following:
    i) Number
    ii) Symbol
    iii) Uppercase English letter
    iv) Lowercase English letter

3. User Warning Messages (UWM)

   User Warning Messages are CalOptima-specific user-restricted warning flags specially designed and assigned to members to denote whether personal representatives access can be auto-approved.

   a. User Warning Message 11 denotes that an active PHI authorization is on file and must be manually cross-checked against the registrant's information.
      - A CalOptima member who has UWM11 on file, and has been authenticated, will be able to register and create a Member Portal account. However, their account will remain in pending status until it is manually cross-checked and approved through CalOptima's K2 process.

   b. User Warning Message 14, denotes that access to the member record is revoked for specific individuals (e.g., parents who have lost legal authority of a minor member).
      - A CalOptima member who has UWM14 on file will not be allowed to register an account with the Member Portal. Such a member will be redirected to the termed page any time they attempt to log in to Member Portal.

   c. User Warning Message 131 denotes that the member has a designated lifetime care giver.
      - CalOptima has a Member Portal batch process. The Batch Job – which runs nightly – identifies all the registered members who have turned 18 years and terminates their PR accounts.
      - PR accounts for members who have a designated a lifetime caregiver and have attained the age of 18 years are not terminated upon running the batch job because they have a UWM131 on file.
      - A member whose PR account has been terminated can register a new account of their own – as an adult.

4. Logging In to Member Mobile App

   a. Capture username and password
   b. Cross verification using multi-factor authentication (MFA)
   c. Explore Biometrics to make the login process simple (e.g. Face ID to login for the devices supporting Face ID feature)

5. User Login Validation using Member Portal API Layer

   Currently Member Portal system verifies that the following conditions are met to complete the login process. The Mobile app will need to leverage the API and create necessary wrappers to leverage the existing logic.

   a. The user entered a valid username and password

   b. The 2nd factor authentication responses from the user are valid

   c. The member's eligibility status.
      - Users with current membership eligibility have full access to view and update their member record in Member Portal.
      - Users whose member eligibility has lapsed within the last 60 days have

view-only access to Member Portal. The user will not be able to make updates to the member record.
- Users whose member eligibility has lapsed in excess of 60 days are not permitted to access Member Portal. The user will be redirected to the Account Term page.

d. The user account status
- Users with “Account Locked” status will not be permitted to access Member Portal. The user will encounter an “Account Locked” message with instructions to contact Customer Service.
- Personal Representative users with “Pending” status have restricted access to Member Portal. The user will have no visibility to PHI or online services. The user will encounter a message indicating that their account is pending approval.
- Personal Representative users with “Denied” or “Revoked” status are not permitted to access Member Portal. The user will be redirected to the Account Term page.

6. Member Dashboard

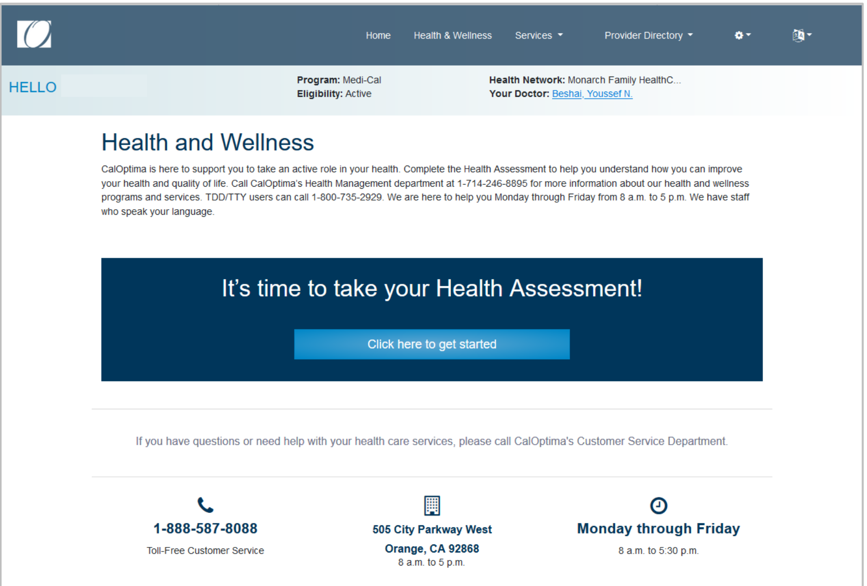
Upon login, display Member Mobile Dashboard where Members can view a snapshot of information pertaining to their health services as well as links to CalOptima.org pages and some online services available on Member Mobile App (e.g., Request ID).

