BOARD OF GOVERNORS

Executive Committee Meeting

June 27, 2025 • 1:30 PM

Lobby Conference Room 100

1055 W. 7th Street, Los Angeles, CA 90017

L.A. Care offices have moved to 1200 W. 7th Street, Los Angeles, CA 90017.
Public meetings will continue to be held in the Board Room at 1055 W. 7th Street.

DRAFT

AGENDA

Executive Committee Meeting
Board of Governors

Friday, June 27, 2025, 1:30 P.M.
1055 West 7th Street, Conference Room 100, 1st Floor
Los Angeles, CA 90017

Members of the Committee, staff and the public can attend the meeting in person at the address listed above. Public comment can be made in person at the meeting. A form will be available at the meeting to submit public comment.

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=m7443b14e264d2efa34fe5a4b04a9b39c
To listen to the meeting via teleconference please dial: +1-213-306-3065
Meeting Number 2496 144 5870 Password: lacare

The purpose of public comment is an opportunity for members of the public to inform the governing body about their views. The Committee appreciates hearing the input as it considers the business on the Agenda.
The process for public comment is evolving and may change at future meetings.
All votes in a teleconferenced meeting shall be conducted by roll call.

If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act (ADA) please contact L.A. Care Board Services staff prior to the meeting for assistance by text to 213 628-6420 or by email to BoardServices@lacare.org.

Welcome — Ilan Shapiro, MD, *Chair*

1. Approve today's Agenda — *Chair*
2. Public Comment *(Please read instructions above.)* — *Chair*
3. Approve the May 23, 2025 Meeting Minutes p.5 — *Chair*
4. Chairperson's Report — *Chair*
   - Suggestion for Board of Governors Meetings start time
     - Approve revised meeting time for Board of Governors **(EXE 100)** p.16
   - ad hoc Nominating Committee update
   - ad hoc Legislative Committee meeting
5. Chief Executive Officer Report — Martha Santana-Chin, *Chief Executive Officer*
   - Government Affairs Update p.18 — Cherie Compartore, *Senior Directors, Government Affairs*

Committee Issues

6.	Legislative Impacts / Product Summary p.63	Phinney Ahn *Executive Director, Medi-Cal Product* Cristina Inglese *Executive Director, Commercial & Group Products* Victor Hurtado *Executive Director, Medicare Product*
7.	Ratify L.A. Care Chief Executive Officer's, Martha Santana-Chin, execution of Amendment A05 L.A. Care's Exclusively Aligned Enrollment (EAE) Duals Special Needs Plan (DSNP) Contract (contract number 22-20236) with the Department of Health Care Services (DHCS) **(EXE 101)** p.77	Augustavia J. Haydel, Esq. *General Counsel* Nadia Grochowski *Senior Director, Health Care Legal Services*
8.	Revisions to Human Resources Policies **(EXE A)** p.186	Terry Brown *Chief Human Resources Officer*
9.	Approve Consent Agenda Items for July 24, 2025 Board of Governors Meeting • June 5, 2025 Board of Governors Meeting Minutes • Approve revised meeting start time for Board of Governors • Ratify L.A. Care Chief Executive Officer's, Martha Santana-Chin, execution of Amendment A05 L.A. Care's Exclusively Aligned Enrollment (EAE) Duals Special Needs Plan (DSNP) Contract (contract number 22-20236) with the Department of Health Care Services (DHCS) • Authorization to execute a contract for Point of Care Tool over a 3-year period with the selected vendor starting in Q1 of FY 2025 – 2026 • Authorization to change to the financial statement reporting period to a calendar year (January 1 – December 31) • Regional Community Advisory Committee Membership • Ratify elected Regional Community Advisory Committee Region 5 Chairperson	*Chair*
10.	Public Comment on Closed Session Items *(Please read instructions above.)*	*Chair*

ADJOURN TO CLOSED SESSION (Est. time: 40 mins.) *Chair*

11. REPORT INVOLVING TRADE SECRET
Pursuant to Welfare and Institutions Code Section 14087.38(n)
Discussion Concerning New Service, Program, Technology, Business Plan
Estimated date of public disclosure: *June 2027*

12. CONTRACT RATES
Pursuant to Welfare and Institutions Code Section 14087.38(m)
- Plan Partner Rates
- Provider Rates
- DHCS Rates

13. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Significant Exposure (3 cases)
Pursuant to paragraph 2 of subdivision (d) of Section 54956.9 of the Ralph M. Brown Act

14. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069
Department of Health Care Services (Case No. Unavailable)

15. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
- Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680
- Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF

16. PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR
Sections 54957 and 54957.6 of the Ralph M. Brown Act
Title: CEO
Agency Designated Representative: Ilan Shapiro, MD
Unrepresented Employee: Martha Santana-Chin

RECONVENE IN OPEN SESSION

ADJOURNMENT *Chair*

There is no Committee meeting in July 2025.
The next Committee meeting is scheduled on Friday, August 22, 2025 at 1:30 p.m.
and may be conducted as a teleconference meeting.
The order of items appearing on the agenda may change during the meeting.

ACTION MAY NOT BE TAKEN ON ANY MATTER RAISED DURING THE PUBLIC COMMENT PERIODS UNTIL THE MATTER IS SPECIFICALLY LISTED ON A FUTURE AGENDA, according to California Govt Code Section 54954.2 (a)(3) and Section 54954.3.

AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION 72 HOURS BEFORE THE MEETING:

1. At L.A. CARE'S Website: http://www.lacare.org/about-us/public-meetings/board-meetings
2. L.A. Care's Reception Area, Lobby, at 1055 W. 7th Street, Los Angeles, CA 90017, or
3. by email request to BoardServices@lacare.org

Any documents distributed to a majority of the Committee Members regarding any agenda item for an open session after the agenda and meeting materials have been posted will be available for public inspection by email request to BoardServices@lacare.org

An audio recording of the meeting is made to assist in writing the minutes and is retained for 30 days.

Meetings are accessible to people with disabilities. Individuals who may require any accommodations (alternative formats – i.e., large print, audio, translation of meeting materials, interpretation, etc.) to participate in this meeting and wish to request an alternative format for the agenda, meeting notice, and meeting packet may contact L.A. Care's Board Services Department at (213) 628 6420. Notification at least one week before the meeting will enable us to make reasonable arrangements to ensure accessibility to the meetings and to the related materials.

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – May23, 2025
1055 West 7th Street, 1st Floor, Los Angeles, CA 90017

Members
Ilan Shapiro, MD, MBA, FAAP, FACHE, *Chairperson*
John G. Raffoul, V*ice Chairperson***
Stephanie Booth, MD, *Treasurer*
Nina Vaccaro, *Secretary*
Alvaro Ballesteros, MBA
G. Michael Roybal, MD

Management/Staff
Martha Santana-Chin, *Chief Executive Officer*
Sameer Amin, MD, *Chief Medical Officer*
Linda Greenfeld, *Chief Product Officer*
Todd Gower, *Interim Chief Compliance Officer*
Augustavia J. Haydel, Esq., *General Counsel*
Alex Li, MD, *Chief Health Equity Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*
Afzal Shah, *Chief Financial Officer*

**Absent **Teleconference*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Ilan Shapiro, MD, *Chairperson,* called to order at 1:35 pm the meetings of the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee. The meetings were held simultaneously. He provided information on how to submit public comments.	
APPROVE MEETING AGENDA	The agenda for today's meeting was approved.	**Approved unanimously by roll call vote.** **6 AYES (Ballesteros, Booth, Raffoul, Roybal, Shapiro, and Vaccaro)**
PUBLIC COMMENT	There was no public comment.	
APPROVE MEETING MINUTES	The minutes of the April 23, 2025 meeting were approved.	**Approved unanimously by roll call vote. 6 AYES**
CHAIRPERSON'S REPORT	Chairperson Shapiro noted that budget discussions are going on in California and the federal legislatures. The Congressional Budget office report noted that unless changes are made in proposed federal legislation, up to 13 million people could lose access to Medicaid and Medicare in the United States. L.A. Care continues to support both	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	programs through active collaboration and welcomes comments, concerns and ideas in support of these important programs.	
CHIEF EXECUTIVE OFFICER'S REPORT	Martha Santana-Chin, *Chief Executive Officer*, reported that L.A. Care is addressing the needs of members. She thanked Dr. Amin for his leadership in organizing the LASSO initiative, and to others in the partnership in that charge. Ms. Santana-Chin is proud of this work to address member issues head on in a way that the members can really understand. She is excited about Sameer Amin, MD, *Chief Medical Officer*, report. Dr. Amin noted that a written report will be in the June 5 Board Meeting packet. After the initial motions were approved, L.A. Care leadership developed a cross-divisional project, L.A. Care Access Service and System Optimization (LASSO). A lot of work has been done with positive results in the short term, there is a work plan to deliver results by the end of the year, and a longer-term work plan with results in 2026. There are three documents: an executive summary, a longer detailed report and a project charter. Dr. Amin presented details of the initiative to the Executive Community Advisory Committee (ECAC) earlier this month. LASSO is meant to make it easier for members to access care and improve the overall member experience. The idea came from member feedback at the Regional Community Advisory Committee (RCACs) and the ECAC, and from listening to L.A. Care members in a variety of ways in recent years. There is an opportunity for L.A. Care to not only be a great local initiative, a great health plan, but to also be a great customer service company. That is a goal and the focus. Teams from across L.A. Care pulled together, and staff is very passionate about this. Staff wants to work toward making sure members are happy and getting what they deserve, finding providers for care they need without a long wait or confusion with referrals, without delays in medical equipment, prescriptions and transportation. L.A. Care will put forward a holistic way to address member concerns. The charter was written to improve member experience, keep members connected to care, improve access to doctors and services. Some issues were resolved in the last few months and short term improvements will be completed by year end. Long term solutions are planned that will be transformational for the plan in 2026. The leadership team strategy will help improve member experience. LASSO has three core objectives and milestones: member engagement, network alignment, and operational efficiency. Noah Paley, *Chief of Staff,* Acacia Reed, *Chief Operating Officer,* and Linda Greenfeld, *Chief Product Officer*, and their teams are among those involved. Immediate actions include ten areas: rapid response to member concerns: understanding the member experience through the	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	members voice, improving access to primary and specialty care, educating members on how to use the health plan, empowering members with self-service and digital tools, provider education for formulary alignment, improving the customer solution center, faster access to medical equipment and supplies, better transportation for members and working with provider groups. Responses from members during his presentation at ECAC reflected their feeling that there are changes happening at L.A. Care. Mr. Paley added that the rapid response protocol is designed and implemented according to suggestions from Board Members Roybal and Vaccaro at a previous meeting to work with providers on issue that members raise at a RCAC and quickly determine the scope of the issue and develop an improvement plan. Ms. Santana-Chin thanked Dr. Amin and the team members for working on this initiative. Board Member Roybal appreciates this work. Providers need to have the opportunity to address any issues. He is glad to hear the members are also hearing what is happening and appreciate what is being done. Board Member Vaccaro added, from the provider's side, she thinks they appreciate understanding member concerns. Providers do not always hear about issues that the patients experience, and it's enlightening for them. Providers want to do better to the extent possible. Having that relationship with the health plan and hearing feedback from the members is valuable to providers. Board Member Booth asked if L.A. Care will make very clear that the last couple of additional issues could be identified separately from the overall changes so the people who raised those issues would be able to see their issue and the solution. Dr. Amin responded that the issues raised about East Valley clinic and Venice Family clinic are included in the report. There is a description of what occurred during the rapid response. A process was developed, which Mr. Paley referred to, in terms of the rapid response to clinic issues as they are raised. Ms. Santana-Chin added that L.A. Care is addressing root causes and partnering collaboratively with the provider community in addressing member concerns. Ms. Santana-Chin reported that Covered California is estimating that the U.S. House bill just passed and proceeding to debate at the Senate Finance Committee, may result in a 30% reduction in Covered California Membership. California Department of Health	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Care Services (DHCS) estimates that it could result in a 20 to 25% decrease in enrollment for Medi-Cal, with the funding impact still unclear for California. The DHCS website indicates that would be a $30 billion reduction in federal funding. It is important to understand that while the May Revise was released, there is a lot of interplay between state and federal funding and at some point, after the federal proposal becomes final in late September or early October, the State will have to revisit the State Budget. L.A. Care is running scenarios and modeling potential impacts, clarity will come later, but it is not expected that there will be an impact in 2025. There may be some impact in 2026 but, based on the state and the federal proposals so far, most of the impact will start in 2027. L.A. Care continues to focus on building a strong core and getting ready for what's to come. L.A. Care is not fighting alone, it is working with coalitions to educate for advocacy. In the meeting materials is information from coalition members. One priority area with significant impact to the people that we serve is proposed work requirements or the job loss penalty. L.A. Care is working on this in way that makes the most sense and minimizes impact. L.A. Care is working on making sure that the provider tax structure is recognized as a financing mechanism for the Medicaid program and that gutting that could gut the program. L.A. Care will raise its voice about the negative consequences of not covering individuals without satisfactory immigration status and downstream consequences of imposing a $100 premium on people who can't afford it. There are ramifications for the state, for uncompensated care, and for the risk pool. At the federal level, L.A. Care is an advocate for avoiding a penalty on states that use state-only funding for specific priorities, such as covering people with unsatisfactory immigration status. At the state level, Medical Loss Ratio (MLR) requirements without the appropriate definition could be detrimental to health plans and destabilize the provider network. The Senate Finance Committee is comprised of several Senators representing states with a significant rural population, areas that will be disproportionately impacted by some of the proposed policy. It is hoped that the House version of the reconciliation bill just passed will be refined to mitigate impact.	
• Government Affairs Update ○ 2025-2026 May Revise	Cherie Compartore, *Senior Director of Government Affairs,* provided an update on key budget proposals at the federal and state levels with significant implications not only on L.A. Care, but also the Los Angeles County Department of Health Services (DHS) and the safety net in Los Angeles County. She referred to memos in the meeting materials that separately provide detail on the State and federal budgets.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The work requirements have some exemptions, the proposal would require most childless adults to meet Medicaid work requirements starting October 1, 2027. The first House version had the implementation in January 2029, it has been moved up to an earlier start date of October 1, 2027. It also repeals the administrative rule that simplified Medicaid eligibility and renewal processes. For instance, the House bill reverses the flexibilities that were allowed to make Medicaid eligibility and renewal processes easier for people without losing coverage due to red tape, such as using existing data like tax filings or Supplemental Nutrition Assistance Program (SNAP) records to automatically renew and reduce paperwork. The bill eliminates flexibility in periodic eligibility checks and puts more restrictive controls in place. The House bill significantly impacts how states fund Medicaid using provider taxes. California has approved a managed care organization (MCO) tax that helps California acquire federal matching funds and covers a large part of Medi-Cal cost. The bill doesn't specifically ban the tax, but it limits them or stops provider taxes from drawing federal matching funds by intentional design, with a focus on California and New York. This would make it harder for California to fund the Medicaid program in the future using a provider tax mechanism. The House bill reduces the federal match rate for the Medicaid expansion population if states provide coverage to those with unsatisfactory immigration status, reducing the current 90% Federal Medical Assistance Percentages (FMAP) to 80%. The House bill includes other provisions that cut off federal funding for gender transition services for children and adults, the former proposed bill cut that funding for children. The bill eliminates funding for Planned Parenthood and tightens Covered California eligibility rules, open enrollment, automatic enrollment in silver plans, and would eliminate coverage for Deferred Action for Childhood Arrival (DACA) recipients. There is language in the House bill that could trigger automatic cuts under the statutory *pay as you go rule*. Depending on future revenue and the provisions in the final bill, the Congressional Budget Office (CBO) estimates it could lead to $500 billion in Medicare reductions over the next decade and could impact Medicare Disproportionate Share Hospital (DSH) payments, other cuts to providers and potentially for enrollees. The House bill does not detail potential cuts that could be triggered. Congress would make the decision at the point when the triggers are included. There's also language that looks like cutting Medicare coverage for legal immigrants. The memo will be updated for the upcoming Board meeting.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The House bill will now go over to the U.S. Senate for negotiations and likely there will be changes to the House version. It would then be sent back to the House for final approval. Congress set a deadline to send the bill to the President by July 4. California's May revise was released on May 14. Beginning in January 2027, adults with unsatisfactory immigration status in Medi Cal would be required to pay a $100 monthly premium. The budget freezes new enrollment for this population effective January 1 2026. California currently doesn't have a system in place to collect premiums, hiring a third-party administrator will add significant cost that could negate any savings. The Governor is proposing to redirect over $2 billion in MCO tax revenue away from provider rate increases. This change will make it harder for providers to improve access to care since many providers can't currently afford to treat Medi-Cal patients. MCO funding already goes into California's General Fund under Prop 35, this was additional money that the Administration is proposing to take away from Prop 35 funding. The budget proposes to eliminate the adult dental benefit in Medi Cal, eliminate the In Home Supportive Services (IHSS) and Long Term Care benefits for the undocumented. It reinstates asset tests for Seniors and Persons with Disabilities. The May Revise also proposes to cut the Prospective Payment System (PPS) reimbursement for members without satisfactory immigration status. These changes will significantly impact clinics, which will still provide care for these patients regardless of receiving the PPS payment. The May Revise doesn't yet account for impacts of the federal policy changes and given the fluidity of the state budget process and its interaction with federal funding decisions, these proposals may change significantly. There is a statutory requirement in California to provide a budget bill to the Governor by June 15, so that will be the main budget bill, and the above proposals likely will not be in that main budget bill but will come in the form of Budget Trailer bills throughout the summer and potentially the fall. Chairperson Shapiro noted that there are a lot of changes. In previous conversations the idea was floated to disseminate information to providers and the networks, so they are aware of what's happening. If we do not start communicating soon it could be a shock when all these changes happen. Ms. Santana-Chin responded that, in addition to other activities, L.A. Care has started that process through the Provider Relations Advisory Committee (PRAC) at the meeting held two days ago. Invitations were extended to the LA County Medical Association, the Community Clinic Association of Los Angeles County, the heads of County agencies. There was a presentation by Linnea Koopmans, *CEO*, Local Health Plans of California and L.A. Care's state lobbyist, Rachael Blucher. A robust discussion was held of initial reactions, concerns, and areas	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	where it was felt that we could advocate together. Most organizations are absolutely thinking about what this means for them and thinking about tightening their belt. Every association at the meeting and beyond are very actively engaged in advocacy work. We are using some feedback from the meeting to inform the continuing advocacy work, alone and in partnership. She invited others to comment on the understanding expressed at that meeting. L.A. Care is open to doing more formal communication across the network when the time is right. Dr. Amin expressed that people were happy to be engaged in the discussion because there has been so much uncertainty, it has not been possible to have a concrete and constructive discussion. The meeting provided an opportunity to talk through concerns and scenario planning. He had side conversations afterwards with a few of the providers and they seem to be getting more clarity. People are very concerned, particularly at the provider level about funding and about operationalizing the changes. They want to make sure that government officials understand exactly what it will take to do what they're asked to do, because they're not sure that that message is getting through properly. He assured them that L.A. Care will advocate to make sure that, at the very least, the government is aware of the burden. Mr. Paley added that the Provider Relations Advisory Committee (PRAC) has proven to be a great forum for sharing issues regarding provider performance and where L.A. Care stands and provides the ability to solicit the input from the providers relative to the headwinds that all are facing. The evolution of issues that are addressed in that forum, have really proven to be invaluable, and this is an extension of that. Board Member Raffoul noted that providers are clear about the proposals, but not very clear about the implementation or what is going to be implemented. Freezing the provider fee to 2024 levels could lead to significant losses for hospitals. There is language introduced that it would freeze at the level of submittal and at the level of the 2025 submittal, there would be an increase in provider fees. The issue of the broadness and equity in the taxation comes up, and Centers for Medicare and Medicaid Services (CMS) can rule it will not approve the 2025 submission unless it meets broadness criteria. Tax liability is not uniform or equitable across the whole industry, so that could be an issue, and it is not known how CMS will react to that and whether CMS will approve the 2025 submittal with the increase in it if it does not meet the criteria. We understand what is being proposed, we do not understand how it will be implemented or the impact.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Board Member Vaccaro commented that as a provider, the anxiety is palpable, and the uncertainty is very uncomfortable. Community Clinic Association of Los Angeles County (CCALAC) is providing as much information as it can in real time and follow up with actionable steps, but it feels gray, and the gray is a very difficult place to be in right now. They are hearing anecdotally about layoffs already happening in anticipation of what's to come, and that is very concerning for her. Board Member Booth asked if that gray is causing people to be more competitive and drawing in, not wanting to collaborate with others. Some in medicine have not worked together if policies do not affect their provider category, and she asked if that is starting to happen now. Board Member Vaccaro could not say that with any certainty but thinks it is something to be mindful of and keep an eye on. Health centers have a very tight relationship. She recognized that other Board Members were at a rally with the health centers. She thinks there is unity among the health centers and the federally qualified health centers (FQHCs) in joint advocacy and strengthening relationships, and she does not know if outside of that some folks are kind of peeling away. Ms. Santana-Chin commented that the organizations that L.A. Care has worked with recognize that all are stronger when working together and recognize that the health care delivery system will be destabilized if MCO is compromised, and all are trying to fight hard against the proposed changes to provider taxes. The County hospitals and the County health system are working with L.A. Care. She added that in a discussion with a leader of a health system here in Los Angeles County that serves both low-income populations and affluent markets with commercial insurance, she learned they plan to exit unaffordable markets. This will affect availability of health care services downstream. Board Member Ballesteros commented that there are a lot of information and organizations are trying to put out the latest information. He is not initially suggesting that L.A. Care create another forum. Many CEOs at FQHCs are worried about how to prepare for changes. There may be some hesitancy to convene when things are not clear, many are in hold mode right now. When the picture becomes clear, it could take six months to a year to adapt and adjust. There is a sense of unity and wanting to collaborate, and the anxiety comes from anticipating a need to act when the timeline for implementation will take many months. Before the Affordable Care Act (ACA) there were many uninsured, there may be fear about going back to that situation. Convening	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	a forum now to let organizations know that although the future situation is not yet known there are plans for a structure, would help providers communicate and work together once concrete information is available. That could alleviate a lot of anxiety. Ms. Santana-Chin noted that county agencies participated in the PRAC meeting, and L.A. Care was asked to keep the conversation and collaboration going and get to work. A few mentioned convening a meeting along the lines of Board Member Ballesteros' suggestion, and L.A. Care could continue to work on that. Board Member Roybal expressed concern that before the ACA there were other scattershot programs to cover small groups of uninsured, and some providers were good at putting programs together to maximize benefits and coverage. But now those small programs are gone, and they are not going to come back. It will be worse overall if the proposals come to fruition, trying to figure out a new system will be a big challenge. Board Member Booth suggested it might be a good opportunity to consolidate the strengths at certain organizations, with help from the smaller organizations which want to help but don't have the resources. Organizations can each concentrate on the service that the organization is good at, avoid duplication of effort and save money. L.A. Care has the wherewithal to focus and align these organizations. She recommended getting the pieces aligned, try to be that center magnetic focus that can do that for this County. Ms. Santana-Chin reported she met with the head of the California Endowment. The Endowment Board granted authority for expenditures and is interested in partnering with L.A. Care to conduct systems work to sustain the health care delivery system. She would be happy to schedule a brainstorming session to propose a project for funding by California Endowment.	
COMMITTEE ISSUES		
APPROVE CONSENT AGENDA ITEMS FOR JUNE 5, 2025 BOARD OF GOVERNORS MEETING	• May 1, 2025 Board of Governors Meeting Minutes • Quarterly Investment Report • Regional Community Advisory Committee Membership • Ratify elected Executive Community Advisory Committee Chairperson, Maritza Lebron, and Vice Chairperson, Estela Lara.	**Approved unanimously by roll call vote. 6 AYES**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
PUBLIC COMMENTS ON CLOSED SESSION ITEMS	There were no public comments.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting adjourned at 2:34 pm. Augustavia J. Haydel, Esq., *General Counsel* announced the items for discussion in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 2:34 pm. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *May 2027* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Initiation of Litigation Pursuant to Paragraph (4) of Subdivision (d) of Section 54956.9 of the Ralph M. Brown Act One Potential Case CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LIT Significant Exposure (3 cases) Pursuant to paragraph 2 of subdivision (d) of Section 54956.9 of the Ralph M. Brown Act CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable) CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR Sections 54957 and 54957.6 of the Ralph M. Brown Act Title: CEO Agency Designated Representative: Ilan Shapiro, MD Unrepresented Employee: Martha Santana-Chin	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 2:42 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 2:42 pm	

Respectfully submitted by:
Linda Merkens, *Senior Manager, Board Services*
Malou Balones, *Board Specialist III, Board Services*
Victor Rodriguez, *Board Specialist III, Board Services*

APPROVED BY:

_____
Ilan Shapiro, MD, MBA, FAAP, FACHE, *Chairperson*
Date: _____

Report Title: Revised Board of Governors' Meeting Timing

Date: June 27, 2025

Prepared By: Malou Balones, *Board Specialist III, Board Services*

1. Purpose / Desired Impact of the Report

To revise the start time of the Board of Governors' meeting to 12 noon to 3 pm.

2. Background / Context

The Board of Governors meetings have been ending past 5:00 pm, creating timing challenges for members. The new start time would allow full Board member participation.

3. Key Considerations / Analysis

Management Considerations: N/A

4. Risk Area and Mitigation Activities

Risk Statement: N/A **Known Key Risk:** ☐ Yes ☐ No ☒ Unknown

Impacted Area/Risk: N/A

☐ Claims	☐ Compliance	☐ Regulatory	☐ Vendor	☐ Community
☐ Financial	☐ Pharmacy	☐ Privacy	☐ Medicare	☐ Access
☐ Reputation	☐ Clinical	☐ IT	☐ SDOH	☐ Legal
☐ Member	☐ Provider	☐ InfoSec	☐ Contract	☐ Employee

Risk Mitigation Activities: **N/A**

5. Recommended Action / Decision Requested

Board Action Needed:

☐ For Information Only
☐ For Discussion with Board/Committee
☒ For Approval / Decision

Proposed Motion (if applicable): **Approve a new start time for Board meetings.**

6. Next Steps / Timeline / Milestones **N/A**

7. Attachments / Supporting Materials / Presentations

Motion EXE 100.0725

Board of Governors
MOTION SUMMARY

Date: June 27, 2025 **Motion No. EXE 100.0725**

Committee: **Chairperson:** Ilan Shapiro, MD

Issue: Approval of the revised timing of the Board of Governors meetings, from 1 – 4 pm to 12 noon – 3 pm, effective with the July 24, 2025 meeting.

Background:

Member Impact: Public input is welcome at all Board and Committee meetings.

Budget Impact: None.

Motion: **Approval of the revised timing of the Board of Governors meetings, from 1 – 4 pm to 12 noon – 3 pm, effective with the July 24, 2025 meeting.**

Report Title: Legislature Approved 2025–26 Budget Summary
Date: June 27, 2025
Prepared By: Cherie Compartore, *Senior Director, Government Affairs*

1. Purpose / Desired Impact of the Report

The purpose of this report is to assist the Board of Governors in understanding key differences between the health provisions in H.R. 1 and those outlined in the language released by the Senate committees of jurisdiction. The chart provided organizes differences by issue area, covering Medicaid, Marketplace, and Medicare provisions, to align with the previously shared comprehensive summary of the House package.

2. Background / Context

- Each year, the federal budget process determines funding for programs critical to L.A. Care's mission, including Medicaid, Medicare, Marketplace, and other healthcare services.
- Key provisions in the budget affect areas such as eligibility, safety net issues, and health equity initiatives, directly influencing L.A. Care's ability to serve members effectively.

3. Key Considerations / Analysis

- Proposed adjustments to Medicaid, Medicare, and Marketplace funding could impact eligibility, enrollment processes, and the safety net.
- Changes in funding may require adjustments to L.A. Care's operational and strategic budgets to align with potential federal requirements.

4. Risk Area and Mitigation Activities

Risk Statement: **Known Key Risk:** ☐ Yes ☐ No ☐ Unknown
Failure to monitor and report out on the federal budget could result in L.A. Care being unprepared to adapt to critical funding changes, jeopardizing the organization's ability to sustain essential programs, meet regulatory requirements, and effectively serve its members.

Impacted Area/Risk: Please select those areas impacted

☐ Claims	☐ Compliance	☒ Regulatory	☐ Vendor	☐ Community
☒ Financial	☐ Pharmacy	☒ Privacy	☐ Medicine	☒ Access
☒ Reputation	☒ Clinical	☒ IT	☒ SDOH	☒ Legal
☒ Member	☒ Provider	☒ InfoSec	☐ Contract	☐ Employee

Risk Mitigation Activities:
Monitor ongoing legislative activities to identify potential impacts on funding and programs.

- Engage with federal stakeholders to ensure alignment with policy changes and timelines for implementation.

5. Recommended Action / Decision Requested

Board Action Needed:

☒ For Information Only
☐ For Discussion with Board/Committee
☐ For Approval / Decision

Proposed Motion (if applicable):
N/A

6. Next Steps / Timeline / Milestones

- **Byrd Bath:** The Senate Budget Reconciliation bill will undergo a review to ensure compliance with rules limiting content to budget-related items.
- **Senate Floor Debate:** Senators will propose and vote on amendments before voting on the bill.
- **House Review:** If the Senate makes changes, the House will review the updated bill, potentially negotiating further.
- **Conference Committee:** If required, differences will be reconciled, and both chambers will vote on the final version.
- **Presidential Action:** The President can sign the bill into law or veto it, with federal agencies beginning implementation once signed.

7. Attachments / Supporting Materials / Presentations

H.R. 1 provisions in House and Senate versions of the budget reconciliation bill.

June 27, 2025

TO: Executive Committee

FROM: Cherie Compartore, *Senior Director, Government Affairs*

SUBJECT: May Revise 2025-26 Budget Summary

The Legislature sent Governor Newsom a budget addressing the state's $12 billion deficit, relying heavily on $7.8 billion in internal borrowing and deferrals to preserve social services rather than implementing the deep cuts proposed by the Governor. While some of the Governor's proposals were accepted, others were delayed or rejected.

The California Legislature approved a $325 billion budget for the 2025–26 fiscal. Faced with a significant $12 billion deficit, lawmakers opted to rely more on borrowing and reserve funds rather than implementing broad spending cuts. The budget preserves funding for critical areas such as education, public transit, health programs, and state employee wages, while also investing with some funding in affordable housing and support for local governments.

Despite passing this budget framework, significant challenges remain as the state's fiscal gap is expected to widen substantially in the coming years. Key issues such as rising healthcare costs, particularly within Medi-Cal, and potential federal funding reductions continue to pressure California's finances.

Medi-Cal Budget Summary

The 2025–26 state budget sent to Governor Newsom underscores the financial strain on Medi-Cal, which faces escalating costs amid a projected $12 billion deficit. Medi-Cal's General Fund expenditures are set to rise to $44.6 billion, an increase of $7.2 billion from the prior year. This growth is driven by factors such as higher pharmacy and medical costs, increased enrollment among residents with unsatisfactory immigration status (UIS), and reduced revenues from managed care organization taxes.

To mitigate immediate budget pressures, the Legislature approved a $1 billion augmentation to the existing $3.4 billion General Fund loan to the Medical Providers Interim Payment Account, deferring repayment until 2027–28. This approach is projected to generate $86.5 million in General Fund savings for the upcoming fiscal year and $3.3 billion over subsequent years. While these measures avert deeper cuts, concerns persist about the program's long-term financial sustainability. Rising costs and reliance on borrowing have sparked debate over enrollment freezes and premiums, with calls for alternative revenue strategies to ensure equitable access to care as Medi-Cal expenditures and the state deficit continue to grow.

- Medi-Cal Caseload Estimate
  The caseload is projected to decrease from 14,970,700 in 2024-25 to 14,837,900 in 2025-26, representing approximately a 1% decrease in overall caseload.

- Medi-Cal Enrollment Freeze for Unsatisfactory Immigration Status (UIS) Population
  Modifies the Governor's Medi-Cal enrollment freeze proposal, applying it to the UIS population 19 years of age and older beginning January 1, 2026, specifying that there is no "age out", and establishing a 6 month re-enrollment grace period for those that fall off the rolls.

  Effective Date: No sooner than January 1, 2026
  Estimated General Fund savings $86.5 million in 2025-26, $2 billion in 2027-28, and $3.3 billion by 2028-29

- Medi-Cal Premiums for UIS Population
  Modifies the Governor's proposal to establish Medi-Cal premiums for the UIS population by lowering the Governor's proposal from $100 per month to $30 per month, limiting the age range from 19-59.

  Effective date: January 1, 2027
  Estimated General Fund savings are $30 million in 2026-27, $250 million in 2027-28, and $675 million ongoing

- Prospective Payment System (PPS) Rates to Federally Qualified Health Centers (FQHC) for UIS Population
  Delays the Governor's proposal to discontinue reimbursement at the PPS rate for state-only services provided to Medi-Cal UIS population by FQHCs and RHCs. Since these services do not qualify for federal matching funds or federal requirements mandating PPS rate reimbursement, they will instead be compensated at the applicable Medi-Cal Fee Schedule rate under the fee-for-service delivery system or at the negotiated rate established between a Medi-Cal managed care plan and the FQHC/RHC within the managed care delivery system.

  Effective Date: Assumes implementation no sooner than July 1, 2027
  Estimated General Fund savings $1.1 billion in 2026-27 and ongoing

- Elimination of Long-Term Care Services for Long-Term Care for UIS Population
  Rejects the Governor's proposal to eliminate long-term care benefits for the UIS population.

- Elimination of Medi-Cal Adult Dental Benefit for UIS Population
  Delays the Governor's proposal to eliminate the adult dental benefit (for those 19 years of age and older) for the UIS Population. Restricted-scope emergency dental coverage will continue to be provided.

  Effective Date: July 1, 2027
  Estimated General Fund savings are $336 million ongoing in 2027-28

- Eliminates the IHSS benefit for the UIS population
  Rejects the Governor's proposal to eliminates the IHSS benefit the UIS population.

- Medi-Cal Acupuncture Benefit
  Rejects the Governor's Proposal to eliminate the Medi-Cal acupuncture benefit for all Medi-Cal recipients.

- Medi-Cal Asset Test Limits
  Restores the Medi-Cal Asset Limit at $130,000, rather than the Governor's $2,000 proposal

  Estimated General Fund Savings are $45 million in 2025-26, $343 million in 2026-27 and $510 billion ongoing

- Medi-Cal Minimum Medical Loss Ratio
  Rejects the Governor's proposal to increase the minimum medical loss ratio for managed care plans from 85% to 90%.

- Proposition 56 Supplemental Payments

  Rejects the Governor's proposal from 2025 to 2027 to eliminate Proposition 56 supplemental payments to family planning, and women's health providers.

  Delays implementation of Governor's proposals to reduce Prop 56 supplemental payments to dental providers to July 1, 2027.

- Proposition 56 Loan Repayment Program
  Terminates to Prop 56 loan repayment program which recruits and retains health care provider in underserves areas by helping repay student loans for those providers who commit to service Medi-Cal populations.

  Effective Date: July 1, 2025
  Estimated General Fund savings of $26 million in 2025-26

- Proposition 35
  Approves the Governor's proposal to increase General Fund offsets from the MCO Tax implemented by Proposition 35 resulting in $1.3 billion of savings in 2025-26 and $236.7 million in 2026-27.

  It is important to note the uncertainty surrounding the continued reliance on MCO tax dollars in the May Revise due to ongoing federal proposals and a proposed CMS rule.

  Includes $1.3 billion in General Fund savings in 2025-26 and $264 million in 2026-27 from Proposition 35. Reflects $804 million in 2024-25, $2.8 billion in 2025-26, and $2.4 billion in 2026-27 for the MCO Tax and Proposition 35 expenditure plan. This includes $1.6 billion across 2025-26 and 2026-27 to support increases in managed care base rates relative to calendar year 2024 for primary care, specialty care, ground emergency medical transportation, and hospital outpatient procedures.

- CalAIM
  The budget continues to fund CalAIM enhanced care management and community support services. In addition, the May Revise assumes transitional rent services will be provided. Additionally, there is $200 million of Prop. 35 funding to support the Flexible Housing Pool rental assistance and housing supports for a two-year period.

- Medi-Cal Prescription Drug Utilization Management
  Implementation of utilization management, step therapy protocols, and prior authorization for prescription drugs. No impact on Medi-Cal managed care as pharmacy benefit is administered by the state – informational only.

  Estimated General Fund savings of $200 million in 2025-26 and $400 million in 2026-27 and ongoing

- Pharmacy Drug Rebates
  Implement a rebate aggregator to obtain state rebates for UIS population. No impact on Medi-Cal managed care as pharmacy benefit is administered by the state - informational only.

  Estimated General Fund savings are $300 million in 2025-26 and $362 million ongoing. Additional General Fund savings of $75 million in 2025- 26 and $150 million ongoing associated with minimum rebate for HIV, AIDS, and cancer drugs.

- Elimination of Over-the-Counter Drug Coverage
  Eliminate pharmacy coverage of certain drug classes including COVID-19 antigen tests, over-the-counter vitamins, and certain antihistamines including dry eye products. No impact on Medi-Cal managed care as pharmacy benefit is administered by the state - informational only.

  Effective Dates: Prior authorizations will be required for all COVID-19 tests effective 01/01/26. COVID-19 test coverage will be eliminated effective 10/01/27
  Estimated General Fund savings are $3 million in 2025-26 and $6 million in 2026-27 and ongoing

- Step Therapy Protocols
  Implement a step therapy strategy to promote utilization management and control prescription drug costs. No impact on Medi-Cal managed care as pharmacy benefit is administered by the state's fee-for service program.

  Estimated General Fund savings of $87.5 million in 2025-26 and $175 million ongoing

- Eliminate Glucagon-Like Peptide-1 Coverage (GLP-1) for Weight Loss
  Eliminate coverage for GLP-1 drugs for weight loss. No impact on Medi-Cal managed care as the pharmacy benefit is administered by the state's fee-for-service program.

  Effective Date: January 1, 2026
  Estimated General Fund savings are $85 million in 2025-26, increasing to $680 million by 2028-29 and ongoing

- Prior Authorization for Continuation of Drug Therapy
  Eliminates the continuing care status for pharmacy benefits under Medi-Cal Rx. The policy, effective January 1, 2026, requires members to obtain drugs no longer on or removed from the Medi-Cal Rx contracted drug list (CDL) through the prior authorization process rather than allow continuing care based upon prior drug usage. No impact on Medi-Cal managed care as pharmacy benefit is administered by the state's fee-for-service program.

  Estimated General Fund savings are $62.5 million in 2025-26 and $125 million in 2026-27 and ongoing

- Pharmacy Benefit Manager Licensure
  Proposed statutory changes to establish licensure and reporting requirements for PBMs to increase transparency, understand cost drivers and develop approaches to improve affordability.

- Hospice
  Delays the implementation of prior authorization requirements for hospice services.

  Effective Date: July 1, 2026
  Estimated General Fund savings of $50 million in 2026-27 and $50 million ongoing

- Skilled Nursing Facilities (SNF)
  Eliminates the SNF Workforce and Quality Incentive Program. Additionally, suspends the requirement for SNFs to maintain a 96-hour backup power system.

  Estimated General Fund savings of $168.2 million in 2025-26 and $140 million annually thereafter

- California Food Assistance Program (CFAP)
  Rejects the Governor's trigger proposal regarding the California Food Assistance Program (CFAP) to undocumented older adults 55 years of age and older. This action maintains current law, as is, which makes the expansion subject to a budget appropriate.

  Effective Date: October 1, 2027

- In Home Supportive Services Overtime and Travel
  Rejects the Governor's proposal to reduce the IHSS provider overtime and travel to 50 hours per week.

- Creation of California Housing and Homelessness Agency (CHHA)
  Creates the California Housing and Homelessness Agency (CHHA) to streamline efforts addressing housing and homelessness. CHHA will coordinate statewide initiatives, support low-income renters and first-time homebuyers, prevent homelessness, and enforce fair housing protections. By integrating housing programs and simplifying administration, CHHA will enhance accountability and align state priorities. It will include entities such as the Department of Housing and Community Development and the California Interagency Council on Homelessness. The agency will incorporate the following entities:
  - Department of Housing and Community Development
  - California Interagency Council on Homelessness

- California Housing Finance Agency
- Civil Rights Department
- Housing Development and Finance Committee

➢ Behavioral Health Services Fund
Rejects the Governor's proposal to use the Behavioral Health Services Fund to offset General Fund costs for the Behavioral Health Bridge Housing program, and redirects Behavioral Health Services Fund for the following:

- $10 million in additional funding for Mental Health Wellness Act resources at the Commission for Behavioral Health, of which $5M will support substance disorder youth programs
- $15 million augmentation for the CalHOPE Warm Line
- $5 million for or the Warm Line Orange County
- $3 million for the Parents Anonymous Warm Line
- $20 million for the Adverse Childhood Experiences (ACEs) Aware initiative
- $30 million for other legislative priorities

➢ Covered California Funding
Allocates $215 million in 2025–26 to support a financial assistance program aimed at offsetting substantial insurance premium increases that could result if federal premium subsidies, set to expire on December 31, 2025, are not renewed

The Senate indicated it would be developing a large employer contribution requirement for employers with employees enrolled in Medi-Cal, beginning as early as 2027-28. This recognizes that large employers benefit from their employees being enrolled in taxpayer funded health programs instead of employer provided health care programs. Implementing any employer contribution will require legislative approval.

Next Steps

With the California Legislature having passed the 2025–26 state budget, the next steps involve the Governor's review and potential revisions. The Governor has until July 1 to sign the budget into law or propose amendments. If the Governor vetoes the budget, the Legislature will need to address his concerns and resubmit a revised version. Given the significant differences between the Governor's original proposals and the Legislature's approved budget, negotiations are expected to continue in the coming weeks. The Governor's choices are to sign, veto, or line-item veto the bill.

Key areas of contention include funding for higher education, Medi-Cal program changes, and public transit investments. The outcome of these negotiations will determine the final structure and implementation of the state's fiscal plan for the upcoming year.

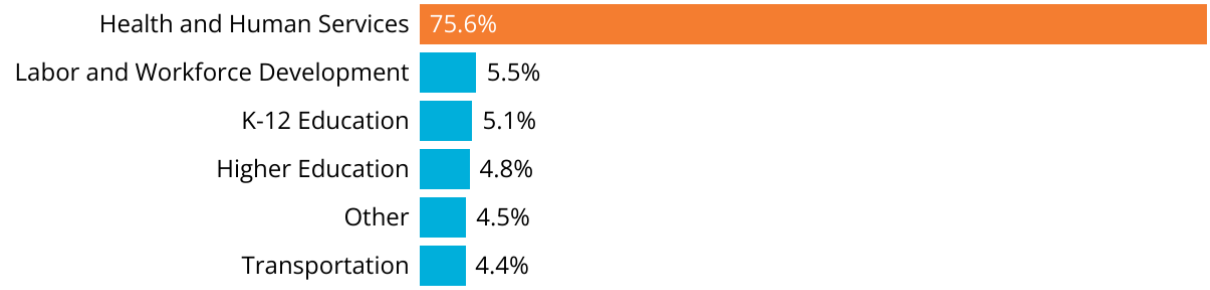
For further information, please contact Cherie Compartore, Senior Director of Government Affairs.