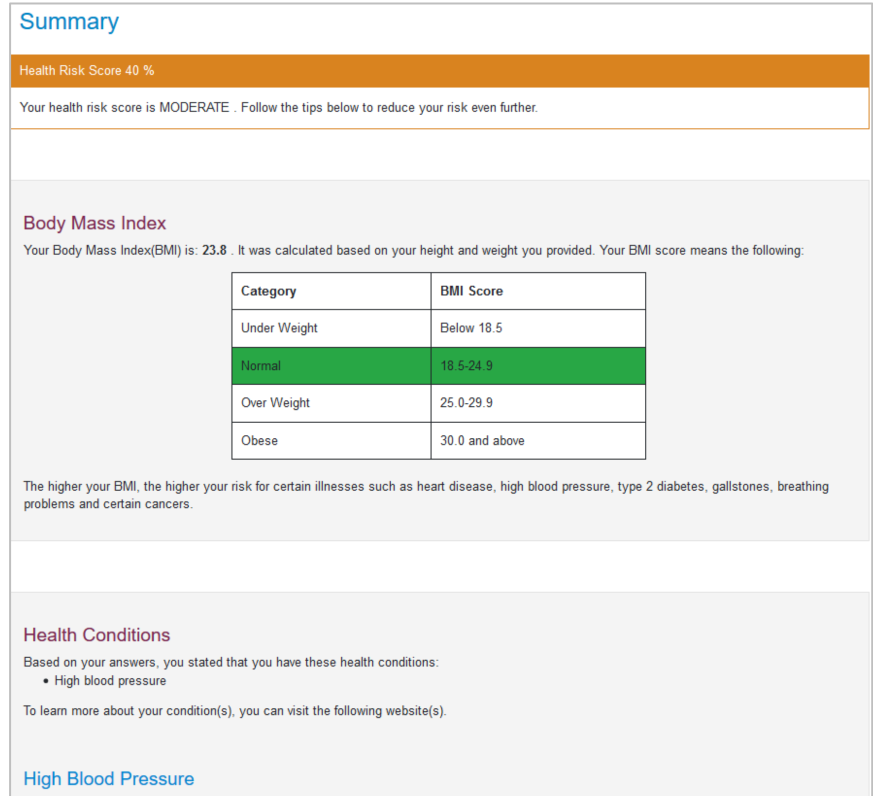
This Dashboard will be defined during the UI/UX Phase of the project, Snapshot of existing Member Portal Homepage is attached for illustration purposes only.

7. Health & Wellness

Authenticated users over the age of 21 can complete a Health Assessment survey twice a year. Users who have completed a survey are able to view historical survey responses for up to 3 years. Through the health assessment survey, Cal-Optima can provide recommendations and additional self-help materials (such as information to help members quit smoking).

For Mobile app, push notifications will be used to remind users to complete their Health Assessment. Screenshot of Member Portal is attached for illustration purposes only.





8. Member Services

Mobile users may perform a variety of updates to their member records or perform various services. Currently members are initiating these services through Member Portal which get recorded in CalOptima's system of record (Facets). The Mobile app will need to leverage the Member Portal API and create necessary wrappers to leverage the existing logic.

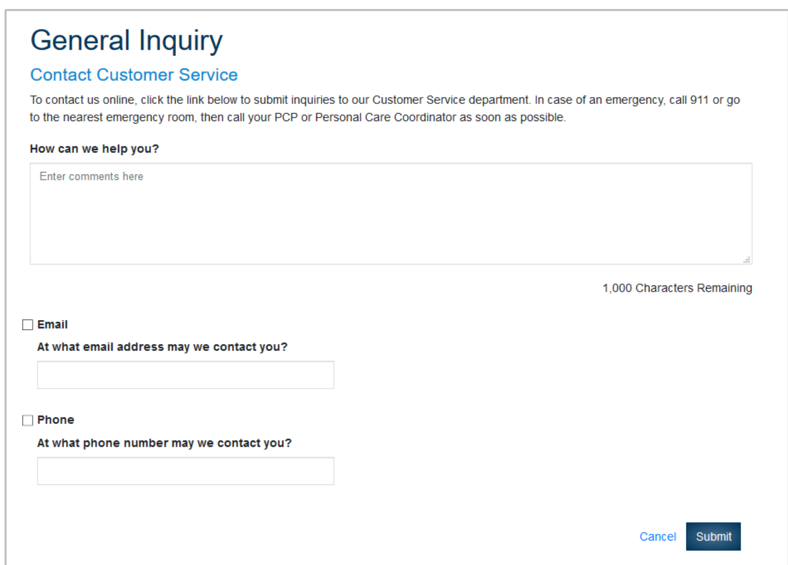
Among the options under Services are:

a) Contact Customer Service
b) Print ID Card
c) Request an ID Card
d) Update Member Profile
e) Schedule Interpretive Service
f) Change Health Network or PCP
g) Authorizations & Referrals
h) Plan Documents & Forms.