References:

- *https://ebudget.ca.gov/FullBudgetSummary.pdf*
- *https://www.dhcs.ca.gov/Budget/Documents/DHCS-FY-2025-26-May-Revision-Budget-Highlights.pdf*
- *https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2025_May_Estimate/MAY-2025-Medi-Cal-Local-Assistance-Estimate.pdf*

75% of Federal Funds Spent Through the State Budget Support Health & Human Services

Federal Funds Estimated to Be Spent Through the State Budget in 2024-25 = $153 Billion



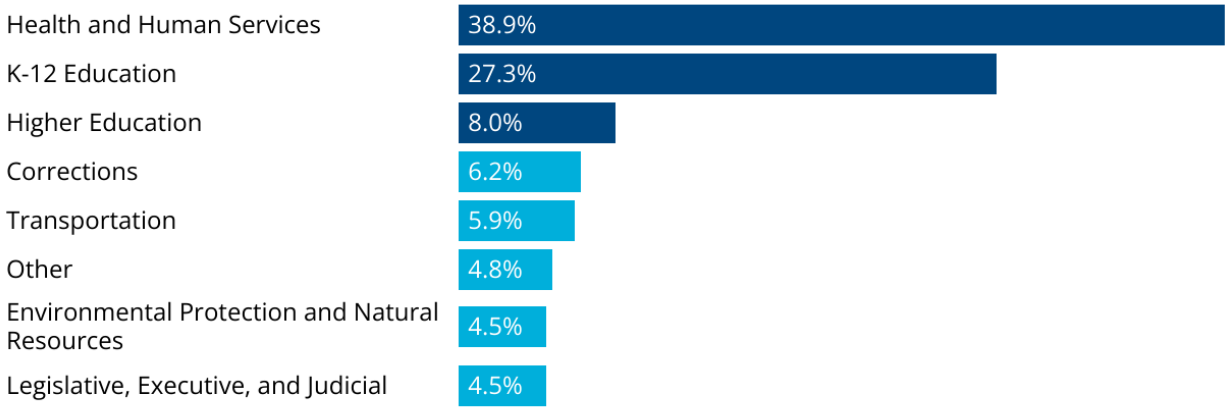
Note: "Other" reflects a number of budget categories, including Environmental Protection, Natural Resources, and Government Operations. Percentages do not sum to 100% due to rounding.

Source: Budget Center analysis of Department of Finance data

California Budget & Policy Center

3 in 4 State Dollars Support Health and Human Services, K-12 Education, or Higher Education

Enacted 2024-25 General Fund and Special Fund Expenditures = $295.5 Billion



Note: "Other" reflects a number of budget categories, including Business, Consumer Services, and Housing; and Labor and Workforce Development. Percentages do not sum to 100% due to rounding.

Source: Budget Center analysis of Department of Finance data

California Budget & Policy Center

Report Title: **Federal Budget Reconciliation**

Date: **June 27, 2025**
Prepared By: **Cherie Compartore, *Senior Director, Government Affairs***

1. Purpose / Desired Impact of the Report

The purpose of this report is to assist the Board of Governors in understanding key differences between the health provisions in H.R. 1 and those outlined in the language released by the Senate committees of jurisdiction. The chart provided organizes differences by issue area, covering Medicaid, Marketplace, and Medicare provisions, to align with the previously shared comprehensive summary of the House package.

2. Background / Context

- Each year, the federal budget process determines funding for programs critical to L.A. Care's mission, including Medicaid, Medicare, Marketplace, and other healthcare services.
- Key provisions in the budget affect areas such as eligibility, safety net issues, and health equity initiatives, directly influencing L.A. Care's ability to serve members effectively.

3. Key Considerations / Analysis

- Proposed adjustments to Medicaid, Medicare, and Marketplace funding could impact eligibility, enrollment processes, and the safety net.
- Changes in funding may require adjustments to L.A. Care's operational and strategic budgets to align with potential federal requirements.

4. Risk Area and Mitigation Activities

Risk Statement: **Known Key Risk:** ☐ Yes ☐ No ☐ Unknown

Failure to monitor and report out on the federal budget could result in L.A. Care being unprepared to adapt to critical funding changes, jeopardizing the organization's ability to sustain essential programs, meet regulatory requirements, and effectively serve its members.

Impacted Area/Risk: Please select those areas impacted

☐ Claims	☒ Compliance	☒ Regulatory	☐ Vendor	☐ Community
☒ Financial	☐ Pharmacy	☒ Privacy	☒ Medicare	☒ Access
☒ Reputation	☒ Clinical	☒ IT	☐ SDOH	☒ Legal
☒ Member	☒ Provider	☒ InfoSec	☐ Contract	☐ Employee

- **Risk Mitigation Activities**:
  Monitor ongoing legislative activities to identify potential impacts on funding and programs.
- Engage with federal stakeholders to ensure alignment with policy changes and timelines for implementation.

5. Recommended Action / Decision Requested

Board Action Needed:

☒ For Information Only
☐ For Discussion with Board/Committee
☐ For Approval / Decision

Proposed Motion (if applicable): N/A

6. Next Steps / Timeline / Milestones

- **Byrd Bath:** The Senate Budget Reconciliation bill will undergo a review to ensure compliance with rules limiting content to budget-related items.
- **Senate Floor Debate:** Senators will propose and vote on amendments before voting on the bill.
- **House Review:** If the Senate makes changes, the House will review the updated bill, potentially negotiating further.
- **Conference Committee:** If required, differences will be reconciled, and both chambers will vote on the final version.
- **Presidential Action:** The President can sign the bill into law or veto it, with federal agencies beginning implementation once signed.

7. Attachments / Supporting Materials / Presentations

- H.R. 1 provisions in House and Senate versions of the budget reconciliation bill.

May 30, 2025

The Honorable Gavin Newsom
California State Governor
1021 O Street, Suite 9000
Sacramento, CA 95814

The Honorable Mike McGuire
Senate President pro Tempore
1021 O Street, Suite 8158
Sacramento, CA 95814

The Honorable Robert Rivas
Speaker, California State Assembly
1021 O Street, Suite 8330
Sacramento, CA 95814

The Honorable Scott Wiener
Chair, Senate Budget Committee
1020 N Street, Room 502
Sacramento, CA 95814

The Honorable Jesse Gabriel
Chair, Assembly Budget Committee
1021 O Street, Suite 8230
Sacramento, CA 95814

Re: Addressing the Latino Physician Shortage Coalition – Critical Budget Priorities for California's Healthcare Future

Dear Governor Newsom, Senate President Pro Tempore McGuire, Assembly Speaker Rivas, and Budget Chairs Senator Wiener and Assemblymember Gabriel,

The Addressing the Latino Physician Shortage (ALPS) Coalition writes to you during these challenging budget deliberations to respectfully urge your leadership to prevent budget decisions that would have significant, negative long-term impacts on Latino communities and undermine California's historic progress in health care access and the healthcare workforce.

The Stakes

California faces a physician workforce crisis that directly undermines health outcomes for Latino communities. Research consistently demonstrates that ethnic and language concordance between patients and providers improves both the quality of care and cost-effectiveness. Yet Latino physicians represent only 6% of our provider workforce (with Latina physicians at just 3%)

despite Latinos comprising nearly 40% of our state's population and the majority of Medi-Cal beneficiaries (51.5%).

This profound shortage perpetuates health disparities when physicians of color provide care to 54% of racial and ethnic minority patients and 70% of non-English speaking patients, populations that include nearly 1 million undocumented immigrants who gained Medi-Cal access through expansion. These populations are particularly dependent on culturally responsive care due to language barriers and immigration-related fears. Budget proposals under consideration risk catastrophically worsening this crisis by simultaneously eliminating healthcare access for the most vulnerable Latino patients while defunding programs designed to train culturally competent providers.

Our Urgent Request

We respectfully urge you to:

1. **Reject the Medi-Cal enrollment freeze and premium proposal** that would eliminate health care access for nearly 1 million Californians while generating massive long-term costs in the form of negative health outcomes and demand on emergency care.
2. **Preserve $26 million for the CalHealthCares loan repayment program** that has proven highly successful, with 86% of participants planning to continue serving Medi-Cal patients after finishing the program.
3. Encourage the Administration to **immediately release the $75 million in Proposition 35** graduate medical education (GME) funding to prevent irreversible delays and the loss of up to 120,000 patient visits per year in underserved communities.
4. **Preserve specific medical workforce pipeline programs within the HCAI budget**, including: $2.8 million ongoing, The California Medicine Scholars Program at the California Community Colleges, and the Preservation of Song Brown funding. These programs are crucial for California's workforce. Last year’s budget significantly reduced support for these programs. It is crucial to protect these programs, ensuring that their budget remains intact. Any cuts would jeopardize progress in addressing California’s workforce shortage.

Reject the Proposed Medi-Cal Enrollment Freeze, Benefit Reduction, and Premium Requirements

The proposal to freeze new Medi-Cal enrollment for undocumented immigrants while imposing $100 monthly premiums and reducing the number of services under full-scope (including IHSS and dental benefits) represents a catastrophic retreat from California's leadership in health equity. This would undermine our state's historic achievement as the first to provide comprehensive Medi-Cal coverage regardless of immigration status and could result in a two-tiered healthcare system of care for 40% of California’s workforce.

Eliminating preventive care will generate massive downstream costs when conditions require emergency treatment. Safety net facilities serving Latino communities face potential closure as

patient revenue disappears, creating healthcare deserts where cultural competence is most needed.

With regards to the proposed premiums, a $100 monthly premium would significantly impact Latino families who are struggling to put food on the table. In a family of four, whose annual income falls right on the line of the federal poverty guideline, an annual $100 premium for each family member would result in 15% of their annual household income. Additionally, the state would need to spend an estimated $30 million to begin to construct a system to collect these premiums, which does not seem fiscally prudent. Any missed payments would result in individuals losing coverage and being unable to re-enroll. Furthermore, the state would begin to charge these premiums while simultaneously reducing the services available to these individuals.

Preserve CalHealthCares Loan Repayment Investment

The Governor's proposal to divert $26 million from CalHealthCares contradicts the evidence of the program's success to date. CalHealthCares has supported 1,414 physicians and dentists with $323 million in loan repayment to date. Most significantly, 97% of providers who complete their 5-year service commitment plan intend to continue serving Medi-Cal patients, thereby establishing lasting practice patterns.

Health care providers carry substantial educational debt, averaging nearly $325,000. For students who can't depend on substantial financial help from their families, as is the case with many Latino families, limiting the ability to seek educational debt relief can prevent them from practicing in safety net settings where Latino patients concentrate. CalHealthCares helps to remove this barrier through voter-approved Prop 56 revenue, specifically designated to strengthen health care access.

Release Graduate Medical Education Funding Without Further Delay

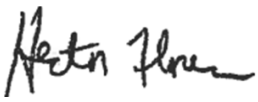
The $75 million in Proposition 35 funding for GME through UC requires immediate release. Programs recruiting for 2026 positions must commit resources by fall 2025, and UC requires several months to design and administer grants in time for this cycle.

The GME programs that UC will support provide both immediate patient care and long-term investment in training residents from and in underserved communities. Delays could result in up to 120,000 patient visits being eliminated in underserved communities in a single year. And medical students from underrepresented backgrounds practice in medically underserved areas at rates two to three times higher than their peers and remain in these communities at four times the rate when trained in safety net settings.

These investments will strengthen California's health care workforce while generating positive economic returns through improved health outcomes and reduced emergency care utilization. The ALPS Coalition stands ready to collaborate in developing sustainable solutions that protect vulnerable populations while addressing fiscal challenges.

Thank you for considering these critical investments in California's healthcare future and for advancing equitable access and outcomes for all.

Sincerely,



Dr. Hector Flores, MD | Medical Director, Altais/Family Care Specialists Medical Group

Martha Santana-Chin | Chief Executive Officer, LA Care

Lupe Alonzo-Diaz, MPA |President and Chief Executive Officer, Physicians for a Healthy California

Berenice Nunez Constant| Senior Vice President, Government Relations and Civic Engagement, AltaMed

Pooja Mittal | Vice President, Chief Health Equity Officer, Health Net

Dr. Seciah Aquino | Executive Director, LCHC

`June 12, 2025

The Honorable John Thune
Senate Majority Leader
U.S. Senate
Washington, D.C. 20510

The Honorable Chuck Schumer
Senate Minority Leader
U.S. Senate
Washington, D.C. 20510

Re: Protect Medicaid by Rejecting Cuts that will Destabilize the Health Care System & Result in Millions Losing Coverage

Dear Majority Leader Thune and Minority Leader Schumer,

The Local Health Plans of California represents 17 public and not-for-profit Medicaid managed care plans in California that collectively serve over 9.5 million Medicaid beneficiaries. Local health plans play a unique role as they are community-based, locally governed and publicly accountable, with a responsibility to ensure the core population we serve, Medicaid beneficiaries, has access to a network of providers that are paid a fair rate to provide care that helps keep enrollees from utilizing unnecessary emergency care. **We urge you to protect Medicaid by rejecting major cuts in H.R. 1 and reject Senate proposals that would result in deeper cuts to Medicaid.**

It is important to acknowledge that Medicaid should not be immune from policy reforms to address waste, fraud and abuse and reduce inappropriate expenditures. However, H.R. 1 goes far beyond that threshold, targeting vital funding mechanisms that have been carefully negotiated by state and local communities over a period of many years, amounting to wholesale reductions in funding for serving Medicaid beneficiaries and destabilizing the system that serves them. Additionally, H.R. 1 creates an implementation timeline for work requirements that will create compliance challenges and exacerbate coverage losses. The Congressional Budget Office (CBO) estimates the totality of Medicaid cuts proposed in H.R. 1 amounts to $864 billion. This savings figure relies on millions of Americans losing coverage. Specifically, 7.8 million individuals on Medicaid will lose access to critical health care services.

Despite these sobering numbers, the cuts currently under Senate consideration surpass those passed by the House, potentially crippling the medical safety net that all Americans depend on during health crises. These proposals would fundamentally undermine our capacity to provide care when people need it most, with consequences that extend far beyond Medicaid

beneficiaries to affect emergency departments, rural hospitals, and the broader healthcare system that serves every community.

The stakes could not be higher—these changes would directly impact whether Americans can access lifesaving care in their most critical moments.

Specifically, we urge Congress to:

1) **Preserve critical Medicaid financing for hospitals and other health care providers to ensure they can continue to serve Medicaid populations.** Provider taxes are essential to keeping hospitals, nursing homes, physicians, and other healthcare safety net providers stable. The CBO-estimated $200 billion in provider tax cuts will create substantial funding gaps in state budgets and force states into an impossible choice: raise state and local taxes to fill the gap, cut provider payments, or cut Medicaid eligibility, benefits, and access to care as provider participation declines. These cuts will disproportionately harm rural states and communities that have heavily relied on such resources.

   Should the Senate consider restricting Medicaid provider taxes even further, the impact will be even more severe on Medicaid providers, patients, and local communities. There are currently 45 states with a hospital provider tax, 20 states with a managed care organization tax, and most states also have provider taxes for skilled nursing facilities and intermediate care facilities. Provider taxes are a core part of how states are supporting Medicaid programs across the nation.

   Further restrictions on state directed payments (SDPs) could destabilize critical hospitals and safety net providers. H.R. 1 caps new SDPs at no higher than Medicare rates. This cap will have a disproportionate impact on rural hospitals, safety net hospitals, and public hospitals. Proposals to further limit SDPs could prove fatal for the many rural and critical access hospitals that are already financially strained. If a hospital is forced to close, every member of the community loses access to hospital care not just Medicaid beneficiaries.

   The Senate must not exacerbate the harmful impacts of H.R. 1 by including more restrictions to Medicaid financing. Instead, we urge the Senate to mitigate the impact of H.R. 1 by including mandatory transition periods of at least three years for the provider tax provisions so that states do not face a funding cliff that will harm patients, providers, and communities.

2) **Provide sufficient time for states to implement Medicaid work requirements to preserve coverage for hardworking adults, families, and caretakers who will otherwise lose coverage due to lack of state readiness and procedural issues.** Consideration of state readiness assessments and incorporation of new technology to create efficiencies must be coupled with a delayed implementation date to effectively mitigate the losses in coverage for hardworking beneficiaries who rely on Medicaid for their healthcare. In most states, there are not currently systems or infrastructure to support implementation of H.R. 1's work requirements. It is simply not feasible to implement these requirements in 2026. **Therefore, we urge the Senate to protect working adults, families, and caretakers by providing additional time for States to implement work requirements.**

Americans across the political spectrum recognize Medicaid as vital to our communities, working families, healthcare system, and economy.

As Congress considers changes to Medicaid, I urge you to proceed thoughtfully. Any modifications should be carefully designed to avoid harming the millions of Americans who depend on this program for their health and economic stability. Our communities' well-being depends on ensuring that Medicaid reforms do not undermine the families and local economies that rely on this essential support.

Sincerely,

Chief Executive Officer
Local Health Plans of California

Cc: Senate Finance Committee

The Honorable John Thune
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Chuck Schumer
Minority Leader
United States Senate
Washington, DC 20510

The Honorable Mike Crapo
Chairman, Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
Washington, DC 20510

June 12, 2025

Dear Majority Leader Thune, Minority Leader Schumer, Chairman Crapo, and Ranking Member Wyden:

We write to you today on behalf of the Medicaid Health Plans of America (MHPA), to amplify the critical importance of the Medicaid program and to urge against policies that create significant barriers to care. MHPA represents 165 Managed Care Organizations (MCOs) who serve more than 51 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. Members across the United States Congress and the Administration have pledged to protect quality Medicaid coverage for those who need it; as MCOs, we share in that commitment. Unfortunately, the House budget reconciliation bill challenges that premise and creates significant barriers for states, health plans, and providers to uphold that charge to the fullest.

As you know, Medicaid is a lifeline for nearly 79 million individuals throughout the U.S., with managed care making up the majority (75%) of that enrollment. Through a public-private partnership, states work with MCOs to ensure that Medicaid beneficiaries receive the services they need. Using a model that prioritizes care coordination, access to preventive care, and support for the full provider network – all while allowing states to reliably predict costs – MCOs are delivering on their promise to provide quality coverage.

It is with this stewardship in mind that we want to ensure the Medicaid program is best meeting the needs of its enrollees. While we applaud the inclusion of policies that eliminate redundancies in the program, and the exclusion of policies like per capita caps, across the board Federal Medical Assistance Percentage (FMAP) match reductions, safe harbor threshold cuts, and block grants, we worry that policies included in the House budget reconciliation bill will ultimately make it harder for rightful beneficiaries to receive and maintain coverage. For that reason, we urge caution against specific provisions listed below that have been found to increase churn, set up additional barriers to receiving coverage, disincentivize essential care, hamstring states in financing the program, and that will likely cause disruption that radiates across the health care system.

Mandatory, Nationwide Community Engagement Requirements

We can all agree that work is an effective tool for lifting individuals out of poverty. The House-passed policy of nationwide Medicaid work requirements (referred to as community engagement requirements) strips states of the autonomy to administer their Medicaid programs to best meet the needs of their residents. As Medicaid MCOs, it is our duty to work with states to administer their Medicaid programs as effectively and efficiently as possible, but imposing a federally mandated policy that could create barriers to coverage for those already working or exempt via the legislation forces states, and by extension plans, into a system that may not best serve their residents. Indeed, for the 92% of Medicaid enrollees that are either working part

time or are not working due to caregiving responsibilities, illness or disability, or school attendance, work requirements impose on states and their Medicaid enrollees procedural hurdles to obtaining coverage that could threaten the ability of eligible beneficiaries to receive health care.[1]

Evidence has already shown the significant investment states have needed to make to stand up Medicaid work requirements. High administrative costs to develop systems to monitor compliance and costly outreach campaigns to educate the public of these changes have led to considerable financial investment from often-limited state budgets.[2] In 2019, GAO examined selected states' estimates of the administrative costs to implement work requirements, finding that some could take over $270 million to operationalize.[3]

When considering the one-size fits all federal imposition of a work requirement, it is also important to acknowledge that Medicaid work requirements haven't bolstered employment, but have created administrative barriers for rightful beneficiaries to retain coverage in the states that have chosen to implement them.[4] And while states have worked to create various guardrails and have made financial investments in implementation, much of the coverage loss is due to the administrative burden associated with compliance and barriers in communication that left the beneficiary population unaware of changes in the program. With beneficiaries unable to maintain Medicaid coverage and unable to afford coverage on the exchange, many go uninsured – ultimately straining the safety net further through uncompensated care costs.

To be clear, the evidence outlined above demonstrating the high-cost of implementation and issues with unintended coverage loss occurred in states that had both the flexibility and time to proactively implement Medicaid work requirements. The House reconciliation bill affords neither flexibility nor time to states moving forward. Language requiring states to operationalize work requirements before the end of next year only intensifies the stress on states and their budgets and increases the likelihood of vulnerable beneficiaries losing coverage. Even with a track record that raises questions regarding their efficacy, if Congress still wishes to move forward with policies seeking to encourage community engagement, it is essential that these policies support the states who proactively desire to do so and not mandate a one-size-fits-all approach that strains Medicaid's essential state-federal partnership dynamic.

Mandatory, Nationwide Medicaid Cost-Sharing

While we appreciate the interest in creating more financial sustainability in the Medicaid program, we caution against policies that subsidize costs on the backs of vulnerable beneficiaries. A single adult in the Medicaid expansion population makes less than $22,000 per year. Imposing a cost-sharing requirement on services – especially at a price point as high as $35 – could have sweeping chilling effects on patients seeking necessary care. This federal mandated policy will only serve to increase more expensive care in emergency and inpatient settings, eschewing both the individual and system-wide benefits of early detection and preventative medicine. Moreover, even with well-intentioned carve-outs for primary care, behavioral health,

---

[1] https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update

[2] https://kffhealthnews.org/news/article/georgia-medicaid-work-requirement-red-tape/

[3] https://www.gao.gov/products/gao-20-149

[4] https://www.healthaffairs.org/content/forefront/reporting-requirements-matter-lot-evidence-medicaid-work-requirements-arkansas#:~:text=About%20Arkansas%20Works,added%20later%20in%20the%20program); and https://gbpi.org/georgias-pathways-to-coverage-program-the-first-year-in-review/

and other services, beneficiaries often assume the existence of a co-pay, which again leads to delayed and often costlier forms of care.

Several studies document the likelihood that higher out-of-pocket costs decrease access to, and utilization of care, even for those who are particularly sick.[5] Cost-sharing can also reduce provider participation in the Medicaid program, already a challenge in rural and underserved areas, as providers typically are expected to absorb unpaid cost-sharing, increasing the risk providers take on by serving the Medicaid population. As stewards of managed care programs, MCOs are particularly aware of both the downstream costs associated with delayed care, as well as the sensitivity to costs in the Medicaid population. States currently have the flexibility to integrate cost-sharing into the Medicaid program – however, most decline to do so, for the reasons listed above. While cost-sharing in Medicaid may be a well-intentioned goal, again – a national, one-sized fits all approach will lead to increased costs to the system and sicker patients forced to make impossible choices between accessing health services and other essentials.