9. General Inquiry

In the member portal, from the navigation bar, under Contact Customer Service, users can access the General Inquiry feature to submit a contact request to Customer Service. Once submitted, the request is recorded in Facets with an open Customer Service task queue item.

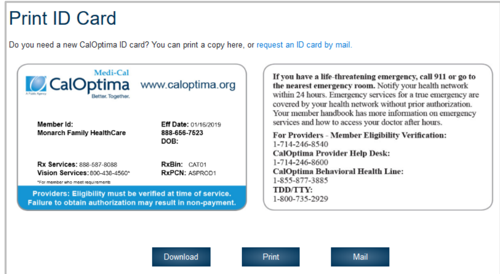
Build a similar feature in the Mobile app to submit inquiry to the customer service. The Mobile app will need to leverage the Member Portal API and create necessary wrappers to leverage the existing logic.



10. Print Member ID

From the navigation bar, under Print ID Card, users can access the Print ID card feature to view, download, request to be mailed a copy, and print a digital copy of their CalOptima ID Card.

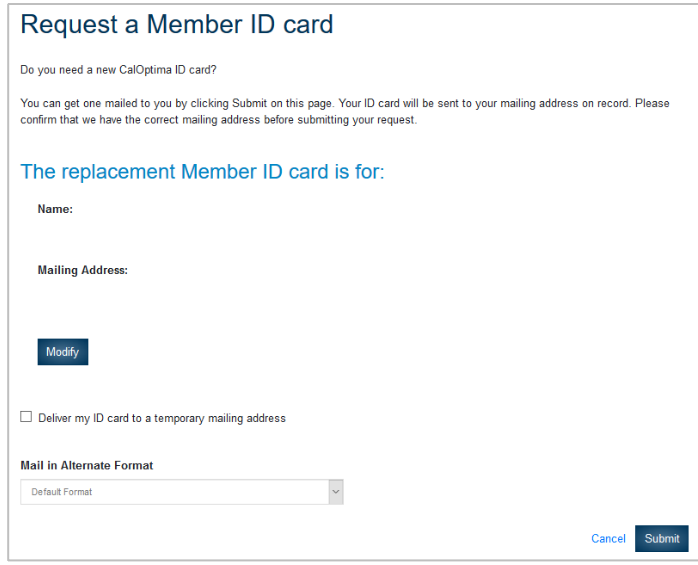
Create a new feature to store the Member ID card in the phone wallet storage. Create a log record when the ID card is stored in user's phone wallet.



11. Request an ID Card - (by Mail)

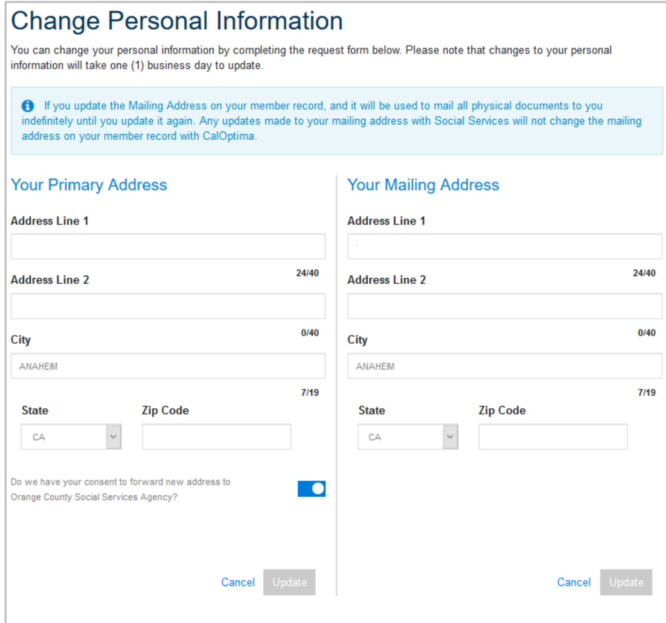
From the navigation bar, under Request an ID Card, users can access the Request an ID card feature to request a replacement of their CalOptima ID card by mail.