Increased Medicaid Eligibility Checks

MHPA shares in Congress' aim to ensure that only eligible beneficiaries are getting coverage. It is for this reason that we are supportive of the program integrity measures in the House passed bill that will reduce the likelihood of duplicate coverage, or that remove deceased individuals from the rolls. However, we have seen from the recent Medicaid redetermination process that accompanied the unwinding of the COVID-19 Public Health Emergency, that increasing administrative hurdles in an already economically stressed population leads to unintentional coverage loss – not because individuals are ineligible, but because they are unable to produce the necessary paperwork in the required timeframes. Furthermore, burdens on seasonal and hourly gig workers are particularly susceptible to these policies, as they tend to fluctuate in income as well as reachable addresses. Given that gig work is the primary job of 29% of all workers in the United States, this policy could create significant barriers to access to eligible Medicaid enrollees.[6] These eligibility checks will increase churn in the Medicaid program. In turn, this churn can limit MCOs' ability to hit managed care quality requirements, increase administrative costs, and make it harder to ensure continuity of care for its beneficiaries.

Retroactive Coverage Period

While MHPA recognizes the importance of ensuring that the Medicaid program is sustainably funded, reducing the mandatory retroactive coverage period in Medicaid from three months to one month will create barriers to care for rightful Medicaid enrollees who are explicitly deemed eligible for the program by their state. Retroactive coverage only applies if the enrollee is deemed to be eligible during the period of retroactivity, meaning that the policy provides access to enrollees who qualify for Medicaid but were not enrolled for procedural reasons. A three-month retroactive coverage period is critical to reducing gaps in coverage and minimizing churn in the Medicaid program. In a 2022 report, the Medicaid and CHIP Payment and Access Commission (MACPAC) found that after an episode of churn, Medicaid beneficiaries were more than twice as likely to be hospitalized for all four ambulatory care sensitive conditions that were studied (COPD or asthma (40-64 yrs), short-term diabetes complications, heart failure, or asthma (18-39 yrs) compared to the baseline rate.[7] MCOs see first-hand that reduced churn in the program helps to keep enrollees healthy and out of the emergency room, while also minimizing uncompensated care.

---

[5] https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/

[6] https://niwr.org/wp-content/uploads/2020/10/Gig-Economy-By-The-Numbers_The-Institute_2020.pdf

[7] https://www.macpac.gov/wp-content/uploads/2022/07/Effects-of-churn-on-hospital-use_issue-brief.pdf

Provider Tax Freeze and State-Directed Payments Cap
Policy in the House budget reconciliation bill that freezes existing provider taxes in place and caps state directed payments will hamstring states unnecessarily. Instituting these policies will make it impossible for states to adapt to changing financial landscapes, leaving them particularly vulnerable to public health emergencies or other disasters. Additionally, by forcing states to maintain their current infrastructure in perpetuity, financing gaps are likely to emerge which may force states to respond with austerity measures – likely in cuts to optional benefits such as home and community-based services, adult dental, and prescription drug coverage.

Global Policy Impact and Expedited Implementation Timeline
While we have concerns about these policies in isolation, we also worry that these provisions could have additional unintended consequences across all populations when operating in tandem. Given the interconnectedness of America's healthcare system, the combination of these policies will likely lead to even more significant coverage loss, larger increases in uncompensated care costs, and greater strains on health systems. As the health ecosystem in states adapts to sicker, and increasingly uninsured populations, there is a greater likelihood that hospitals close, state and county budgets are further strained, and access to care becomes harder for all beneficiaries, regardless of insurance type and status. Additionally, shortening the timeline for implementation, especially for policies like work requirements which come with an immense administrative burden, will further stress already thinly-stretched providers and state compliance offices. Policy in the budget reconciliation bill amounts to a significant sea-change in Medicaid processes; tying the hands of the entities charged with implementing these programs will only increase the likelihood of adverse downstream consequences across health systems. As you work to refine policy in the budget reconciliation bill, we urge you to consider the full scope of implications – not just for Medicaid beneficiaries, but for all individuals.

We understand the importance of containing costs, and we appreciate your efforts to create greater sustainability in the Medicaid program. While we have concerns about the existing proposal, we are eager to work with you on policy that will ensure the program is fully serving beneficiaries while being mindful of rising costs. Again, we thank you for your consideration and we stand ready to collaborate as the reconciliation process continues. We look forward to working together to ensure we have an accountable and efficient Medicaid program that best supports the millions of Americans who rely on it for life saving coverage and care.

Respectfully,

Craig Kennedy
President and Chief Executive Officer
Medicaid Health Plans of America (MHPA)

Comparative Table: Health-Related Provisions in Senate and House Reconciliation Packages

Background

On May 22, 2025, the US House of Representatives passed its reconciliation package, the One Big Beautiful Bill Act (H.R. 1), by a vote of 215 – 214 – 1. The reconciliation process has now moved to the US Senate, where additional revisions are being made to: (1) ensure the provisions of the bill abide by the Byrd rule (see our +Insight for additional background on the Byrd rule); and (2) ensure that Majority Leader Thune (R-SD) can secure enough votes to advance the party-line bill through his chamber, where he can only lose three Republican votes.

Senate committees of jurisdiction did not hold markups, but instead each released bill language that contains provisions within their jurisdiction. On the healthcare front, the Senate Committee on Commerce, Science, and Transportation released its language, which modifies the House's artificial intelligence (AI) provisions, on June 5, 2025. The Senate Committee on Health, Education, Labor, and Pensions (HELP) released its language, which includes a provision related to cost-sharing reductions (CSRs) for Affordable Care Act (ACA) Marketplace plans and policies impacting medical education, on June 10, 2025. The Senate Committee on Finance, which has jurisdiction over most of the bill's health-related provisions, released its language on June 16, 2025.

Set forth below is a chart that compares the health provisions in H.R. 1 with the language released by the Senate committees of jurisdiction. It is arranged by issue area, in the same order as the comprehensive summary of the health provisions in the House package that we previously shared with you.

Again, it is important to note that, given the ongoing "scrubbing" of the bill to ensure Byrd rule compliance (without which the bill would lose its ability to advance by a simple majority in the Senate) and ongoing negotiations to secure Republican votes, additional revisions to the provisions set forth below are possible before the bill reaches the Senate floor. This chart will be updated accordingly when any such revisions occur.

Medicaid

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
Repealing Biden- Era Eligibility Regulations	Section 44101 would delay implementation, administration, or enforcement of the September 2023 eligibility final rule until January 2035, and Section 44102 would require the same for the March 2024 eligibility final rule.	Section 71101 and Section 71102 have different language from the House, but similarly prohibit the implementation, administration and/or enforcement of the eligibility regulations.

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
Ensuring Address and Eligibility Verification	Section 44103 would require states to establish processes to regularly obtain beneficiary address information from reliable data sources, including from managed care entities. It would also require HHS to establish a system to prevent individuals from being simultaneously enrolled in multiple state programs by October 1, 2029. States would be required to submit the Social Security numbers of individuals enrolled under state Medicaid plans to identify Social Security numbers that appear in two or more state plans at the same time. The bill allots $10 million in fiscal year (FY) 2026 to establish the system and $20 million in FY 2029 to maintain it. Section 44107 would require HHS to reduce federal financial participation (FFP) to states for errors that the OIG or the secretary identify through the **ratio of a state's erroneous excess payments for medical assistance that** are directly attributable to payments to ineligible individuals or for ineligible **services. The Rules Committee manager's amendment added a** requirement that when the secretary determines the amount of erroneous excess payment for medical assistance, the secretary will include any payments identified under the payment error rate measurement program or the Medicaid Eligibility Quality Control program in addition to those originally identified. Section 44108 requires that states verify expansion enrollees' **eligibility** every six months, rather than annually, by December 31, 2026.	Section 71103 is identical to Section 44103 in the House. Section 71106 has different language than Section 44107 in the House but achieves the same changes to erroneous excess payments. Section 77107 has different language than Section 44108 in the House but similarly requires eligibility redeterminations every six months.
Ensuring Deceased Individuals Do Not Remain Enrolled	Section 44104 would require states to quarterly review the Social Security **Administration's Death Master File**, disenroll deceased beneficiaries, and discontinue any payments for medical assistance.	Section 71104 is identical to Section 44104 in the House.
Increasing Provider Screening Requirements to Prevent Fraud and Abuse	Section 44105 requires states to conduct monthly checks of databases to determine whether HHS or another state has terminated a provider or supplier from participating in Medicaid and to disenroll them. Section 44106 would require state Medicaid programs to check, during provider enrollment and re-enrollment and on a quarterly basis thereafter, the	Section 44105 was not included in the Senate text. Section 77105 in the Senate is identical to Section 44106 in the House.

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
	Social Security Administration's Death Master File to determine whether providers enrolled in Medicaid are deceased.	
Revising Home Equity Limit for Determining Eligibility for Long-Term Services and Supports	Section 44109 would set the federal home equity maximum limit at $1 million beginning in 2028. It would also prohibit the use of asset disregards from being applied to waive home equity limits.	Section 71108 is identical to Section 44109 in the House.
Reducing or Prohibiting Federal Matching for Certain Populations or Services	Section 44110 would prohibit FMAP for individuals without verified citizenship, nationality, or specified immigration status, including by eliminating the state requirement to cover medical care during reasonable opportunity periods when an individual has not yet verified citizenship, nationality, or immigration status. This policy would give states the option to provide coverage during the reasonable opportunity period if the state does not request FFP until citizenship, nationality, or immigration status has been verified. Section 44111 would reduce the federal match for the ACA expansion population from 90% to 80% for states that use state-only resources to provide Medicaid coverage to undocumented or other specified legal **immigrants outside of "qualified aliens." This grou**p includes permanent residents, those granted asylum, and certain refugees, as defined by Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Children or pregnant women lawfully residing in the country are also specified as qualified aliens.	Section 71109 is identical to Section 44110 in the House. Section 71111 is identical to Section 44111 in the House. Section 71110 is added in the Senate text. Section 71110 amends the definition of qualified alien for Medicaid eligibility to include lawful permanent residents, certain Cuban immigrants and individuals living in the United States through a Compact of Free Association (CoFA). In the House passed version for SNAP eligibility, Section 10012, similar language was included. This would extend **the 'qualified alien' language** to Medicaid eligibility.
Repealing Biden-Era Nursing Home Regulation	Section 44121 would essentially repeal the nursing home staffing rule by delaying its implementation, administration, or enforcement until January 1, 2035.	Section 71113 has different language from the House, but similarly essentially repeals the nursing home staffing rule by providing a prohibition on implementation, administration and/or enforcement of amendments made by the rule.
Modifying Retroactive Coverage During	Section 44122 would modify presumptive eligibility requirements so that individuals receive retroactive eligibility for one month rather than three months. The provision would be applicable to medical assistance, child	Section 71114 modifies the retroactive eligibility policy to differentially apply to the expansion population and non-expansion population.

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
Presumptive Eligibility	health assistance, and pregnancy-related assistance, and would be effective for applications on or after December 31, 2026.	Retroactive coverage would be limited to one month for the expansion population but provided for two months for non-expansion beneficiaries. It would be effective for applications made on or after the first day of the first quarter that begins after December 31, 2026.
Ensuring Accurate Payments to Pharmacies and Eliminating Spread Pricing	Section 44123 would require participation by retail and applicable nonretail pharmacies in the National Average Drug Acquisition Cost survey, which measures pharmacy acquisition costs and is often used in Medicaid to inform reimbursement to pharmacies. Section 44124 would ban spread pricing in Medicaid.	Section 71115 requires participation by retail and applicable nonretail pharmacies in the National Drug Acquisition Cost survey. Section 71116 bans spread pricing in Medicaid. Language in both are identical to House passed, minus formatting changes.
Prohibiting Medicaid Funding for Gender Transition Procedures and Prohibiting Coverage of Gender Transition Procedures as an Essential Health Benefit (EHB) in ACA Exchanges	Section 44125 would prohibit federal Medicaid and CHIP funding for specified gender transition procedures. Explicit exceptions include where **consent is given by a minor's parent**/legal guardian for puberty suppression or blocking drugs and other medically necessary treatments. In section 44201, for plan years beginning on or after January 1, 2027, qualified health plans in the ACA exchanges would not be permitted to **include a "gender transition procedure" as an EHB. Th**is provision defines **"gender transition procedure" similarly to the definition** in Medicaid and CHIP and includes similar exceptions.	Section 71117 is identical to House Section 44125. Provisions in section 44201 are not included in the Senate version, as the Senate version does not **codify the Trump Administration's ACA program** integrity regulation which was included in the House-passed bill.
Restricting Payments to Entities That Provide Abortions	Section 44126 would prohibit Medicaid payments to nonprofit essential community providers that primarily engage in family planning or reproductive services, provide abortions other than for Hyde Amendment exceptions, and received $1 million or more (to either the provider or the **provider's affiliates) in Medicaid payments in 2024.**	Section 71118 implements this policy, but lowers the payment threshold to $800,000 and changes the year examined to 2023.
Sunsetting the American Rescue Plan Temporary FMAP Increase	The American Rescue Plan provided states that expand their programs a 5% increase to their regular federal matching rate for two years after expansion takes effect. Section 44131 would sunset the 5% increase prospectively, not affecting states currently receiving it.	Section 71119 is identical to House Section 44131.

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
Limiting State Taxes on Providers	Section 44132 would grandfather existing state provider taxes but prohibit states from enacting new provider taxes or increasing the amount or rate of an existing provider tax, effective the date the legislation is signed into law.	Section 71120 prohibits states from enacting new provider taxes or increasing provider tax rates. However, it treats expansion and non-expansion states differently. In non-expansion states, they would not be able to modify existing taxes or enact new provider taxes. In expansion states, section 71120 would gradually lower the 6% hold harmless threshold by 0.5% per year, starting in 2027, until the threshold is 3.5% in 2031. In expansion states, the reduction in the hold harmless threshold would not apply to provider taxes on nursing facilities or intermediate care facilities. Section 71120 appropriates $6 million for HHS for implementation.
Limiting State Directed Payments (SDPs)	Section 44133 would require CMS to revise the regulations finalized in the Biden administration's managed care rule so that the prospective SDP payment ceiling for certain services is 100% of the total published Medicare payment rate in expansion states and 110% of the total published Medicare payment rate in non-expansion states. If a state expands Medicaid after this bill is enacted, its SDPs for the specified services would be capped at 100% of the total published Medicare rate, even if the state received prior written approval. A grandfathering provision would exempt any existing or pending SDP applications submitted prior to the enactment of the bill from the new payment ceiling. The bill appropriates $7 million annually from FY 2026 – 2033.	Section 71121 retains the language from House Section 44133 that requires CMS to revise regulations from the managed care rule so the SDP payment ceiling for those services is capped at 100% of the total published Medicare payment rate in expansion states and 110% of the total published Medicare payment rate in non-expansion states. However, Section 71121 would no longer grandfather in existing SDPs or pending SDP applications. Instead, it would require those SDPs to be reduced by 10% annually until they reach the applicable payment limit. SDPs that received approval before May 1, 2025, for the rating period occurring within 180 days of the bill's enactment date, would be required to comply with this new policy. SDP preprints that were submitted prior to the bill's enactment would also be required to comply with this new policy. The 10% annual reduction would begin in for the rating period beginning on or after January 1, 2027.

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
		Section 71121 also specifies that if a total published Medicare payment rate is not available, the payment rate under Medicaid would apply.
Increasing Requirements for Managed Care Organization Taxes	Section 44134 would specify that a provider tax would not be considered generally redistributive in three scenarios: • If, within a permissible class, the tax rate imposed on the taxpayer or tax rate group explicitly defined by its relatively lower volume or percentage of Medicaid taxable units is lower than the tax rate imposed on any other taxpayer or tax rate group explicitly defined by its relatively higher volume or percentage of Medicaid taxable units. • If, within a permissible class, the tax rate imposed on any taxpayer or tax rate group based upon its Medicaid taxable units is higher than the tax rate imposed on any taxpayer or tax rate group based upon its non-Medicaid taxable unit. • If the tax excludes or imposes a lower tax rate on a taxpayer or tax rate group based on or defined by any description that results in the same effect as described above. This provision would be effective upon the date of enactment, but CMS could apply a transition period for states that are impacted not to exceed three fiscal years.	Section 71122 adds a new paragraph that was not included in the House bill that clarifies that a state shall not be considered in violation of the moratorium on new or increased provider taxes if it imposes a tax or modifies a tax to come into compliance with this section.
Requiring Section 1115 Waivers to Be Budget Neutral	Section 44135 would codify the existing CMS practice that Section 1115 waivers be budget neutral. It specifies that CMS cannot approve an application, renewal, or amendment of a Section 1115 waiver unless budget neutrality is certified. CMS must develop methods to consider savings in subsequent approval periods if expenditures were less under the waiver than they would have been absent the waiver. CMS must consider all expenditures, not solely federal expenditures, meaning that the provision would also apply to state expenditures and savings.	Section 71123 clarifies that a Section 1115 waiver budget neutrality certification would be based on expenditures for the state program in the preceding fiscal year. Section 71123 also specifies that a budget neutrality decision would be based on an estimation that the project would not result in an increase in the amount of *federal* expenditures, whereas the House language noted CMS must consider all expenditures. Section 71123 includes $5 million per year to HHS for implementation funding for FYs 2026 and 2027.

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
Enacting Work Requirements	Section 44141 would implement work requirements for able-bodied adults, aged 19 to 64, without dependents, targeting the expansion population. Individuals would be required to show at least 80 hours per month of work, community service, or participation in a work program; a monthly income equivalent to at least minimum wage for 80 hours; or part-time enrollment in an educational program. An individual could combine any of those activities to meet the requirement. Exemptions include but are not limited to parents or caretakers for a disabled individual or dependent and pregnant or postpartum women. A state could exempt an individual for a month because of a short-term hardship event, which could include an inpatient stay for part or all the month. A short-term hardship may also apply if the individual lives in a county with a natural disaster or where the unemployment rate is greater than 8% or greater than 150% of the national average. For individuals applying for Medicaid coverage, states must verify their compliance with this requirement in the month *preceding* their application. For individuals renewing Medicaid coverage, states must verify their compliance with this requirement in the month *preceding* their regularly scheduled redetermination; however, a state may choose to verify compliance more frequently. If a state finds an individual noncompliant, it must provide the individual with a notice of noncompliance and give them 30 calendar days to show compliance or prove that the requirement does not apply. The state must continue to provide coverage in that 30-day period. Before denying or disenrolling the individual, the state must determine if the individual is eligible on another basis and provide written notice and an opportunity for a fair hearing. Individuals found noncompliant would be ineligible for advance premium tax credits on the ACA Marketplaces. States would be required to implement work requirements by December 31, 2026, and CMS would have to promulgate guidance by December 31, 2025. The provision would require states to notify individuals of this requirement before it goes into effect and periodically thereafter. The provision provides $100 million for state implementation grants.	Section 71124 specifies that a state must verify a Medicaid applicant's compliance with this provision for one or more, *but not more than three*, consecutive months; that limitation would not be provided for individuals already enrolled in Medicaid. This section also allows a state to not require an individual to verify information that proves they are exempt from this policy. Section 71124 would allow a state to apply for a Section 1115 waiver to implement the requirement earlier. Section 71124 adds a short-term hardship exemption for individuals with serious or complex medical conditions who must travel outside of their community for an extended period to receive care not available in their area. Section 71124 adds a special implementation rule so that CMS may exempt a state from compliance if it is making a good faith effort to comply but is facing barriers. In such cases, the state would detail a plan and timeline for achieving full compliance. States with an approved exemption would be required to provide quarterly progress reports to show milestones towards compliance. The exemption would expire before December 31, 2028, and CMS would be able to terminate an exemption early if the state failed to comply with the reporting requirements. Section 71124 prohibits a state from using a managed care entity or other contractor to determine beneficiary compliance unless the contractor has no direct or indirect financial

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
		relationship with any managed care organization or other entity that provides Medicaid coverage. Section 71124 requires CMS to issue an interim final rule, not guidance, and extends the deadline for the interim final rule from December 31, 2025, to June 1, 2026.
Requiring Minimum Cost Sharing for the Expansion Population	Section 44142 would require states to enact cost sharing beginning October 1, 2028 for expansion individuals with incomes greater than 100% of federal poverty level (FPL). Cost-sharing levels would be left to the discretion of the states but would be capped at $35 per service. Cost sharing could not be applied to prenatal care, services furnished to individuals in inpatient facilities or receiving hospice care, emergency room care, COVID-19 testing, certain vaccinations, primary care services, mental health care services, or substance use disorder services. The existing cap on out-of-**pocket costs at 5% of an individual's income would** remain.	Section 71125 is essentially identical to House Section 44142.
Streamlining Enrollment for Certain Out-of-State Medicaid	Section 44302 would require states to establish a process for qualifying pediatric out-of-state providers to enroll as participating providers without undergoing additional screening requirements.	Not included.
Delaying Medicaid Disproportionate Share Hospital (DSH) Reductions	Section 44303 would delay the effective date of DSH reductions for FYs 2026 through 2028 to instead take effect for FYs 2029 to 2031.	Not included.

Medicare

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
Updating Medicare Physician Fee Schedule	Section 44304 would eliminate the dual CF structure currently scheduled to take effect in 2026 and instead establish a single CR for all clinicians beginning in 2026, regardless of Advanced Alternative Payment Model	Not included.

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
Conversion Factor (CF)	(APM) participation. It would establish a single CF for all clinicians beginning in 2026, regardless of participation in APMs. This single CF would be updated by 75% of the Medicare Economic Index (MEI), a measure of practice cost inflation for physicians, in 2026 and 10% of the MEI in 2027 and all subsequent years.	
Expanding Drugs Exempt from the Medicare Drug Negotiation Program	Section 44301 would expand exemption from the Medicare Drug Price Negotiation Program to prescription drugs that treat more than one rare disease until or unless they receive an indication for a non-rare disease. The seven- or 11-year period of non-eligibility would begin upon the drug's first non-orphan indication.	Not included.
Reforming Pharmacy Benefit Managers (PBMs)	Section 44305 would prohibit PBM compensation based on the price of a drug as a condition of entering a contract with a prescription drug plan. Service fees would not be connected to the price of a drug, discounts, rebates, or other fees. This section would also require PBMs to report several items annually to the HHS secretary and Medicare Part D plan sponsors, including the drugs dispensed by the plan, the average wholesale acquisition, the total out-of-pocket spending by enrollees, and any rebates, or direct and indirect remuneration with respect to drugs furnished under the Part D plan. PBMs would have to report on any affiliates, including mail-order pharmacies, and any preferential treatment given to prescriptions filled by affiliates. MedPAC would be required to report on PBM contract agreements, including trends, major differences between agreements, and their effects on enrollee out-of-pocket spending and average pharmacy reimbursement.	Not included.
Expanding the Definition of Rural Emergency Hospital (REH)	Section 111201 would allow hospitals that closed between January 1, 2014, and December 26, 2020, an opportunity to reopen under the REH designation. Facilities located less than 35 miles from the nearest hospital would not be eligible for the 5% increase on outpatient payments. Facilities located less than 10 miles from the nearest hospital would not be eligible for the REH facility fee.	Not included.
Limiting Medicare Coverage for Immigrants	Section 112103 would reduce the number of immigrants who qualify for Medicare coverage. It would disqualify asylum recipients, refugees, and individuals with temporary protected status, even if they met previous work requirements. Individuals deemed ineligible for coverage would lose access within one year of enactment.	Section 71201 contains an identical provision.