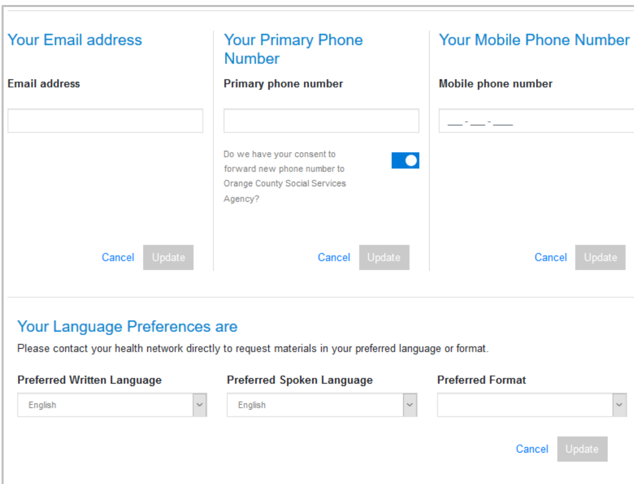
Build a similar feature in the Mobile App. The Mobile app will need to leverage the Member Portal API and create necessary wrappers to leverage the existing logic.



12. Update Member Profile

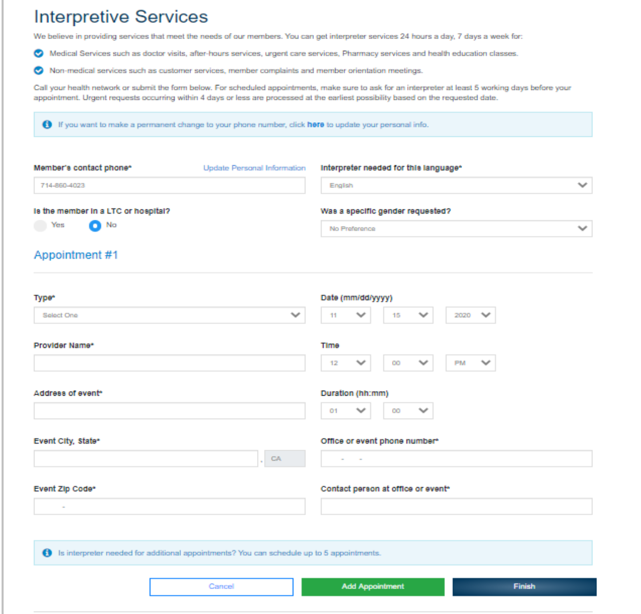
From the navigation bar, under Update Member Profile, users can access the Update Member Profile feature to update their contact information and language preference. These requests are recorded in Facets. Build a similar feature in the Mobile App. The Mobile app will need to leverage the Member Portal API and create necessary wrappers to leverage the existing logic.





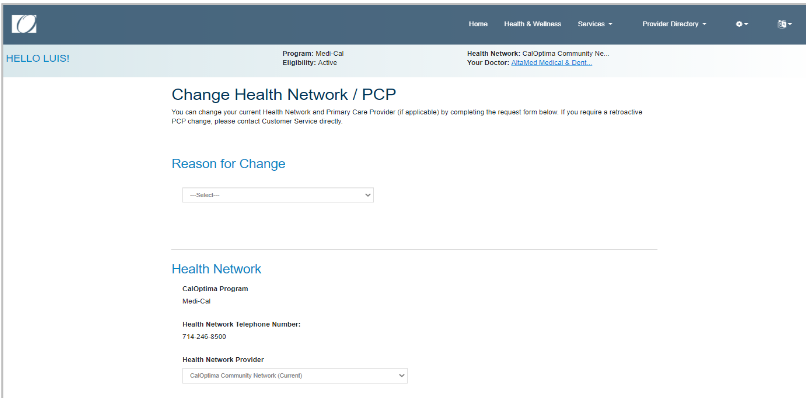
13. Interpretive Service

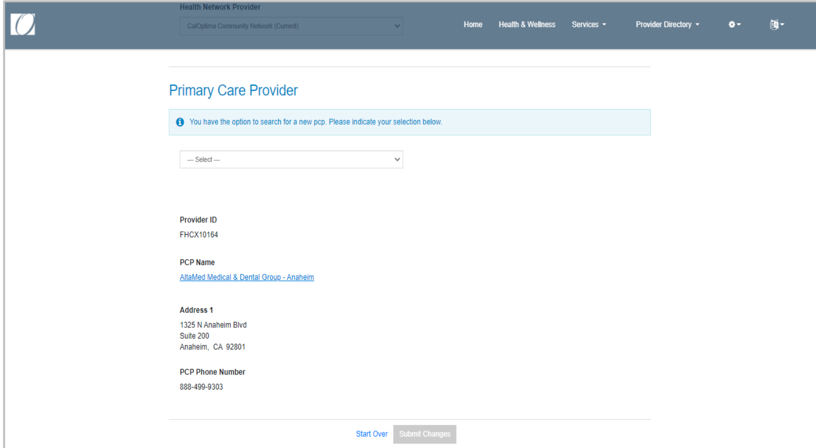
From the navigation bar, under Interpretive Service, users can access the Interpretive Service and request for an interpreter for their future appointments. These requests are recorded in Facets. Build a similar feature in the Mobile App. The Mobile app will need to leverage the Member Portal API and create necessary wrappers to leverage the existing logic.



14. Change Health Network and/or PCP

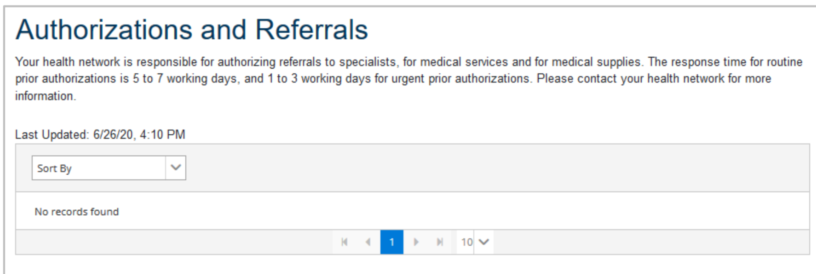
From the navigation bar, under Change Health Network or PCP, users can access the Change Health Network or PCP feature to update their plan or primary care provider. Please see Appendix for further details. These requests are recorded in Facets. Build a similar feature in the Mobile App. The Mobile app will need to leverage the Member Portal API and create necessary wrappers to leverage the existing logic.





15. Authorizations & Referrals

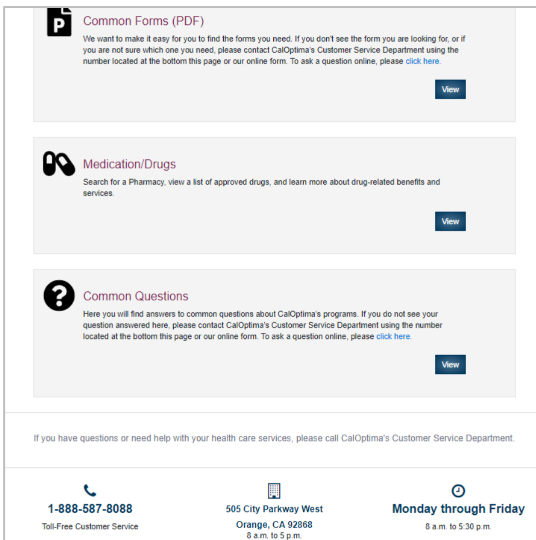
From the navigation bar, under Authorizations & Referrals, users may view historical Authorizations and Referrals associated to their member record from the past 3 years. Build a similar feature in the Mobile App. The Mobile app will need to leverage the Member Portal API and create necessary wrappers to leverage the existing logic.

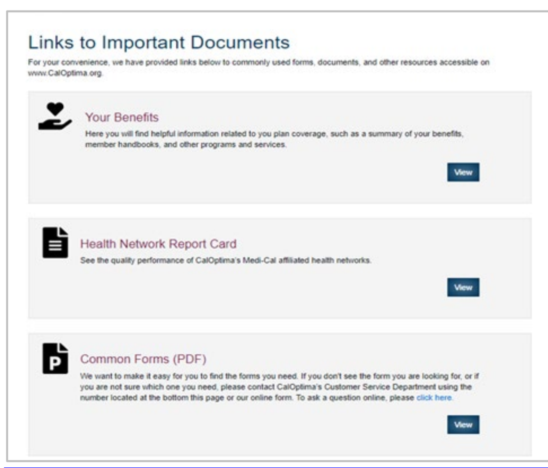


16. Plan Documents & Forms

From the navigation bar, under Plan Documents & Forms, users may access links to commonly used forms, documents, and other resources accessible on www.caloptima.org

Build a similar feature in the Mobile App. The Mobile app will need to leverage the Member Portal API and create necessary wrappers to leverage the existing logic.