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
Using Artificial Intelligence in Medicare	The bill would provide the HHS secretary with $25 million to implement artificial intelligence (AI) tools to reduce improper Medicare payments and identify and recoup improper overpayments.	Not included.

Affordable Care Act (ACA)

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
Codifying the ACA Program Integrity Proposed Rule	Section 44201 would codify the March 2025 proposed rule, which includes provisions to shorten the annual open enrollment period for individual market coverage, end availability of the monthly special enrollment period (SEP) for individuals with household incomes below 150% of FPL, and require all Marketplaces to reinstitute pre-enrollment verifications of eligibility for SEPs and require further verifications of income when no tax data is available for verification, among other policies. In addition to the proposed rule policies, this section includes provisions that require additional eligibility verification for enrollees with specified income discrepancies, including instances where the Exchange receives data from the secretary of the treasury, or other reliable third-party data, that indicates the applicant's household income is less than 100% – 400% of FPL.	Not included.
Funding Cost Sharing Reduction Payments (CSRs)	Section 44202 would appropriate "such sums as may be necessary" for purposes of making CSR payments to those enrolled in ACA Marketplace plans, beginning with calendar year 2026. Funds would not be available to plans that cover abortions, other than those necessary to save the mother's life or in cases of rape or incest.	Section 87001 makes no substantive changes to the House-passed version.
Limiting Premium Tax Credits for Undocumented and Lawfully Present Immigrants	Section 112101 would, beginning with calendar year 2027 tax and plan years, limit refundable tax credits to certain lawfully present aliens (aliens with permanent residence, certain aliens from the Republic of Cuba, and individuals who lawfully reside in the United States in accordance with a Compact of Free Association). The bill also specifies that basic health programs are not allowed to cover ineligible individuals and CSRs would not apply to ineligible individuals.	Sections 71301 and 71302 contain similar provisions, but the Senate version does not contain the provision specifying that ineligible individuals would not be eligible for CSRs.

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
	Section 112102 would, beginning with tax year 2026, repeal a special rule for lawfully present aliens, so that lawfully present aliens with household incomes less than 100% of FPL who are ineligible for Medicaid by reason of alien status would no longer be eligible for premium tax credits.	
Requiring Advance Exchange Verification of Eligibility	Section 112201 would, beginning with tax year 2028, make refundable tax credits unavailable for months of coverage under a qualified health plan for which the Exchange has not verified an individual's eligibility for: • Plan enrollment. • Advance payment of the refundable tax credit. • CSRs. It would also require verification of eligibility for pre-enrollment for individuals qualifying for an APTC or CSRs.	Section 71303 makes several changes to this provision. The section does not require verification of an individual's eligibility for CSRs. It also adds a provision that allows the HHS Secretary (though does not require the Secretary) to waive the verification requirements for individuals who enroll during a SEP on the basis of a change in family size. This change is likely in response to criticism that newborn babies, adoptions, people getting married or divorced would likely be unable to get immediate coverage under the House bill language. Section 71303 also allows Exchanges to use any data available to them or reliable third-party sources to assist enrollees to verify their eligibility for re-enrollment. However, the provision still requires active re-enrollment by individuals. Additionally, it makes other changes to the House-passed language which we are still analyzing to see if they result in substantive policy changes.
Disallowing Premium Tax Credit in Case of Certain Coverage Enrolled in During SEPs	Section 112202 would, beginning with the third calendar month after the date of enactment, make refundable tax credits unavailable for plans in which individuals enrolled using the monthly SEP available for individuals with projected annual household income no greater than 150% of FPL. This would be effective the third calendar month ending after the bill's enactment.	Section 71304 is largely similar. The section removes a reference to the issuance of interim final and temporary regulations from a provision directing the secretaries of the Treasury and HHS to issue rules and other guidance to implement the section. The effective date is also changed to December 31, 2025.
Eliminating Limitation on Recapture of Advance Payment	Section 112203 would specify that, for individuals with household income below 400% of FPL, beginning in tax year 2026, liability for excess advance payments of refundable tax credits would no longer be limited, so that all excess payments would be subject to recapture.	Section 71305 includes the same language, but adds a provision clarifying that if an Exchange determines an individual is projected to have a household income of greater than or equal to 100% of FPL at the time of enrollment and

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
of Premium Tax Credit		receives an APTC, the individual will not be forced to pay back the tax credit if their actual household income ends up being less than 100% of FPL, unless the HHS secretary determines they knowingly provided incorrect information.

Paid Leave

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
Paid Family and Medical Leave (PFML) Credit	The PFML credit is set to expire after December 31, 2025. Section 110106 would make the PFML tax credit permanent with some modifications, including expanding the credit for a portion of paid family leave insurance premiums, making the credit available in all states, and lowering the minimum employee work requirement from one year to six months.	Section 70304 makes no substantive changes to the House-passed version.

Health Plans

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
CHOICE Arrangement Modifications	Section 110201 would generally codify the final rules permitting employers to offer individual coverage health reimbursement arrangements (HRAs) (renaming them Custom Health Option and Individual Care Expense, or CHOICE, arrangements) without violating the group health plan requirements. The bill would make three changes to the final rules. It specifies that CHOICE arrangements would satisfy the requirement of Section 2715 of the Public Health Service Act to provide a summary of benefits and coverage. Second, it would allow an employer that offers its employees a fully insured group health plan (subject to the requirements of the small group market) to also offer those employees a choice between that plan and a CHOICE arrangement. Third, it would amend the notice	Not included.

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
	requirement to provide that employers generally must provide the required notice 60 days before the beginning of the plan year. Section 110202 would specify that employees participating in a CHOICE arrangement that is available in conjunction with a cafeteria plan could purchase individual Exchange coverage using a cafeteria plan election, similar to CHOICE arrangement participants not using salary reduction. Section 110203 would establish a new credit for employers whose employees are enrolled in CHOICE arrangements maintained by the employer.	

Health Savings Accounts (HSAs)

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
Medicare Part A **Beneficiaries' HSA** Contributions	Section 110204 would, beginning in 2026, allow individuals enrolled only in Medicare Part A to continue to contribute to their HSAs, but if they were to use those funds for nonqualified medical expenses, they would be subject to the 20% tax penalty for such use. They would also lose the ability to use the HSA funds to pay for health insurance premiums.	Not included.
Direct Primary Care (DPC) Service Arrangements	Section 110205 would clarify that beginning in 2026, DPC service arrangements should not be treated as health plans that make individuals HSA ineligible. For these purposes, the arrangements cannot cost more than $150 per person per month, adjusted annually for inflation.	Not included.
Bronze and Catastrophic Plans	Section 110206 would specify that beginning in 2026, any bronze or catastrophic plan offered in the individual market on the ACA Exchange would be treated as an HDHP, meaning enrollees would be HSA eligible.	Not included.
Onsite Employee Clinics	Section 110207 would clarify that beginning in 2026, employer-sponsored health clinics can provide a longer list of services as allowable costs, and therefore employees with HSAs can utilize these services pre-deductible.	Not included.

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
HSA Payment for Physical Activity, Fitness, and Exercise	Section 110208 would, beginning in 2026, expand the definition of qualified medical expenses to include membership at a fitness facility and participation or instruction in physical exercise or activity (essentially, gym memberships and workout classes). These expenses would be limited to $500 for single taxpayers and $1,000 for a joint or head of household return per year. This includes several exemptions. Videos, books, or similar materials and one-on-one personal training would not be qualified medical expenses. Any amounts paid for remote or virtual instruction must be synchronous. Fitness facility memberships must last more than one day, and amounts paid for participation or instruction in physical exercise or activity must be for more than one occasion.	Not included.
Allowance of Spouses Making Catch-Up Contributions to the Same HSA	Section 110209 would, beginning in 2026, allow spouses who are both eligible for catch-up contributions to choose the HSA to which they wish to distribute the funds. This means they could both make catch-up contributions to only one spouse's HSA instead of both.	Not included.
Flexible Spending Arrangements and HRA Rollovers to HSAs	Section 110210 would allow health flexible spending arrangement (FSA) and HRA funds to rollover to an HSA if the individual enrolls in an HDHP, as long as the individual was not enrolled in an HDHP in the previous four years.	Not included.
Medical Expenses Incurred Before Establishment of HSA	Section 110211 would specify that, beginning in 2026, HSAs established during the first 60 days of an HDHP plan period would be considered to have been established on the first day of the plan year. This means that the HSA could pay for expenses occurring during that 60-day period even if the HSA was not established at the time.	Not included.
Contributions Permitted If Spouse Has Health FSA	Section 110212 would specify that, beginning in 2026, individuals could be considered HSA-eligible as long as their spouse's health FSA does not consider the HSA-eligible individual in determining the amount that can be contributed to the FSA.	Not included.
Increase in HSA Contribution Limitation	Section 110213 would double the basic limit on annual contributions for individuals making less than $75,000 a year or spouses filing jointly making less than $150,000 a year. This benefit would phase out for	Not included.

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
	individuals making $75,000 to $100,000 a year and couples making $150,000 to $200,000 a year. There would be no increase to the limit on employer contributions to an employee's HSA.	

Research

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
Deduction for Domestic Research and Experimental Expenditures	Section 111002 would allow taxpayers to immediately deduct domestic research or experimental expenditures paid or incurred in taxable years beginning after December 31, 2024, and before January 1, 2030.	Section 70302 makes this change permanent and includes other technical changes. It would also allow small businesses with annual gross receipts of $31 million or less to retroactively apply for the tax credit for expenses incurred after December 31, 2021.
Exclusion of Research Income Limited to Publicly Available Research	Section 112025 would amend the Internal Revenue Code to increase the unrelated business taxable income of a tax-exempt organization by including only the income derived from fundamental research with results freely available to the public. Private research would become tax eligible.	Not included.

Artificial Intelligence (AI)

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
AI and Information Technology (IT) Modernization Initiative	Section 43201 would implement a 10-year moratorium on states enforcing regulations or laws governing AI models, AI systems, or automated decision systems. States would still be allowed to enforce policies meant to remove legal impediments to, facilitate the operation of, or adopt AI models, AI systems, or automated decision systems. States could continue to enforce laws and regulations that impact AI models, AI systems, and automated decision systems as long as they were treated in the same manner as comparable models and systems. This section would	Instead of a blanket moratorium on states, Section 0012 would repurpose the $500 million in appropriations to instead establish a grant program for the construction and deployment of infrastructure for the provision of broadband services and AI technologies. This section would make compliance with the 10-year AI moratorium a condition of receiving funds through the grant program.

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
	also appropriate $500 million to modernize and secure federal IT systems with the deployment of AI technologies.	

Student Loans for Medical Students

PROVISION	HOUSE-PASSED VERSION	SENATE VERSION
Loan Limits for Medical Students	Section 30011 caps the maximum annual amount of federal unsubsidized loans that a medical student may borrow in any academic year as the amount of the median cost of **a student's program of study.** Further, it would set the maximum aggregate limit for unsubsidized loans for medical students at $150,000. If a medical student previously went to graduate school, they would only be eligible for $150,000 in unsubsidized loans minus the amount borrowed during graduate school. This would be effective beginning July 1, 2026.	Section 81001 includes a similar provision but would set an annual limit for unsubsidized loans for medical students at $50,000 and an aggregate limit at $200,000. If a medical student previously went to graduate school, they would only be eligible for $200,000 in unsubsidized loans minus the amount borrowed during graduate school.
Public Service Loan Forgiveness for Doctors and Dentists	Section 30024 would change the Public Service Loan Forgiveness Program so that payments made by doctors and dentists during their residency would no longer count toward loan forgiveness. This would be effective beginning July 1, 2025.	Section 82004 would implement the same policy, but with an effective date of July 1, 2026 instead of July 1, 2025.

June 2, 2025

Senate Pro Tempore Mike McGuire
1021 O Street, Suite 7730
Sacramento, CA 95814

Assembly Speaker Robert Rivas
1021 O Street, Suite 8330
Sacramento, CA 95815

Honorable Akilah Weber Pierson, Chair
Senate Budget Subcommittee 3
1021 O Street, Room 7310
Sacramento, CA 95814

Honorable Dawn Addis, Chair
Assembly Budget Subcommittee 1
1021 O Street, Room 4120
Sacramento, CA 95814

RE: May Revision – Medical Loss Ratio Proposal

Dear Pro Tem McGuire, Speaker Rivas, Chair Weber, and Chair Addis

L.A. Care Health Plan, the nation's largest public health plan serving over 2.3 million Medi-Cal members, strongly urges the Legislature to reject the May Revise proposal to increase the Medi-Cal managed care Medical Loss Ratio (MLR) from 85% to 90%. This proposal offers minimal cost savings, just 0.124% for fiscal year 2025-26, and no meaningful budget impact is estimated until at least three years from now, signaling a lack of urgency and no immediate benefit to California's state budget. Notably, this policy is being advanced without any stakeholder engagement, restricting the opportunity to fully assess and mitigate its potential impacts.

While we pride ourselves in minimizing unnecessary administrative costs and support the goal of ensuring that an adequate share of plan revenues is directed toward medical services, raising the MLR floor from 85% to 90% requires careful and deliberate consideration. The current proposal threatens essential safety-net providers and jeopardizes critical investments in innovations to build infrastructure and other needs aimed at addressing workforce development needs, improved maternal health outcomes, supporting the justice involved population, housing and homelessness initiatives, expanding mental health supports and other programs proven to improve health outcomes and reduce unnecessary emergency department utilization as well as costly hospitalizations. It risks reducing vital community reinvestments that address social determinants of health and limits our ability to absorb unexpected cost increases or respond flexibly to economic challenges. Furthermore, the proposal undermines ongoing investments in data exchange, integration, and interoperability, which are key to streamlining care coordination, improving quality, and reducing administrative burdens across the Medi-Cal managed care system. Without these investments, the system's capacity to innovate and adapt to evolving member needs will be severely constrained, ultimately impacting the health and well-being of the vulnerable populations we serve.

This budget proposal comes at a time of major changes to the state's MLR oversight, changes that could significantly affect the Medi-Cal patients served by delegated entities. Until recently, the Department of Health Care Services (DHCS) used a long-standing "four-part test" to assess MLR compliance for plans operating under delegated arrangements. This rule, approved by the federal government, allowed health plans to count all payments to providers as medical costs, as long as the providers managed patient care coordination and did not separately charge for administrative tasks. This approach supported strong

partnerships between health plans and risk-bearing organizations (RBOs), such as Independent Physician Associations (IPAs) and Federally Qualified Health Centers (FQHCs), which deliver critical care to millions of Medi-Cal enrollees.

However, in 2025, DHCS ended the four-part rule and replaced it with a more restrictive MLR standard, one that has only been in place for a few months and whose full consequences are not yet known. Under the new system, many essential provider activities, like hiring care coordinators, implementing health IT systems, or participating in health data exchanges, may now be categorized as administrative costs instead of medical expenses. This shift could reduce a RBO's MLR, eliminating the incentive for RBOs to invest in crucial infrastructure to improve care coordination and effectively support providers at the front lines of caring for members. If the MLR falls below the proposed 90% threshold proposal, they may be required to repay funds severely compromising their ability to capitalize needed investments.

This places providers in a bind: they must comply with costly state mandates, but those same investments could now count against them. The proposed 90% MLR requirement under the new definition would likely make delegated care models unsustainable, forcing health plans to take back administrative responsibilities now handled by providers under shared-risk agreements. Such a shift threatens to disrupt provider networks, limit access to care, and destabilize services for the millions of Californians who depend on Medi-Cal. Moving forward with this change before fully understanding its impact could cause lasting harm to the state's healthcare safety net.

Furthermore, given ongoing uncertainty surrounding the federal government's final budget decisions, moving forward with a significant MLR change now is premature. With no immediate fiscal relief and anticipated savings delayed for several years, this policy risks destabilizing Medi-Cal's framework without delivering meaningful financial benefits. To ensure the best outcomes for the Medi-Cal program, it is critical to engage stakeholders fully in assessing potential impacts and exploring alternatives that avoid unintended harm and result in better policy solutions.

For these reasons, we urge the Administration and Legislature to reconsider and reject this proposal in the June budget, ensuring Medi-Cal managed care continues to deliver high-quality, accessible, and sustainable care to California's most vulnerable populations.

Sincerely,

Martha Santana-Chin
Chief Executive Officer

cc: Marjorie Swartz, Principal Consultant, Senate Pro Tempore's Office
Rosielyn Pulmano, Policy Consultant, Speaker's Office
Scott Ogus, Deputy Staff Director, Senate Budget Sub 3
Patrick Le, Consultant, Assembly Budget Sub 1

Modern Medicaid ALLIANCE

June 12, 2025

The Honorable John Thune
Majority Leader
U.S. Senate
Washington, D.C. 20510

The Honorable Chuck Schumer
Minority Leader
U.S. Senate
Washington, D.C. 22515

Dear Majority Leader Thune and Minority Leader Schumer,

The members of the Modern Medicaid Alliance (MMA) and its supporters write to you today to express deep concerns and opposition to many of the policies contained in the Energy and Commerce (E&C) Committee's portion of H.R. 1, the reconciliation bill passed by the House on May 22. In light of these concerns, we urge all Senators to reject the Medicaid provisions included in the House reconciliation package and protect the Medicaid program from the harmful funding cuts it proposes.

Since its creation in 1965, Medicaid has provided access to health care for Americans in need. At its creation, the program was much simpler with many fewer covered lives and a much more limited list of covered services. Importantly, however, over the past 60 years, the Medicaid program has evolved and grown, adding new services to reflect the current health care system as well as extending coverage to more Americans who experience challenges obtaining access to adequate health insurance. These changes allow the Medicaid program to remain a vital lifeline to care for Americans, just as it was in 1965.

While the policies contained in this bill are presented as rooting out waste, fraud and abuse or preserving it for those the program was intended for, the reality is that cutting upwards of $700 billion from the program will do real harm to all enrollees and among all providers. According to the Congressional Budget Office (CBO), the bill would result in coverage losses for approximately 11 million people by 2034 — with more than 7.8 million of those individuals losing Medicaid coverage.[1] Such losses in coverage could lead to significant destabilization of hospitals and providers, with some studies suggesting a total of $1 trillion in lost revenue and a projected increase in uncompensated care of $278 billion by 2034, before taking into account the reductions in provider taxes or impacts of other eligibility policies.[2]

This bill negatively modifies longstanding legal funding mechanisms utilized by states to maintain stable Medicaid coverage and benefits while also imposing new, massively bureaucratic mechanisms that will result in unprecedented coverage loss, specifically:

- New bureaucratic barriers on enrollment and eligibility that will unintentionally harm and impact coverage and benefits for **eligible** Medicaid enrollees;
- Increases in uncompensated care through misguided limits on retroactive coverage;
- Limitations on provider taxes and state-directed payments that will undermine states' ability to fund their Medicaid programs and will negatively impact coverage and access to care;
- Work requirements that replicate previously tried, ineffective and misguided policies, leading to few changes in employment and an administrative mess for states, individuals, families and caregivers; and
- Harmful cost-sharing provisions that will make it harder for millions of low-income Americans to access care they need and shift undue costs onto safety net providers.

[1] https://www.cbo.gov/publication/61461
[2] https://www.rwjf.org/en/insights/our-research/2025/05/reconciliation-bill-and-end-of-enhanced-subsidies.html

Modern Medicaid ALLIANCE

Together, the policies contained in the House bill have the potential to harm millions of low-income, older adults, children, pregnant women, disabled and rural Americans. Instead of improving the Medicaid program, the result would dramatically reduce federal funding by erecting unnecessary administrative barriers and reducing funding by changing longstanding, lawful mechanisms. For these reasons, we urge all Senators to reject any cuts to the Medicaid program and ensure continued access to health care for millions of Americans.