17. Links to CalOptima.org

The Member Portal links to plan benefit information that is accessible through CalOptima. Org. This includes:

1. Benefit information and commonly used forms through CalOptima.org. This includes, but are not limited to:
    a. Health and Wellness page
    b. Member Handbook
    c. Health Network Report Card
    d. Common Forms page
    e. Pharmacy Program page
    f. Common Questions page

2. CalOptima's Online Provider Directories:
    a. Search for a Provider
    b. Search for a Facility
    c. Search for a Behavioral Health Provider
    d. Search for a Pharmacy
    e. Search for a Vision Provider
    f. Search for an Urgent Care Provider

3. Access product disclaimers, including:
    a. Website Privacy Policy
    b. Member Portal Terms of Use Statement
    c. CalOptima's Notice of Privacy Practices

Deliver a similar feature in the Mobile App leveraging Member Portal API or by creating necessary wrappers to leverage the existing logic.

18. Provider Directory Function

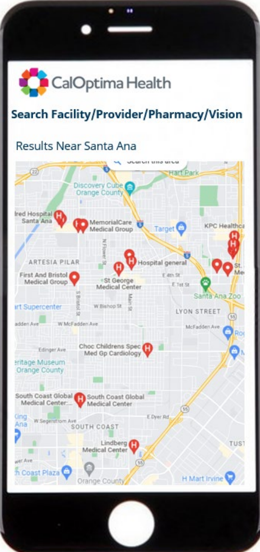
Member Portal has implemented Provider Directory function which allows users to

a. Search for a provider and change their PCP or Specialist. These changes are recorded in Facets.
b. Search for a provider or Specialist
c. Search for a Facility a hospital, facility or ancillary provider
d. Search for a Behavioral Health Provider
e. Search for a Pharmacy
f. Search for a Vision Provider
g. Search for an Urgent Care facility

The existing Directory function needs to be redesigned in conjunction with Communications Department and implemented using integration with google maps to allow search using a common UI and also to perform backend updates as necessary.

As a long-term roadmap, the new interface will be embedded in the Member Portal and on the CalOptima.org main page.

The concept of this tool is depicted in the picture below.



19. Multiple Language Support

a. CalOptima supports seven (7) "threshold" languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese, and Arabic.
b. At a minimum, the Mobile Platform must be developed in English,,Spanish and Vietnamese in the initial phase, and support all other threshold languages incrementally in subsequent phases.

C. SUPPLIER'S RESPONSIBILITIES

1. Validation of detailed business requirements and Development of software to support requirements
2. Test integration with CalOptima systems for Member Portal and backend systems like facets
3. Test deployed software and equipment prior to system launch
4. Provide end-user training to business users and IT application support resources
5. Provide system configuration and technical training to IT resources
6. Provide live on-going support services
7. Provide end-user reference guides

D. Appendix

Business rules for Change HN and/ or PCP

Line of Business	Change HN	Change PCP	Responsibility	Effective Date
Medi-Cal in CCN		Yes	CalOptima	16th and 1st
Medi-Cal not in CCN	Yes	Yes	Respective Health Network	16th and 1st
OC	No	Yes	Respective Health Network	1st

Members who have NO access to Change HN/PCP page

- Member who no longer eligible
  - No active eligibility segment(s)
- (6203) All PACE members
- (6403) Medi-Cal Members with following Aid Code:
  - B, E, G, L, M, R, T
- (6469) Medi-Cal Members with following health Network code:
  - CODMEBX
  - CODMECX
  - CODMEDB
  - CODMEDC
  - CODPERM
  - CODPERX
  - CODRTRO
  - CODRTRX
  - CODSPDP

Member who can change PCP only

- (6212) All OC members
- (5835) Medi-Cal members with following HN code:
  - CODRESD
  - CODRESX
  - CODCNET
  - CODCNEX
  - CODMEDA

Member who MUST change Health Network

- (6399) All Medi-Cal members EXCEPT health network:
    - CODRESD
    - CODRESX
    - CODCNET
    - CODCNEX
    - CODMEDA

END OF DOCUMENT

CalOptima Health Board Action Agenda Referral

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

Report Item
14. Approve Actions Related to the Procurement of a Privileged Access Management Solution

Contacts
Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
James Steele, Sr. Dir. Information Security, (714) 497-6046

Recommended Actions
1. Approve the scope of work (SOW) for the Privileged Access Management (PAM) 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
Approving the SOW and issuing the RFP for a PAM solution will allow CalOptima Health to procure a vendor solution and the professional services for the implementation of the PAM solution.

A PAM solution is a security tool that provides control and monitoring of privileged accounts within an organization. PAM solutions allow organizations to manage, monitor, and audit the activity of privileged users, such as system administrators, developers, and executives. PAM solutions enable organizations to secure their sensitive data and systems by restricting access to privileged accounts, enforcing strong passwords and multifactor authentication, and providing granular access controls based on the principle of least privilege. PAM solutions also enable organizations to record and analyze user activity for compliance and forensic purposes. By implementing a PAM solution, organizations can reduce the risk of insider threats, external attacks, and data breaches, and improve their overall security posture.

The ITS teams will work in conjunction with Vendor Management to issue the RFP, to review the proposals received, and 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 years at an estimated cost of no more than $600,000.

Fiscal Impact

The recommended action is a budgeted item. Funding for the recommended action of up to $200,000 is included in the Fiscal Year 2022-23 Digital Transformation Year One Operating Budget, approved by the Board on June 2, 2022. Management will include the remaining administrative expenses in future Digital Transformation operating budgets.

Rationale for Recommendation

By implementing a PAM solution, organizations can ensure that access to privileged accounts is strictly controlled and monitored, reducing the risk of insider threats and external cyber-attacks. Additionally, a PAM solution can help organizations enforce best practices for security and risk management.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Statement of Work for the PAM solution

/s/ Michael Hunn *02/23/2023*

Authorized Signature **Date**

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A. OBJECTIVE

The objective of the current initiative is for CalOptima to identify and select the most appropriate vendor for Privilege Account Management (PAM Solution).

The vendor should provide all the services outlined in the Scope of Work (SOW).

B SCOPE OF WORK

This statement of work aims to outline the requirements and objectives for a Privilege Access Management (PAM) solution, which will be implemented to enhance security and control access to sensitive information and resources within the organization. The PAM solution will store and automatically rotate privileged account passwords for both administrators and services; reducing the ability for a password to be compromised. Furthermore, with the PAM solution, the number of systems that can remotely access servers is significantly reduced, minimizing the footprint of an attack. A PAM solution can mitigate this risk by ensuring just-in-time and just-enough access and multifactor authentication for all admin identities and accounts.

Scope for the PAM solution:

- The PAM solution will be implemented to manage and monitor access to critical systems and data within the organization or 3rd party SaaS applications.
- The PAM solution will allow administrators to define and enforce access policies, such as assigning users roles and permission, revoking access, and monitoring user activity.
- The PAM solution will integrate with existing authentication and authorization systems, Active Directory and Azure AD, to ensure seamless and secure authentication.
- The PAM solution will have the capability to manage privileged accounts, such as those used by system administrators, and provide a secure way to store and manage shared passwords.
- The PAM solution will have the capability to manage service accounts, such as those used by system services, scheduled tasks, and applications.
- The PAM solution will have the ability to manage and vault passwords.
- The PAM solution will include a dashboard that provides real-time visibility into user activity, including session recordings, and reports on privileged access usage.
- The PAM solution will include a centralized session access to allow for the reduction systems permitted to administer resources.
- The PAM solution will work in the various server and workload environments, including on-premises and cloud servers, O365, Azure, AWS, and GCP

Objectives:

- To implement a centralized and secure system for managing and monitoring access to critical systems and data.
- To improve the security of privileged accounts and sensitive information by implementing secure password management practices.
- To provide administrators with the ability to define and enforce access policies and monitor user activity in real-time.

- To integrate with existing authentication and authorization systems for seamless and secure authentication.
- To enhance the organization's overall security posture by reducing the risk of unauthorized access to sensitive information and resources.

C. SUPPLIER'S RESPONSIBILITIES

Deliverables:

- Implementation of a Privilege Access Management solution that meets the requirements and objectives outlined in this statement of work.
- Detailed documentation of the PAM solution, including installation instructions, user guides, and technical specifications.
- User training on the PAM solution, including how to manage and monitor access, create and enforce policies, and use the dashboard.
- Ongoing technical support and maintenance for the PAM solution, including software updates and bug fixes.

Timeline:

- The implementation of the PAM solution will take place over a period of 6 to 8 weeks, with user training and documentation being completed in the following 2 weeks.
- Ongoing technical support and maintenance will be provided for the duration of the contract.

CalOptima Health Board Action Agenda Referral

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

Report Item

15. Authorize the Chief Executive Officer to Execute a Contract Amendment with Delphix Corp. to Procure and Implement a Data Masking Solution in Support of CalOptima Health's Digital Transformation Strategy

Contacts

Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
David O'Brien, Sr. Director, Information Technology Services, (657) 900-1269

Recommended Actions

1. Authorize reallocation of budgeted but unused funds of $200,000 from Medi-Cal: Other Operating Expense Budget to fund the expansion of the Delphix Corp. (Delphix) contract with a Data Masking Solution; and
2. Authorize the Chief Executive Officer to execute a contract amendment with Delphix to implement the Data Masking Solution.