Sincerely,

AAP California Chapter 1
AAP Vermont Chapter
AARP
AASA, The School Superintendents Association
Academy of Managed Care Pharmacy
ADVION (formerly National Association for the Support of Long Term Care)
AiArthritis
Alabama Chapter-American Academy of Pediatrics
Alliance for Aging Research
Alliance for Women's Health and Prevention
Alliance of Community Health Plans
America's Physician Groups
American Academy of Addiction Psychiatry
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Nursing
American Academy of Pediatrics
American Academy of Pediatrics South Dakota Chapter
American Academy of Pediatrics, California Chapter 3
American Academy of Pediatrics, California
American Academy of Pediatrics, District of Columbia Chapter
American Ambulance Association
American Association for Community Psychiatry
American Association of Nurse Practitioners
American Association of People with Disabilities
American Association of Psychiatric Pharmacists
American Association on Health and Disability
American Cancer Society Cancer Action Network
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American Diabetes Association
American Foundation for Suicide Prevention
American Mental Health Counselors Association
American Music Therapy Association
American Network of Community Options and Resources (ANCOR)
American Nurses Association
American Psychological Association Services
American Society of Pediatric Hematology/Oncology
American Speech-Language-Hearing Association
AmeriHealth Caritas
Anxiety and Depression Association of America
Arizona Chapter of the American Academy of Pediatrics
Arthritis Foundation

Association for Behavioral Health and Wellness
Association for Community Affiliated Plans
Association of Assistive Technology Act Programs
Association of Maternal & Child Health Programs
Association of People Supporting Employment First (APSE)
Asthma and Allergy Foundation of America
Autistic Self Advocacy Network
Bazelon Center for Mental Health Law
Black Women's Health Imperative
Caregiver Action Network
Caring Across Generations
Center for Health Law and Policy Innovation
Center for Medicare Advocacy
Center to Advance Palliative Care
Changent
CHC: Creating Healthier Communities
Children's Hospital Association
Color of Gastrointestinal Illnesses
CommunicationFIRST
Community Catalyst
Community Servings
COPD Foundation
Cystic Fibrosis Foundation
Diabetes Leadership Council
Diabetes Patient Advocacy Coalition
Disability Belongs
Easterseals, Inc.
Epilepsy Foundation of America
Evangelical Lutheran Church in America
Faces & Voices of Recovery
Families USA
Fight Colorectal Cancer
Florida Chapter of American Academy of Pediatrics, Inc.
Food Is Medicine Coalition
Foundation for Sarcoidosis Research (FSR)
Georgia Chapter of the American Academy of Pediatrics
Gerontological Society of America
Global Liver Institute
Hand in Hand: The Domestic Employers Network
Health Care Transformation Task Force
Health Hats
Healthcare Leadership Council
Healthy Schools Campaign
HealthyWomen
Hearing Loss Association of America
Hematology/Oncology Pharmacy Association
Hemophilia Alliance
Hemophilia Federation of America
HIV Medicine Association
Huntington's Disease Society of America
Hydrocephalus Association
Hypertrophic Cardiomyopathy Association
IC&RC

Idaho Chapter of the American Academy of Pediatrics
Illinois Chapter, American Academy of Pediatrics
Infusion Access Foundation
Inseparable
Institute for Exceptional Care
International Society of Psychiatric-Mental Health Nurses
International Society of Psychiatric Nurses
Iowa Chapter of the American Academy of Pediatrics
Justice in Aging
Kaiser Permanente
Kansas Chapter American Academy of Pediatrics
Kentucky Chapter of the AAP
L.A. Care
Lakeshore Foundation
LeadingAge
Lifelong Health for All
Little Lobbyists
Local Health Plans of California
Lupus and Allied Diseases Association, Inc.
Lupus Foundation of America
Lutheran Services in America
Maine Chapter, American Academy of Pediatrics
Maryland Chapter, American Academy of Pediatrics
Maryland Counseling Association, Inc.
Massachusetts Chapter of the American Academy of Pediatrics
Medicaid Health Plans of America (MHPA)
Medicare Rights Center
Mental Health America
Metropolitan Area Neighborhood Nutrition Alliance (MANNA)
Michigan Chapter, American Academy of Pediatrics
Minnesota Chapter, American Academy of Pediatrics
Mississippi Chapter of the American Academy of Pediatrics
Montana Chapter of the American Academy of Pediatrics
Mosaic
National Academy of Elder Law Attorneys (NAELA)
National Adult Day Services Association
National Alliance for Caregiving
National Alliance on Mental Illness
National Association for Behavioral Healthcare
National Association of Dental Plans (NADP)
National Association Of Emergency Technicians
National Association of Pediatric Nurse Practitioners
National Association of Rural Health Clinics
National Bleeding Disorders Foundation
National Board for Certified Counselors
National Coalition for Cancer Survivorship
National Consumers League
National Council for Mental Wellbeing
National Council on Problem Gambling
National Federation of Families
National Health Council
National Health Law Program
National Hispanic Health Foundation

National Infusion Center Association
National Kidney Foundation
National Organization on Disability (NOD)
National Register of Health Service Psychologists
National Rural Health Association
North Carolina Pediatric Society
Nebraska Chapter of the American Academy of Pediatrics
New Hampshire Chapter of the American Academy of Pediatrics
New Hampshire Psychological Association
New Jersey Chapter, American Academy of Pediatrics
New Mexico Pediatric Society
North Atlantic Region of ACA
North Dakota Chapter of the American Academy of Pediatrics
Nurses Who Vaccinate
New York State AAP - Chapter 2
New York State AAP - Chapter 3
Ohio Chapter, American Academy of Pediatrics
Oregon Pediatric Society
PAN Foundation
Partnership to Fight Chronic Disease
Pennsylvania Chapter, American Academy of Pediatrics
Pennsylvania Psychological Association
Providence
Relevance
Santa Clara Family Health Plan
School-Based Health Alliance
South Carolina Chapter of the American Academy of Pediatrics
Speak Foundation
Susan G. Komen
TASC, Inc. (Treatment Alternatives for Safe Communities)
TASH
Technical Assistance Collaborative
Tennessee Chapter of the American Academy of Pediatrics
The American Counseling Association
The Arc of the United States
The Kennedy Forum
The Louisiana Chapter of the American Academy of Pediatrics
Treatment Communities of America
Triage Cancer
UnidosUS
United Spinal Association
Utah AAP
Utah Health Policy Project
Virginia Counselors Association
Washington Chapter of the American Academy of Pediatrics
Well Spouse Association
West Virginia Chapter, American Academy of Pediatrics
Wisconsin Chapter of the American Academy of Pediatrics (WIAAP)

Report Title: **Legislative Impacts: Product Summary**
Date: **June 27, 2025**
Prepared By: **Linda Greenfeld, *Chief Product Officer***

1. Purpose / Desired Impact of the Report

The purpose of this report is to provide the Board with a forward-looking summary of key state and federal legislative and regulatory proposals expected to impact Medi-Cal, Medicare, and Commercial lines of business in 2026 and beyond. The goal is to raise awareness, align strategic planning, and discuss actions needed to mitigate member and provider impacts while maintaining continuity of care.

2. Background / Context

The healthcare landscape faces significant policy shifts at both the state and federal levels, including the reinstatement of asset tests, increased documentation requirements, changes in enrollment periods, and premium adjustments. These policies are anticipated to affect coverage stability, provider reimbursement, and patient access. This report aggregates anticipated impacts across L.A. Care's product lines to inform proactive planning.

3. Key Considerations / Analysis

Management Considerations:

- Member Impacts: Increased risk of coverage loss disrupted treatments, and higher out-of-pocket costs due to shortened enrollment windows, new premium requirements, and reinstated eligibility verifications.
- Provider Impacts: Anticipated care disruptions increased uninsured visits, reimbursement reductions, and billing complications.
- Organizational Impacts: Operational and financial strain due to administrative burden, decreased member retention, and increased customer service needs.
- Community Impact: Safety net providers may experience elevated demand and reduced funding, compromising care access for vulnerable populations.

4. Risk Area and Mitigation Activities

Risk Statement: **Known Key Risk:** ☒ **Yes** ☐ **No** ☐ **Unknown**

If these policy changes are not actively monitored and addressed through sustained advocacy and strategic partnerships, L.A. Care risks increased member disenrollment, reduced provider participation, and diminished access to essential health services for vulnerable populations. Proactive engagement at the local, state, and federal levels is essential to influence policy outcomes and safeguard the continuity and equity of care.

Impacted Area/Risk: Please select those areas impacted

☐ Claims	☐ Compliance	☐ Regulatory	☐ Vendor	☒ Community
☒ Financial	☐ Pharmacy	☐ Privacy	☒ Medicare-DSNP	☒ Access
☐ Reputation	☒ Clinical	☐ IT	☐ SDOH	☐ Legal
☒ Member	☒ Provider	☐ InfoSec	☒ Medi-Cal (MCLA)	
☒ L.A. Care Covered (LACC)				

Risk Mitigation Activities:
L.A. Care is leveraging strategic advocacy and partnerships to address emerging policy risks. Key efforts include:

- Policy Advocacy: Collaborating with CAHP, LHPC, ACAP, and other state and national associations to shape legislation and protect member coverage.
- Regulatory Engagement: Submitting comments and data to state and federal agencies to inform implementation and reduce operational disruption.
- Provider and Hospital Coordination: Working closely with FQHCs, hospital systems, and safety-net providers to manage care transitions and maintain access.
- Community-Based Support: Partnering with agents, brokers, and community-based organizations to assist members with eligibility, renewals, and plan navigation.
- Operational Readiness: Preparing internally and developing communications for phased messaging approach, with a focus on high-risk populations.

5. Recommended Action / Decision Requested

Board Action Needed:

☐ For Information Only
☒ **For Discussion with Board/Committee**
☐ For Approval / Decision

Proposed Motion (if applicable): N/A.

6. Next Steps / Timeline / Milestones

Summer 2025:

- Continue coordinated advocacy through CAHP, LHPC, ACAP, and other associations.
- Provide input to regulatory agencies during rulemaking periods.

Fall 2025:

- Finalize operational readiness plans for phased implementation of new requirements.
- Expand provider and community partner engagement on member transition strategies.

Q4 2025 – Q1 2026:

- Launch tailored member communications and outreach campaigns, leveraging brokers, agents, and CBOs.
- Begin staff training and system updates to support eligibility and benefit changes.

Ongoing (2025–2028):

- Monitor policy developments and adjust mitigation strategies as legislation and rules evolve.
- Evaluate member and provider impact to inform future advocacy and operational response.

7. Attachments / Supporting Materials / Presentations

Presentation: Legislative Summary/Impact Products

Legislative Impacts Product Summary

L.A. Care HEALTH PLAN®

For All of L.A.

Phinney Ahn, Executive Director of Medi-Cal Product
Cristina Inglese, Executive Director of Commercial & Group Products
Victor Hurtado, Executive Director of Medicare Product

June 2025

L.A. Care | PSSM Product, Strategy, Sales and Marketing

Key State Proposals Impacting Medi-Cal

2026

		Member Impact	Provider Impact
Enrollment Freeze for New UIS Adults	**Jan 1, 2026**	No coverage for residents who do not apply before deadline or renew coverage on time	Safety net providers will see an increase in uninsured patients
Benefit Changes **All: Acupuncture** **UIS: LTC and Dental**	**Jan 1, 2026** **July 1, 2026**	Disruptions in care for those currently accessing these services	Need to transition members to other care options
Restoration of Asset Test	**Jan 1, 2026**	Loss of coverage and inability to build savings	May face disenrollments mid-care leading to treatment disruptions

Key State Proposals Impacting Medi-Cal

2026 and 2027

		Member Impact	Provider Impact
Reduction in Prospective Payment Systems Rates	**Jan 1, 2026**	Longer wait times and other access to care issues	Funding challenges for FQHCs and RHCs
Premiums for Adult UIS Members	**Jan 1, 2027**	Affordability issues may lead to increased risk of coverage loss	Safety net providers will see an increase in uninsured patients

Key Federal Proposals Impacting Medi-Cal

2027 and beyond

		Member Impact	Provider Impact
Work Requirements for Expansion Adults	**Jan 1, 2027**	Coverage loss due to burdensome paperwork	Disruption in treatment and increase in uninsured patients
Redetermination Every Six Months	**Jan 1, 2027**	More paperwork leading to increased risk of coverage loss	Disruption in treatment and increase in uninsured patients
Shortened Retroactive Coverage Period	**Oct 1, 2027**	Shorter coverage period leading to gaps in care	Providers may see less reimbursement for retro services

Key Federal Proposals Impacting D-SNP

At Enactment

		Member Impact	Provider Impact
Suspends CMS rule Streamlining Medicare Savings Program (MSP) Enrollment	**Suspension at enactment through Jan 1, 2035**	Fewer seniors auto-enrolled in MSP which helps with out of pocket costs, creates burdensome paperwork	Increase of patients with higher out of pocket costs (partial duals)
Suspends CMS Rule to Streamline Medi-Cal Enrollment	**Suspension at enactment through Jan 1, 2035**	Potential delays in Medi-Cal coverage due to burdensome paperwork	Disruption in care and payments for Medi-Cal services
Medicare eligibility for Citizens and Lawful Residents	**1 year after enactment**	Updates the law for excluded groups to lose coverage after 12 months (e.g. Delayed Lawful Residency Renewals)	May face disenrollments mid-care; billing/payment disruptions

Key Federal Proposals Impacting D-SNP

2026

		Member Impact	Provider Impact
Value Benefit Insurance Design Termination	**Jan 1, 2026**	Increased member cost sharing for prescription drugs. Stricter rules for non-medical benefits like groceries, gas, and utility allowances mean some people no longer qualify.	May require provider assessment to qualify members for non-medical benefits via Special Supplemental Benefit for Chronically Ill (SSBCI)
Redetermination Every Six Months	**Dec 31, 2026**	More paperwork leading to increased risk of coverage loss	Claim rejections and care gaps from retroactive disenrollments
Work Requirements for Expansion Adults	**Dec 31, 2026 (or sooner)**	Work requirement for able-body adults could lead to coverage loss for duals due to burdensome paperwork	Disruption in treatments, Claim denials from mid-cycle disenrollment

Key Federal Proposals Impacting LACC

Open Enrollment 2026

Effective Date | Jan 1, 2026		Member Impact	Provider Impact
Expiration of ARP / IRA Enhanced Premium Subsidies	Returns the 400% FPL subsidies cliff	• Loss of $0 premium for ~450k statewide ~ 97k subscribers for LA Care • Risk of dropping coverage due to cost • DACA recipients lose eligibility for marketplace coverage	• Fewer patients with stable coverage due to increased premiums • More gaps in coverage • Challenges maintaining care in mixed family status
Shorter Open Enrollment Period	Shortens OEP from 11/1-1/30 to 11/1-12/15	• Less time to enroll • Some may miss coverage timeline	• Reduction in membership • Disruption of Care • Missed / delayed appointments
Eliminate Low-Income SEP (<150% FPL)	Ends monthly SEP for low-income consumers	• No second change to enroll mid-year • Risk of being uninsured	• Fewer low-income patients covered • Patients may lose coverage during treatment
Return of Cost Sharing Reduction (CSR) Plan Subsidies	Eliminates "Silver Loading"	• Cost sharing (deductibles, copays) vary by Silver variation • Harder to compare plan value & true cost	• Patients unclear on what's covered • Increased billing and benefit questions
Removal of Bronze → Silver Auto Re-enroll	Ends automatic plan upgrades	• Loss of better value coverage unintentionally • Risk of delaying care due to benefit coverage or cost confusion	• Increase of patients with higher out of pocket costs • Risk of members skipping care • Increased billing challenges

Key Federal Proposals Impacting LACC

Open Enrollment 2027 & Beyond

		Member Impact	Provider Impact
Effective Date | Jan 1, 2027			
$5 Minimum Premium for Auto-Enrolled APTC Consumers	Adds at $5 premium for enrollees in subsidized plans who don't recertify/update enrollment info	• Member abrasion if small balanced is missed or forgotten • Risk of gap in care due to non-payment	• Increased coverage termination • Increased front-office time re-verifying eligibility
Gender Transition Procedures	Excludes gender-transition procedures from Essential Health Benefits (EHB)	• Reduction in benefits • Increased out of pocket for these services	• Care gaps for this community • Increased billing denials and/or appeals
Effective Date | Jan 1, 2028			
Pre-Enrollment Verification Process	Removes passive renewals	• Risk of losing subsidies if documents not submitted • May go uninsured while waiting	• Delays in starting treatment • Increased administrative work to check status
No Subsidies During Inconsistency Period	Applicants will not receive APTCs/CSRs until they complete their pre-enrollment verification	• Members must actively confirm info to stay enrolled • Increased risk of unintentional coverage loss	• Increased likelihood of patients without active coverage at visits

Key Actions to Support Members and Providers

Education and awareness

- Provide awareness of upcoming changes to programs and policies on member materials and other outreach modalities
- Educate members on how to take action to stay covered and access care
- Monthly outbound calls, mailings, emails, text messages, on Medi-Cal renewals to support retention
- Utilize CRCs as hubs for awareness and CBOs for coverage navigation support

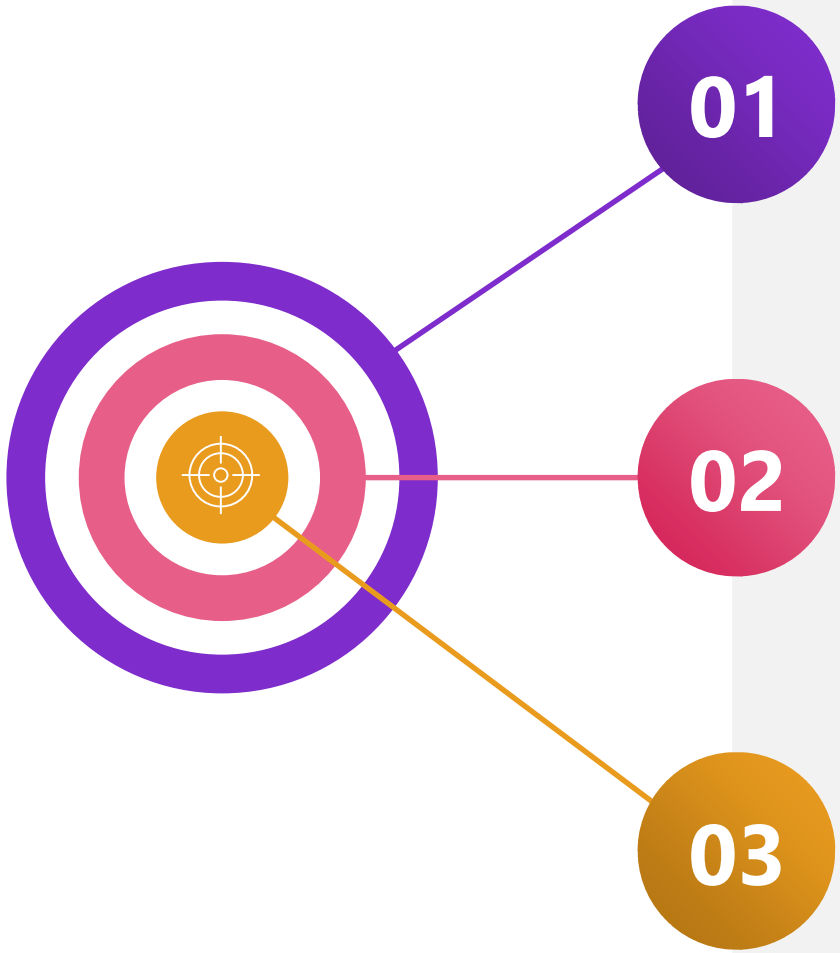
Access to care

- Transition members to other care options to avoid disruptions in treatment plans in advance of benefit eliminations
- Monitor utilization including timely access for appointments
- Partner with safety net providers to ensure smooth transition of care for members who may become uninsured

Partnership and Advocacy

- Align messaging and outreach strategies with DHCS and Covered CA
- Partner with DPSS & Brokers to support retention
- Communication and partnership with trade associations such as ACAP, CAHP, LHPC, CCALAC, and HASC
- Continue advocacy against cuts and changes that negatively impact coverage and access to care

Next Steps



Monitor Policy Development

Track legislative updates to anticipate impacts.

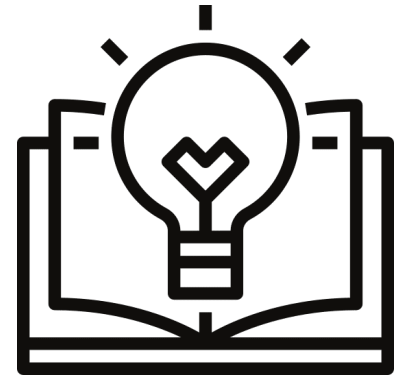
Impact Analysis

Evaluate impact of changes

Adjust Action Planning

Develop contingency plans to mitigate impact and prepare for implementation of requirements

Discussion Questions



- What other actions or opportunities could help support access to care and coverage?
- How can L.A. Care further target/tailor our outreach activities to specific populations?
  - Additional outreach modalities?
  - Personalized messaging to specific populations?
- Are there additional community or provider partnerships L.A. Care should be considering?

Thank you!

Report Title: Department of Health Care Services (DHCS) Exclusively Aligned Enrollment (EAE) State Medicaid Agency Contract (SMAC) for Dual Eligible Special Needs Plans (D-SNPs) (contract number 22-20236) (Amendment A05)

Date: June 27, 2025
Prepared By: Nadia Grochowski, *Associate Counsel III, Legal Services*

1. Purpose / Desired Impact of the Report

The purpose of this report is to inform the Board about Amendment A05 to the DHCS EAE SMAC with L.A. Care. The goal is to seek the Board's ratification of the execution by the CEO of Amendment A05 to the DHCS EAE SMAC between DHCS and L.A. Care.

2. Background / Context

Amendment A05 extends the term of the EAE SMAC contract to December 31, 2026. Amendment A05 also includes revisions to various sections of the contract, including language related to Community Based Services, reporting requirements, enrollment continuation following loss of Medi-Cal eligibility, and enforcement actions related to performance and compliance issues, among others (see attached change matrix).

3. Key Considerations / Analysis

Management Considerations:

L.A. Care's internal business units reviewed the revisions in A05 and indicated that, other than three issues that are called out, they have no concerns related to L.A. Care's ability to comply with the contract revisions.

DHCS released the CY 2026 SMAC for execution on Tuesday June 10 and requires execution and submission back to DHCS no later than Tuesday June 17, to allow for countersignature. D-SNP plans must subsequently submit the fully executed SMAC to CMS by the first Monday in July.

4. Risk Area and Mitigation Activities

Risk Statement: **Known Key Risk:** ☒ Yes ☐ No ☐ Unknown

L.A. Care's internal business units reviewed the revisions in A05 and indicated that, other than three issues that are called out, they have no concerns related to L.A. Care's ability to comply with the contract revisions. L.A. Care will engage in additional analysis to address the 3 areas of concern.

The Plan opted to sign A05 by the requested due date in order to maintain the contract with DHCS.

Impacted Area/Risk: Please select those areas impacted

☐ Claims	☐ Compliance	☐ Regulatory	☐ Vendor	☐ Community
☐ Financial	☐ Pharmacy	☐ Privacy	☒ Medicare	☐ Access
☐ Reputation	☐ Clinical	☐ IT	☐ SDOH	☐ Legal
☐ Member	☐ Provider	☐ InfoSec	☐ Contract	☐ Employee

Risk Mitigation Activities:
The Plan chose to sign the amendment to comply with the deadline set by DHCS so that L.A. Care can continue to operate the DSNP line of business.

5. Recommended Action / Decision Requested

Board Action Needed:

☐ For Information Only
☐ For Discussion with Board/Committee
☒ For Approval / Decision

Proposed Motion (if applicable):
Motion to ratify execution of EAE SMAC Contract Amendment A05.