Background

As part of CalOptima Health's Workplace Modernization and Digital Transformation Strategy, Information Technology Services will be evaluating and deploying multiple solutions. The solutions coincide with CalOptima Health's Cloud First strategy and take regulatory, compliance, and security measures into consideration. 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 maintains, supports, and develops applications against large complex databases. These databases include member protected health information (PHI) and require continuous updates to add features, improve performance, and resolve issues. Updates to these databases are coded and tested in non-production copies to reduce impact and risk to CalOptima Health's production systems and data. These non-production databases include PHI, and, as a security control, this data should be obfuscated or masked to reduce the potential for exposure.

To perform data masking, a static data masking (SDM) solution is required. SDM can permanently replace protected information with obfuscated data in a realistic manner so that development and testing of applications, in a non-production environment, can proceed effectively, securely, and without disclosing sensitive information.

The existing CalOptima Health SDM tool, from Informatica, has the following issues that impede ongoing data masking tasks:

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- The existing Informatica tool is not robust enough to handle CalOptima Health's database sizes and the database complexities.
- The existing Informatica tool requires an additional component (EDI Transformation Library) to be effective. This add-on would incur additional annual costs for CalOptima Health.
- The existing Informatica tool does not meet CalOptima Health's testing window. Currently, it takes 60 hours to mask a limited set of data. Long masking periods will extend projects and adversely affect ongoing project development cycle and deliverables.

In summary, the Informatica solution is not robust enough for CalOptima Health's databases, requires an expensive add-on component, and is not timely enough to meet development and testing needs.

Discussion

Delphix began providing services to CalOptima Health in late 2022 when the CalOptima Health Information Technology Service team began leveraging Delphix's virtual database product to enable data replication from production to non-production environments, in real time. Since then, staff have tested Delphix data masking capabilities and found that they are fully integrated with Delphix data virtualization. This integration allows development and testing teams to quickly deliver masked, virtual database copies for testing and updates. It is simpler to use and requires no complex programming and scripting. Delphix provides a single solution for profiling, masking, and data delivery.

Fiscal Impact

The recommended action is budget neutral. Unspent funds from the Medi-Cal: Other Operating Expense approved in the CalOptima Health Fiscal Year 2022-23 Operating Budget on June 2, 2022, will fund the total budget reallocation of $200,000 for this action.

Rationale for Recommendation

Amending the Delphix contract to allow staff to purchase and utilize the Data Masking Solution will greatly improve overall security posture as well as enhance the efficiency of the Digital Transformation Program.

Concurrence

James Novello, Outside General Counsel, Kennaday Levitt

Attachments

None

/s/ Michael Hunn *02/23/2023*

Authorized Signature **Date**

Board of Directors Meeting
March 2, 2023

Regular Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee

Report to the Board

The Member Advisory Committee (MAC), and the Provider Advisory Committee (PAC) held their regular joint meeting on February 9, 2023 to discuss topics of mutual interest.

Michael Hunn, Chief Executive Officer, notified the committees that with the ending of the California public health emergency that would start the Medi-Cal Redetermination efforts which is being undertaken by the Orange County Social Services Agency. He noted that Medi-Cal members will be redetermined during the month that they initial signed up for benefits and that the Department of Health Care Services (DHCS) estimates that as much as 20% of Medi-Cal members may lose their eligibility throughout the State. He also noted that CalOptima Health could experience a possible reduction of 13-15% of its membership. Mr. Hunn also noted that 90% of CalOptima's funding comes from the State and 10% comes from Federal and noted that CalOptima did not receive any funding from the County of Orange.

Yunkyung Kim, Chief Operating Officer, welcomed Javier Sanchez back to CalOptima Health and noted that he was returning in the role of Executive Director, Medicare. Ms. Kim also addressed the new Brown Act Rules and how they would affect the Board Advisory Committees. This generated much discussion among the members and she noted that staff would be looking at various options for the committees and that she would update the committees once options were identified for future meetings.

Evelyn Rounds, Manager, Multipurpose Seniors Services Program (MSSP), provided a presentation on MSSP and provided the members with information on how to apply for this seniors program.

Nicole Garcia, Director, Program Implementation, presented on the Enhanced Care Management portion of the CalAIM program which provided the members with the opportunity to ask questions and preview the materials that are on the CalOptima Health website.

The members of the MAC and PAC appreciate the opportunity to update the Board on their current activities.