5. Next Steps / Timeline / Milestones

- Approve motion requesting ratification
- L.A. Care submitted signed Amendment A05 to DHCS on June 16, 2025, in order to comply with the deadline set by DHCS.

6. Attachments / Supporting Materials / Presentations

- Exclusively Aligned Enrollment (EAE) State Medicaid Agency Contract (SMAC) for Dual Eligible Special Needs Plans (D-SNPs) (contract number 22-20236) (Amendment A05)
- A05 Contract change matrix

Board of Governors
MOTION SUMMARY

Date: June 27, 2025

Motion No. EXE 100.0725

Committee: Executive

Chairperson: Ilan Shapiro, MD

Requesting Department: Legal Services Department

Issue: Request to ratify execution of Amendment A05 to L.A. Care's Exclusively Aligned Enrollment (EAE) Duals Special Needs Plan (DSNP) contract (contract number 22-20236) with the Department of Health Care Services (DHCS).

☐ **New Contract** ☒ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted in** <<year>>

Background: L.A. Care received Amendment A05 to the EAE D-SNP contract on June 10, 2025. DHCS required that the Plan submit the executed Amendment on or before June 17, 2025. Amendment A05 extends the contract term to December 31, 2026 and includes additional revisions (see attached change matrix). This amendment allows for the continuation of the services identified in the original agreement.

Member Impact: The Plan's D-SNP Members are positively impacted by extending the Plan's contract applicable to the D-SNP line of business.

Budget Impact: Finance has reviewed for impact on relevant budgets.

Motion: **To ratify L.A. Care Chief Executive Officer's, Martha Santana-Chin, execution of Amendment A05 L.A. Care's Exclusively Aligned Enrollment (EAE) Duals Special Needs Plan (DSNP) Contract (contract number 22-20236) with the Department of Health Care Services (DHCS).**

OVERVIEW OF A05 CHANGES

Section	Previous Language	Amendment A05 Update
Scope of Work	General responsibilities for D-SNP coordination	Defines EAE model; requires integration across Medi-Cal FFS, managed care, and other systems; includes SNF, DME, and Home Health under MCP contract.
Care Coordination	Not previously detailed	Requires coordination with IHSS, HCBS, behavioral health, dental, and pharmacy; includes caregiver assessments, dementia care specialists, palliative care, and SSBCI/EPHRB tracking.
Information Sharing	Not addressed	Requires real-time SNF/hospital notifications using secure electronic methods; D-SNP remains accountable even if delegated.
Integrated Member Materials	Medicare-compliant materials only	Requires integrated Medicare–Medi-Cal materials, single Member Services phone line, and translations meeting both DHCS and CMS thresholds.
Consumer Governance	Not required	Must establish consumer advisory boards; quarterly meetings; diversity and regional representation required; report charters/minutes to DHCS.
State-Specific Supplemental Benefits	Not applicable	Requires minimum: $0 eye exam (annual), $100 eyeglasses/contacts (every two years), funded by Medicare rebates.
Eligibility & Enrollment	General duals language	Limits enrollment to full-benefit duals age 21+ in both D-SNP and affiliated MCP; requires monthly and annual certification/reporting.
Billing and Cost Sharing	General federal references	Explicitly prohibits billing members for any Medicare cost-sharing; provider contracts must reflect this prohibition.
Provider Network & Continuity	Continuity based on general Medicare rules	Requires reporting overlap in dental networks; 12-month continuity for PCP/specialist and DME services.
Quality & Data Reporting	Medicare standards	Must report encounter data and quality metrics to DHCS per 2026 CalAIM D-SNP Policy Guide.
Appeals & Grievances	Based on Medicare rules	Unified Medicare/Medi-Cal process required; detailed requirements on timeframes, notice, IMRs, State hearings, tracking, and escalation protocols.
Noncompliance & Enforcement	CAPs often precede penalties	DHCS may impose sanctions with or without CAPs; includes enrollment freezes, contract termination, and performance reporting penalties.
General & Special Terms	Standard State terms	Reaffirms audit rights, confidentiality, nondiscrimination, debarment/suspension clauses, and human subjects requirements.
Contract Term	Not changed	Confirms contract term: Jan 1, 2026 – Dec 31, 2026.
Compensation	No direct DHCS payment specified	Remains unchanged: no State payment; plan operates under Medicare Advantage rebate funds and MCP capitation.

Exclusively Aligned Enrollment D-SNP Contract 22-20236 A05

Page of Redline	Section Title	Exhibit	Attachment	Provision	Type	Changes	Contract Language	Responsible Business Unit	Authority & Reference	Approval Status	Comments
1 & 3	Exclusively Aligned Enrollment D-SNP	A	1		Revise	Updated plan information	1.A. ...~~L.A. Care~~Local Initiative Health ~~Plan~~Authority for LA County… 2. Telephone: ~~213-523-1854~~ 925-595-1021	Legal Regulatory Compliance		Approved-No Concerns	Legal Approved Regulatory Operations Approved
5	Coordination of Care	A	1		Add	Added new requirement for coordination with 1915(c) HCBS waiver agencies.	C. For coordination of 1915 (c) Home and Community-Based Services (HCBS) waivers, D-SNP Contractor must establish a cooperative working relationship with HCBS waiver agencies for care coordination, information sharing, and oversight. A list of waiver programs can be found at: https://www.dhcs.ca.gov/services/Pages/medi-calwaivers.aspx.	Utilization Management Care Management MLTSS	https://www.dhcs.ca.gov/services/Pages/medi-calwaivers.aspx; 42 CFR Part 441	Approved-No Concerns	Utilization Management Approved Care Management Approved Community Health MLTSS Approved
5-8	Coordination of Care	A	1		Revise	Removal of Contact inforation for ASO	D.~~Organization (ASO)~~ Fiscal Intermediary-Dental Business Operations (FI-DBO) for provider information and the coordination of dental benefits for Members enrolled in Medi-Cal dental fee-for-service or contact the Medi-Cal Dental Managed Care Plan for Members enrolled in Medi-Cal Dental Managed Care. ~~ASO contact information can be found at the following link: https://smilecalifornia.org/contact-us/ and below are Medi-Cal Dental Managed Care contact information:~~ FI-DBO contact information can be found at the following link: https://smilecalifornia.org/contact-us/ and below is Medi-Cal Dental Managed Care contact information: ~~Access~~California Dental ~~Plan~~Network Sacramento: ~~(877) 821-3234 | TTY: (800) 735-2929~~833) 479-1984 | 800-466-7566 (TTY/TTD) Los Angeles: ~~(888) 414-4110 |~~ 855) 388-6257 | 800-466-7566 (TTY: ~~(800) 735-2929~~/TTD)	Utilization Management Care Management MLTSS CSC	2026 CalAIM D-SNP Policy Guide	Approved-No Concerns	Utilization Management Approved Care Management Approved MLTSS Approved
8-9	Coordination of Care	A	1		Revise	Update Policy guide reference to 2026	G. ...Contractor must include State-specific requirements outlined in the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx. ~~https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx~~	Utilization Management Care Management MLTSS Community Health Medicare Product	2026 CalAIM D-SNP Policy Guide	Approved-No Concerns	Utilization Management Approved Care Management Approved Community Health Approved MLTSS Approved
10-11	Coordination of Care	A	1		Revise	Remove POF and clarify requirement for caregiver needs assessment, face-to-face care coordination, and CICM service delivery.	8)~~Including four (4) or more populations of focus from the Medi-Cal Enhanced~~ Providing California Integrated Care Management ~~(ECM) program~~ CICM to specific vulnerable populations as defined in the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide and demonstrating how the D-SNP Contractor's modelModel of Care includes and reflects the delivery of ECM core services to CICM populations: 9) Providing in-person care management to the CICM population, Adults Experiencing Homelessness;	Utilization Management Care Management MLTSS Community Health Medicare Product	2026 CalAIM D-SNP Policy Guide	Approved- Concerns Noted	Utilization Management Approved, **Care Management** Approved, however there are **implementation** concerns. Community Health Approved MLTSS Approved
14	Encounter Data	A	1		Add	Details electronic submission of Medicare-paid encounter data.	D-SNP Contractor must submit monthly Medicare encounter data to DHCS in a mutually agreed format, including zero-claim encounters.	Encounters Medicare Product	42 CFR Part 422; CalAIM D-SNP Policy Guide	Approved- Concerns Noted	**Encounters** Approved however there are concerns: 1) The requirements for compliance are TBD so it's not possible to completely assess LAC's ability to comply. 2) This is a data extract requirement that is downstream from Encounter team's scope of responsibilities.
16-17	Integrated Materials	A	1	3	Revise	Update regulatory and APL references	1)Medicare's five percent (5%) threshold for language translation as outlined in 42 CFR Part 422.2267(a) and 423.2267(a); and ~~translation as outlined in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V); and~~ 2)DHCS prevalent language requirements, i.e. the DHCS threshold and concentration standard languages, as specified in APL ~~21-004 or subsequent iterations~~25-005, that provides guidance to Contractors on specific translation requirements for their Service Areas	C&L	42 CFR Part 422 2267(a) and 423.2267(a); DHCS APL 25-005	Approved-No Concerns	C&L Approved

19	Quality and Data Reporting	A	1	5	Revise	Directed to DHCS website for reporting measure. Removal of Reporting components within contract,	**5. Quality and Data Reporting** A.D-SNP Contractor is responsible for reporting quality measures to DHCS. These quality measures are fully outlined in the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx. ~~B.This reporting will include:~~ ~~1)Selected Healthcare Effectiveness Data and Information Set (HEDIS) measures, calculated at the plan benefit package (PBP) level for the PBPs included in this Contract;~~ ~~2)State-specific Care Coordination and LTSS process measures;~~ ~~3)State-specific dementia measures;~~ ~~4)State-specific ECM-like care management measures;~~ ~~DHCS will add additional measures as needed, and details will be provided in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.~~ ~~5)State-specific palliative care measures; and~~ ~~6)Integrated Appeals and Grievances data.~~	QI Medicare Product	2026 CalAIM D-SNP Policy Guide	Approved-No Concerns	QI Approved
32	CMS Documentation	A	1		Revise	Bid language removal	A. D-SNP Contractor must submit to the DHCS contract manager, after execution of this Contract but no later than September 30, ~~2024~~2025, a complete and accurate copy of the Medicare Advantage bid for the contract containing the PBPs covered by this Contract, as approved by CMS., as well as any of the following materials (if not included in the approved bid): ~~B. If not included in the approved bid, the D-SNP Contractor must also provide to DHCS the following information, in a format as specified by DHCS, after execution of this Contract but no later than September 30, 2024 to the DHCS contract manager:~~	Legal Medicare Product	CalAIM D-SNP Policy Guide	Approved-No Concerns	Legal Approved
33	Deeming Period	A	1		Add	Requires continued enrollment for 3-month deeming period post-Medi-Cal eligibility loss.	D-SNP Contractor is required to continue enrollment for Members who lose Medi-Cal eligibility for a minimum 3-month deeming period.	Utlization Management Care Management MLTSS		Approved-No Concerns	Utilization Management Approved, Care Management Approved MLTSS Approved
33	CMS Documentation	A	1	18	Revise	Add MLR requirement	B. D-SNP Contractor must submit to DHCS copies of CMS reporting, compliance, Medical Loss Ratio (MLR), and audit findings.	Medicare Product Regulatory Affairs	CalAIM D-SNP Policy Guide	Approved-No Concerns	Regulatory Operations Approved
35	CMS Documentation	A	1		Add	Specifies submission requirements for Medicare Advantage bids and reports.	D-SNP Contractor must submit approved Medicare Advantage bid documents, including model of care and list of supplemental benefits, by 9/30/2025.	Legal Medicare Product	CMS Guidance; CalAIM D-SNP Policy Guide	Approved-No Concerns	Legal Approved
49	22. Noncompliance and Enforcement	A	1		Revise	DHCS addresses corrective action for performance and compliance issues	DHCS may implement enforcement action to address Contractor's performance and compliance issues through monitoring and oversight activities. If DHCS finds the Contractor is noncompliant with any of the obligations set forth in the Contract, the D-SNP Policy Guide, or D-SNP Reporting Requirements, DHCS may require the Contractor to develop and submit a Corrective Action plan response designed to correct or resolve such noncompliance. Corrective Action includes specific identifiable activities or undertakings by the Contractor which address deficiencies or noncompliance. DHCS is not required to impose a Corrective Action plan on Contractor before any of the sanctions set forth in State and federal law. Noncompliance with this Contract may subject the Contractor to discontinuance of new enrollment, or termination of the Contract by DHCS.	Regulatory Compliance Legal	CalAIM D-SNP Policy Guide	Approved-No Concerns	Regulatory Operations Approved Legal Approved
73	Program Terms & Conditions	E	2	8	Delete	Removed prohibition of delegation language	~~8.Prohibition Against Assignments or Delegation of D-SNP Contractor's Duties and Obligations Under this D-SNP Contract~~ ~~The D-SNP Contractor must not negotiate or enter into any agreement to assign or delegate the duties and obligations under this D-SNP Contract. If D-SNP Contractor fails to comply with this Provision, DHCS may terminate the D-SNP Contract for cause in compliance with Exhibit E, Attachment 2, Provision 17.~~	Legal Regulatory Compliance Medicare Product	42 CFR 438.604, 438.606; SSA §1902(a)(68); Gov Code 14841; Mil. & Vets. Code 999.5(d); W&I Code 14124.70	Approved-No Concerns	Regulatory Operations Approved Legal Approved
76	Notices	E	2	12	Revise	Update DHCS and L.A. Care Contact informtion	California Department of Health Care Services Managed Care Operations Division Attn: Michelle Retke, Division Chief MS 4408 P.O. Box 997413 Sacramento, CA 95899-7413 Local Initiative Health Authority for LA County Attn:~~John Baackes~~ Martha Santana-Chin, CEO 1200 West 7th Street Los Angeles, CA 90017	Legal Regulatory Compliance		Approved-No Concerns	Regulatory Operations Approved Legal Approved

80	Disputes	E	2	17	Revise	Provide clarification related to CAPs	~~18~~17. **Disputes** D-SNP Contractor must comply with and exhaust the requirements of this Provision when it initiates a contract dispute with DHCS. This Provision (Disputes) does not apply to challenges to Corrective Action plans as described in Exhibit A, Provision 22, or any other contract compliance action initiated by DHCS. In addition to Exhibit C, Provision 6, Disputes, D-SNP Contractor also agrees to the following:	Regulatory Compliance Legal		Approved- Concerns Noted	**Regulatory Operations** Approved however there are concerns regarding the inability to dispute Legal Approved
109	Appeals & Grievances	A	1		Add	Unified process including timelines for State Hearings, IMR, and CMS appeals.	D-SNP Contractor must process a grievance for discrimination as required by APL 21-004 or subsequent iterations25-005…	CSC- A&G	42 CFR 422.618, 422.629–634, 438.210, 438.400, 438.402; H&S 1374.30	Approved-No Concerns	A&G Approved
1	Marketing Requirements	A	1		Revise	Mandates inclusion of Medi-Cal dental benefits in marketing materials.	C.For coordination of 1915 (c) Home and Community-Based Services (HCBS) waivers, D-SNP Contractor must establish a cooperative working relationship with HCBS waiver agencies for care coordination, information sharing, and oversight. A list of waiver programs can be found at: https://www.dhcs.ca.gov/services/Pages/medi-calwaivers.aspx. C.For coordination of Medi-Cal dental benefits, D-SNP Contractor must contact the DHCS Dental Administrative Service D.Organization (ASOFiscal Intermediary-Dental Business Operations (FI-DBO) for provider information and the coordination of dental benefits for Members enrolled in Medi-Cal dental fee-for-service or contact the Medi-Cal Dental Managed ~~Care Plan for Members enrolled in Medi-Cal Dental Managed Care. ASO contact information can be found at the following link: https://smilecalifornia.org/contact-us/ and below are Medi-Cal Dental Managed Care contact information:~~ Care Plan for Members enrolled in Medi-Cal Dental Managed Care. FI-DBO contact information can be found at the following link: https://smilecalifornia.org/contact-us/ and below is Medi-Cal Dental Managed Care contact information:	Marketing Materials Review	CalAIM D-SNP Policy Guide	Approved-No Concerns	Marketing Approved Material Review Approved
22	Enforcement	A	1		Add	Outlines DHCS authority to require CAPs or impose sanctions for noncompliance.	DHCS may implement enforcement action or require a Corrective Action Plan (CAP) if the Contractor is noncompliant with contract terms or reporting requirements.	Regulatory Compliance Legal	CalAIM D-SNP Policy Guide	Approved-No Concerns	Legal Approved
1	Scope of Work Addendum	A			Update	Updated contact info for LA Care and DHCS representatives. Clarifies scope attachments.	Updated DHCS and LA Care contact info. Clarified that Exhibit H is incorporated by reference as part of the scope of work.	Legal Regulatory Compliance	Administrative	Approved-No Concerns	Legal Approved Regulatory Operations Approved
1	Enrollment Scope	A			Add	Specifies eligibility for enrollment only includes full-benefit duals in affiliated MCPs.	D-SNP Contractor must limit enrollment to full-benefit duals enrolled in affiliated MCPs. These must be EAE D-SNPs as defined under 42 CFR section 422.561.	CSC- Enrollment Services Medicare Product	42 CFR 422.561; W&I Code 14184.208(h)(6)	Approved-No Concerns	
4	Program Terms & Conditions	E	2		Remove	Added requirements on: governing law, amendment procedures, delegation of authority, novation prohibition, inspection/audit rights, records retention, data sharing, confidentiality, false claims compliance, and DHCS approval processes.	~~8.Prohibition Against Assignments or Delegation of D-SNP Contractor's Duties and Obligations Under this D-SNP Contract The D-SNP Contractor must not negotiate or enter into any agreement to assign or delegate the duties and obligations under this D-SNP Contract. If D-SNP Contractor fails to comply with this Provision, DHCS may terminate the D-SNP Contract for cause in compliance with Exhibit.~~	Legal Regulatory Compliance Medicare Product	42 CFR 438.604, 438.606; SSA §1902(a)(68); Gov Code 14841; Mil. & Vets. Code 999.5(d); W&I Code 14124.70	Approved-No Concerns	Regulatory Operations Approved Legal Approved Privacy Approved
1–10	Business Associate Addendum	G			Revise	Updated definitions of PHI and confidential info; breach notification protocols; SSA data responsibilities; records access; and termination for cause clauses.	Expanded definitions and expectations for PHI and confidential info; updated breach notification timelines; clarified SSA data use and access requirements.	Health Information IT- Security Privacy Legal	45 CFR 160, 164; California Civil Code 1798.3(a); DHCS Privacy Policy	Approved-No Concerns	Legal Approved Privacy Approved IT- Security Approved

Exhibit A
SCOPE OF WORK

Exclusively Aligned Enrollment D-SNP

1. Service Overview

A. This Contract is being executed with this Contractor that is a Dual Eligible Special Needs Plan (D-SNP), Local Initiative Health Authority for LA County, that will be referred to in this Contract as D-SNP Contractor. The Medicare Advantage organization offering the D-SNP, D-SNP Contractor's parent organization, or another entity that is owned and controlled by the D-SNP Contractor's parent organization Local Initiative Health Authority for LA County must also hold a Medi-Cal Managed Care Health Plan (MCP) Contract with California Department of Health Care Services (DHCS), or must be a subcontracted delegate health plan as defined in Welfare and Institutions Code (W&I) section 14184.208(h)(6), also referred to as an Exclusively Aligned Enrollment (EAE) D-SNP. D-SNP Contractor must have a Medicare Advantage Contract (H-Contract) that only includes D-SNPs within California in accordance with 42 CFR section 422.107(e). The H-Contract must include both EAE and Non-EAE plan benefit packages.

B. This D-SNP Contract is a Care Coordination and benefit coordination agreement. D-SNP Contractor is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including those benefits not covered by the Medicare Advantage health plan under whose authority the D-SNP Contractor operates, and the Medi-Cal benefits identified in the Exhibit H attachment to this Contract and referenced below in Provision 3 of this Exhibit A. Coordination responsibility includes coordination of those Medi-Cal Services that are delivered via Medi-Cal Fee-For-Service (FFS), managed care, or other Medi-Cal delivery systems. These Medi-Cal benefits and services are defined in the contents of this D-SNP Contract.

C. This D-SNP Contract is for Applicable Integrated Plans as defined in 42 CFR section 422.561. D-SNP Contractor must limit enrollment to full-benefit Dual Eligible Members enrolled in an affiliated MCP, per 42 CFR section 422.561, that holds a capitated contract with DHCS or is a subcontracted delegate health plan as defined in W&I 14184.208(h)(6). Through the capitated MCP Contract, Medi-Cal benefits include primary care and acute care, including Medicare cost-sharing as defined in 28 Social Security Act (SSA) section 1905(p)(3)(B), (C), and (D), without regard to the

limitation of that definition to qualified Medicare beneficiaries. Members enrolled in Applicable Integrated Plans have Skilled Nursing Facility (SNF) services (with coverage for a minimum of 180 days), Home Health Services (as defined at 42 CFR section 440.70), and Durable Medical Equipment (DME) including equipment and appliances, as well as medical supplies (as defined at 42 CFR section 440.70(b)(3)) covered by the capitated MCP Contract.

2. Project Representatives

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

Department of Health Care Services	**D-SNP Contractor**
Managed Care Operations Division Attn: Procurement & Contract Development Branch Chief	Local Initiative Health Authority for LA County Attn: Todd Gower, Chief Compliance Officer
Telephone: (916) 449-5000 FAX: (916) 449-5090	Telephone: 925-595-1021 Email: TGower@lacare.org

B. Direct all inquiries to:

Department of Health Care Services	**D-SNP Contractor**
Managed Care Operations Division Attn: Michelle Retke, Division Chief	Local Initiative Health Authority for LA County Attn: Todd Gower, Chief Compliance Officer
MS 4408 P.O. Box 997413 Sacramento, CA 95899-7413	1200 West 7th Street Los Angeles, CA 90017
Telephone: (916) 449-5000 FAX: (916) 449-5090	Telephone: 925-595-1021 Email: TGower@lacare.org

C. Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this D-SNP Contract.

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

Exhibit A
SCOPE OF WORK

be performed:

A. Exhibit A: Scope of Work

B. Exhibit H

Exhibit A, Attachment 1
COORDINATION OF CARE

1. Care Coordination

This D-SNP Contract is a Care Coordination and benefit coordination agreement between D-SNP Contractor and DHCS. D-SNP Contractor is responsible for coordinating the delivery of all benefits and services covered by both Medicare and Medi-Cal, including when Medi-Cal Services are delivered via Medi-Cal FFS, managed care, or other Medi-Cal delivery systems. Without limitation, when Medically Necessary for the Member, D-SNP Contractor must coordinate care with providers and other entities for the Medi-Cal Services outlined in Exhibit H. D-SNP Contractor must educate Members through Member handbook and other contacts that D-SNP Contractor, and not the Member, is responsible for coordination of the Member's Medi-Cal and Medicare Services.

A. For coordination of behavioral health services, including specialty mental health and substance use disorder services, D-SNP Contractor must establish a cooperative working relationship with the Member's MCP and/or the county behavioral health plan for care coordination, information sharing, and oversight. County behavioral health plan contact information can be found at the following link: https://www.dhcs.ca.gov/services/MH/MHSUD/Pages/CountyProgAdmins.aspx.

B. For coordination of In-Home Supportive Services (IHSS), D-SNP Contractor must establish a cooperative working relationship with the County IHSS Office for care coordination, information sharing, and oversight. County IHSS Office contact information can be found at: https://www.cdss.ca.gov/inforesources/county-ihss-offices.

C. For coordination of 1915 (c) Home and Community-Based Services (HCBS) waivers, D-SNP Contractor must establish a cooperative working relationship with HCBS waiver agencies for care coordination, information sharing, and oversight. A list of waiver programs can be found at: https://www.dhcs.ca.gov/services/Pages/medi-calwaivers.aspx.

D. For coordination of Medi-Cal dental benefits, D-SNP Contractor must contact the DHCS Dental Fiscal Intermediary-Dental Business Operations (FI-DBO) for provider information and the coordination of dental benefits for Members enrolled in Medi-Cal dental fee-for-service or contact the Medi-Cal Dental Managed

Exhibit A, Attachment 1
COORDINATION OF CARE

Care Plan for Members enrolled in Medi-Cal Dental Managed Care. FI-DBO contact information can be found at the following link: https://smilecalifornia.org/contact-us/ and below is Medi-Cal Dental Managed Care contact information:

Liberty Dental Plan
Sacramento: (888) 703-6999 or (877) 855-8039 (TTY/TTD)
Los Angeles: (888) 703-6999 or (877) 855-8039 (TTY/TTD)

Health Net Dental Plan
Sacramento: (800) 977-7307 | TTY (800) 977-7307 (TTY 711)
Los Angeles: (800) 977-7307 | TTY (800) 977-7307 (TTY 711)

California Dental Network
Sacramento: (833) 479-1984 | 800-466-7566 (TTY/TTD)
Los Angeles: (855) 388-6257 | 800-466-7566 (TTY/TTD)

Please note: the Dental Managed Care Plans are subject to change. DHCS reserves the right to provide updated contact information for Dental Managed Care plans.

E. For coordination of Medi-Cal pharmacy benefits, D-SNP Contractor must contact Medi-Cal Rx, and contact information can be found at: https://medi-calrx.dhcs.ca.gov/home/contact.

F. If D-SNP Contractor offers Supplemental Benefits as referenced in Exhibit E, Attachment A, Definitions, of this Contract, also including Special Supplemental Benefits for the Chronically Ill (SSBCI) or Expanded Primarily Health-Related Benefits (EPHRB), those services must be coordinated as needed to ensure D-SNP Contractor tracks Member use of Supplemental Benefits and exhausts Supplemental Benefits prior to or concurrent with authorization of or referral for Medi-Cal benefits, including but not limited to Dental, Vision, Transportation, Community Supports, and Behavioral Health.

G. D-SNP Contractor must implement a Special Needs Plan Model of Care (MOC). In addition to meeting requirements detailed at 42 CFR section 422.101(f) and earning approval from the National Committee for Quality Assurance (NCQA), the Contractor must include State-specific requirements outlined in the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-

Exhibit A, Attachment 1
COORDINATION OF CARE

Guide.aspx. D-SNP Contractor must additionally comply with State-specific Care Coordination requirements, which are fully outlined in the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website and may be amended from time to time. These State-specific requirements, which are outlined fully in the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide, include the following:

1) Incorporating Medi-Cal data into the D-SNP risk stratification process;

2) Incorporating Medi-Cal Services and providers, including palliative care teams as appropriate, into the development and execution of the Member's care plan and care team, including Medi-Cal Services accessed through the aligned MCP as well as Medi-Cal FFS and other Medi-Cal delivery systems (including Home and Community-Based Services programs);

3) Including a question in the Member's Health Risk Assessment (HRA) to identify any engaged Caregiver and submit the HRA tool to DHCS;

4) Assessing Caregiver support needs, if a Member identifies a Caregiver, as part of the D-SNP assessment process;

5) Providing on at least an annual basis as feasible, and with the Member's consent, face-to-face encounters for the delivery of health care or care management or Care Coordination services;

6) Incorporating trained Dementia Care Specialists in care teams and encouraging primary care providers to leverage Dementia Care Aware resources for any primary care appointment to detect cognitive impairment;

7) Utilizing Long-Term Services and Supports (LTSS) liaisons in supporting care transitions;

8) Providing California Integrated Care Management (CICM) to specific vulnerable populations as defined in the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide and demonstrating how the D-SNP Contractor's Model of Care includes and reflects the delivery of

services to CICM populations;

9) Providing in-person care management to the CICM population, Adults Experiencing Homelessness;

10) Providing and coordinating inpatient and outpatient/community-based palliative care referrals and services for Members who meet Medi-Cal criteria for palliative care; and

11) Discussing advance care planning in the annual wellness visit or other provider visits.

H. D-SNP Contractor is not responsible to provide or pay for any Medi-Cal benefits, or Medicare cost sharing obligations which are covered in full through Medi-Cal FFS or MCP Contract. Medi-Cal MCPs are responsible to pay Medicare cost sharing obligations for contracted benefits for MCP members. In addition, the MCP Contract requires the MCP to enter into a Coordination of Benefits Agreement with the Medicare program through the Centers for Medicare & Medicaid Services (CMS), and to participate in Medicare's automated claims crossover process for full-benefit Dual Eligible Members, in accordance with 42 CFR section 438.3(t). D-SNP Contractor shall maintain a current knowledge and familiarity of Medi-Cal benefits through ongoing reviews of California laws, rules, policies, and further guidance as posted on the DHCS website or otherwise provided by DHCS. D-SNP Contractor shall coordinate with the aligned MCP to support Medi-Cal eligibility retention efforts to the extent permitted by law, and guidance from CMS and DHCS. D-SNP Contractor shall timely coordinate Medi-Cal Services requiring referral and coordination of care as outlined in Exhibit H for its Members under this Contract.

This Provision details D-SNP Contractor's specific Medicare-Medi-Cal care coordination requirements. Medi-Cal Services are described in Title XIX of the Social Security Act, 42 CFR parts 440 and 441; the California Medicaid State Plan; Exhibit H; the DHCS and Medi-Cal websites and other relevant materials.

2. Information Sharing

A. D-SNP Contractor is responsible for complying with State policy implementing federal information sharing requirements for D-SNPs per 42 CFR section 422.107(d)(1), for the purpose of coordinating

Exhibit A, Attachment 1
COORDINATION OF CARE

Medicare and Medi-Cal covered services between settings of care for all Members. This State policy is in addition to federal requirements for hospitals regarding electronic notifications listed in 42 CFR section 482.24(d). The goal of the information sharing policy is for D-SNP Contractor, either directly or through contracted providers or other entities, to timely notify the Member's MCP, or hospital and SNF admissions. Timely notification supports the coordination of and referrals to Medicare and Medi-Cal Services, including Home and Community Based Services.

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

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

3) To the extent permissible under applicable federal and State law and regulations, and not inconsistent with the Member's expressed privacy preferences, D-SNP Contractor will require their contracted SNFs to use a secure email, a data exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform D-SNP Contractor of any SNF admission, discharge, or transfer for all Members. For SNF admissions, D-SNP Contractor will require contracted SNFs to make this notification within 48 hours after any SNF admission. For SNF discharges or transfers, D-SNP Contractor will require contracted SNFs to make this notification in advance, if at all possible, or at the time of, the Member's discharge or transfer from the SNF.

4) 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.

B. D-SNPs will coordinate care management for their Members and facilitate Member access to needed LTSS, including in community-based settings to support care transitions.

3. Integrated Materials

A. D-SNP Contractor is responsible for providing integrated Member materials to Members. The State requirements described in this Paragraph are in addition to all existing Medicare marketing and communications requirements outlined in 42 CFR Part 422 Subpart V, 42 CFR Part 423 Subpart V, and 42 CFR section 438.10(d)(2), and as described in the Medicare Communications and Marketing Guidelines (MCMG). Required integrated Member materials will include:

1) Annual Notice of Change (ANOC);

2) Member Handbook;

3) Summary of Benefits;

4) Member Identification (ID) Card;

5) Provider/Pharmacy directory; and

6) List of Covered Drugs (Formulary).

B. D-SNP Contractor must have a single Member services/customer service phone number for Members to contact D-SNP Contractor regarding their Medicare or Medi-Cal benefits. D-SNP Contractor must use the single Member services phone number in all integrated Member materials.

C. D-SNP Contractor will be required to make all integrated Member materials available in the threshold languages for their aligned MCP Service Area. Threshold languages include both:

1) Medicare's five percent (5%) threshold for language translation as outlined in 42 CFR Part 422 2267(a) and 423.2267(a); and

2) DHCS prevalent language requirements, i.e. the DHCS

threshold and concentration standard languages, as specified in APL 25-005, that provides guidance to Contractors on specific translation requirements for their Service Areas.

D. D-SNP Contractor must have a process for ensuring that Members can make a standing request to receive materials in alternative formats and in any non-English languages, at the time of request and on an ongoing basis thereafter, in accordance with 42 CFR section 422.2267 and section 423.2267, APL 25-005, APL 22-002, and the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide as applicable. The process must include how D-SNP Contractor 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 item of material, and how a Member can change a standing request for preferred language and/or format.

E. D-SNP Contractor must identify in its provider directory those providers that accept both Medicare and Medi-Cal, i.e. providers that are currently registered providers under Medi-Cal and are also within D-SNP Contractor's network. D-SNP Contractor must comply with existing federal and State guidelines regulating print and online provider directories. Print and online directories for D-SNP Contractor must reflect all contracted and in-network providers for D-SNP Members. The provider directories must show the providers that are in the D-SNP Medicare and/or Medi-Cal networks in a clear manner for Members.

F. D-SNP Contractor must submit all communication and marketing materials in the Health Plan Management System (HPMS) that are required to be submitted as described here and in the MCMG under D-SNP Contractor's Medicare contract ID number. The multi-plan submission process is not applicable to D-SNP only contracts. In addition, when a third party, such as a pharmacy benefit manager (PBM), creates and distributes Member-specific materials on behalf of multiple organizations, it is not acceptable to use the material ID for another organization for materials the third-party providers to D-SNP enrollees. The material must be submitted in HPMS using a separate material ID number for the D-SNP contract and that material ID number must be included in the material. Additional guidance including the submission and review process for integrated Member materials is fully outlined in the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available

on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

G. D-SNP Contractor must have a single Application Programming Interface (API) for Members to access both Medicare and Medi-Cal information.

4. State-Specific Supplemental Benefits

Using Medicare rebate dollars, D-SNP Contractor must provide, at a minimum, the following supplemental benefits to Members:

A. $0 copay for one (1) routine eye exam every year; and

B. Every two (2) years, $100 for eyeglasses (frames and lenses) or up to $100 for contact lenses.

5. Quality and Data Reporting

A. D-SNP Contractor is responsible for reporting quality measures to DHCS. These quality measures are fully outlined in the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

6. Consumer Participation in Governance Boards

A. D-SNP Contractor must comply with federal requirements outlined in 42 CFR section 422.107(f) in addition to State-specific requirements outlined below. D-SNP Contractor must ensure consumer participation in governance boards that will provide regular feedback to the D-SNP Contractor on issues of duals-related topics, including plan management and Member care. D-SNP Contractor must consider region-specific meetings based on geographic county proximity rather than one State-wide setting, and ensure that the committee completes the following:

1) Meets at least quarterly throughout the Contract Year;

2) Has at least four (4) Member seats for individuals who have knowledge and perspective of EAE D-SNP topics to facilitate a variety of Member perspectives and unique lived

experiences, including those using services such as Home and Community Based Services and Long-Term Care;

3) Includes a ratio of Members on the governance board focused on duals-related topics relative to the ratio of dual eligible Members enrolled with D-SNP Contractor;

4) Includes a reasonably representative sample of the population enrolled in D-SNP including Members, Member's family members, consumer advocates, and caregivers that reflect the demographic diversity of the D-SNP population, including individuals with disabilities; and

5) Solicits input on ways to improve access to Covered Services, coordination of services (including all Medicare and Medi-Cal services), and health equity for underserved populations, among other topics.

B. D-SNP Contractor is responsible for reporting their committee charter and membership to DHCS annually by March 1, 2026, through its DHCS Contract Manager via email. D-SNP Contractor is also responsible for reporting meeting minutes and agendas to DHCS quarterly through its DHCS Contract Manager via email no later than 30 days after the end of each quarter. DHCS reserves the right to review and approve Enrollee membership. D-SNP Contractor can engage and recruit Members serving on existing committees.

7. State Guidance

A. In addition to the terms and conditions of this Contract, D-SNP Contractor must comply with State-specific departmental guidance in the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

B. To the extent that State guidance conflicts with Medicare requirements or regulations, D-SNP Contractor must comply with Medicare requirements and regulations. For purposes of this Provision State guidance only conflicts with Medicare requirements or regulations to the extent that the guidance requires conduct that would violate Medicare requirements or

regulations.

8. Coverage Area and Eligible Beneficiaries

A. This Contract covers the Medicare H-contract and Plan Benefit Package (PBP) listed within the following table.

Plan PBPs	H-Contract	Service Area of PBP	Eligible Populations within PBP
001	H1224	Los Angeles	QMB+, SLMB+, and other Full-Benefit Medi-Cal

B. Members covered under this Contract must include all full-benefit Dual-Eligible Beneficiaries 21 years of age or older, such as Qualified Medicare Beneficiaries Plus (QMB+), Specified Low-Income Medicare Beneficiaries Plus (SLMB+), and other full-benefit Dual-Eligible Beneficiaries who are enrolled with D-SNP Contractor and with the aligned Medi-Cal MCP. Covered Members include those who meet the following:

1) Are enrolled with D-SNP Contractor;

2) Who reside in the following county or counties to maximize the continuum of services available through both Medicare and Medi-Cal: Los Angeles

3) Are already enrolled in the MCP affiliated with D-SNP Contractor.

C. D-SNP Contractor agrees to conduct enrollment of eligible persons in accordance with the policies and procedures set forth in this Contract and maintain EAE for the duration of the D-SNP Contract term.

9. Certification and Enrollment Reporting

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

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

10. Member Billing Prohibitions

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

B. Any Dual-Eligible Beneficiary (including full-benefit Dual-Eligible Beneficiaries such as QMB+, SLMB+, and other full-benefit Dual-Eligible Beneficiaries) has no legal obligation to make further payment to a provider or to D-SNP Contractor for Medicare Part A or Part B cost sharing amounts. D-SNP Contractor's provider agreements must specify that a contracted Medicare provider agrees to accept D-SNP Contractor's Medicare reimbursement as payments in full for services rendered to Dual-Eligible Enrollees, or to bill Medi-Cal or the Member's Medi-Cal MCP as applicable for any additional Medicare payments that may be reimbursed by Medi-Cal. D-SNP Contractor's provider agreements must require a contracted Medicare provider to comply with Welfare and Institutions Code section 14019.4.

11. Provider Network Requirements

A. D-SNP Contractor can obtain Medi-Cal participating providers by reviewing the California Health and Human Services Open Data Portal. Medi-Cal FFS Provider data can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers. Medi -Cal Managed Care Provider

Network data can be found at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-provider-listing. Alternatively, D-SNP Contractor can obtain the file from the affiliated MCP.

B. D-SNP Contractor must comply with all applicable network guidance and network requirements outlined in the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

C. D-SNP Contractor that offers Dental Supplemental Benefits must report to DHCS on the level of overlap for their Medicare dental network and the Medi-Cal Dental network, as outlined in the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide.

12. Medicare Continuity of Care

A. D-SNP Contractor must comply with State-specific requirements for Medicare primary and specialty care provider continuity of care. D-SNP Contractor must also comply with State-specific requirements for Durable Medical Equipment continuity of care as outlined in 42 CFR section 422.100(I)(2)(iii) and APL 23-022 to the extent that this requirement applies to the D-SNP Contractor. Further guidance is outlined in the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx. D-SNP Contractor must provide Members with the following:

1) A 12-month continuity of care period from the date of the Member's Enrollment in the D-SNP, for primary and specialty providers with whom the Member has a pre-existing relationship and who are willing to work with the D-SNP Contractor; and

2) Access to Medically Necessary Medicare-covered Durable Medical Equipment and medical supplies.

13. Medi-Cal and Medicare Eligibility Verification and MCP Enrollment Verification

Exhibit A, Attachment 1
COORDINATION OF CARE

A. It is the responsibility of D-SNP Contractor to verify the Medi-Cal eligibility of a Member. To facilitate this verification, D-SNP Contractor will have real-time access to the Medi-Cal eligibility verification system. D-SNP Contractor is required to check a Member's Medi-Cal MCP enrollment eligibility on a monthly basis.

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

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

2) If the beneficiary meets the criteria for enrollment listed in Provision 8, Coverage Area and Eligible Beneficiaries, the eligible beneficiary may be enrolled with D-SNP Contractor.

C. D-SNP Contractor must ensure appropriate training of plan personnel and contracted providers regarding the use of the Medi-Cal Automated Eligibility Verification System (AEVS) interface and the appropriate interpretation of its eligibility results.

D. D-SNP Contractor's providers may use the Medicare Administrative Contractor (MAC) online provider portal to check their patient's Medicare eligibility. Additional information on checking Medicare eligibility can be found on the following link: https://www.cms.gov/MAC-info.

14. Medicare Deeming Period

For those Members who have lost Medi-Cal eligibility, D-SNP Contractor is required to maintain enrollment for such Members for at least a three-month deeming period following notification that the Member lost Medi-Cal eligibility. This requirement does not preclude D-SNP Contractor from offering a longer deeming period. D-SNP Contractor should inform its DHCS Contract Manager of the deeming period that it will provide.

15. Contract Term

This D-SNP Contract is effective from January 1, 2026, through December 31, 2026.

16. Termination

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

17. Compensation

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

18. CMS Documentation

A. D-SNP Contractor must submit to the DHCS contract manager, after execution of this Contract but no later than September 30, 2025, a complete and accurate copy of the Medicare Advantage bid for the contract containing the PBPs covered by this Contract, as approved by CMS, as well as any of the following materials (if not included in the approved bid):

1) The current approved model of care, if not already submitted to DHCS.

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

3) A list of approved Supplemental Benefits, inclusive of all benefits listed in the final Plan Benefit Package.

B. D-SNP Contractor must submit to DHCS copies of CMS reporting, compliance, Medical Loss Ratio (MLR), and audit findings.

19. Medicare Encounter Data Requirements

D-SNP Contractor must submit to DHCS electronic records of all encounters, including encounters resulting in zero Medicare claims, monthly, in a mutually agreed upon format. Each encounter record must be specific to the Member and provider, listing all the data elements required for each service. This data will provide DHCS with information on services paid for by Medicare. Additional details regarding this requirement are fully outlined in the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

Exhibit A, Attachment 1
COORDINATION OF CARE

20. Integrated Appeals and Grievances

A. D-SNP Contractor must adhere to the State-specific requirements described in this Contract, in addition to all existing Medicare requirements. In addition, D-SNP Contractor must implement a unified approach to appeals and grievances per 42 CFR sections 422.629-422.634, 438.210, 438.400, and 438.402. 42 CFR section 422.629(c) allows the State, at its discretion, to implement standards for timeframes or notice requirements that are more protective for the Member than required by 42 CFR section 422.630 through 422.634.

B. D-SNP Contractor must provide information about its Integrated Appeals and Grievance system to all providers and subcontractors at the time they enter into a contract, including, at a minimum, information on Integrated Appeals, Integrated Grievances, State Hearings, and Independent Medical Review (IMR) procedures and timeframes, as applicable.

C. D-SNP Contractor must maintain records of the Integrated Appeals, Integrated Grievances, and Integrated Organization Determinations. The record of each Integrated Appeals, Integrated Grievances, and Integrated Organization Determinations must be accurately maintained in a manner accessible to the State and available upon request to CMS. Additionally, D-SNP Contractor must establish, implement, maintain, and oversee an Integrated Grievance and Integrated Appeal system to ensure the receipt, review, and resolution of Integrated Grievances and Appeals. D-SNP Contractor must ensure that the following requirements are met through its Integrated Grievance and Integrated Appeal system.

D. Integrated Appeals and Grievances procedures apply to all benefits offered under D-SNP Contractor including optional supplemental benefits. For benefits that are carved out, such as Medi-Cal Dental, D-SNP Contractor must also follow the regulations at 42 CFR section 422.562(a)(5) and 422.629(e) that require D-SNP Contractor to provide Members reasonable assistance completing forms and taking other procedural steps to assist Members with appeals and grievances. This includes offering to assist Members with obtaining Medi-Cal covered services and navigating Medi-Cal appeals and grievances in connection with the Member's own Medi-Cal coverage, regardless of whether such coverage is in Medi-Cal fee-for-service or a separate Medi-Cal Dental Managed Care Plan.

Exhibit A, Attachment 1
COORDINATION OF CARE

If the Member accepts the assistance, the D-SNP Contractor should assist the Member as needed, such as identifying and reaching out to a Medi-Cal fee-for-service point of contact, providing assistance in filing an appeal or grievance, helping to obtain documentation to support a request for Medi-Cal appeal or grievance, or completing paperwork that may be needed in filing an appeal or grievance.

E. For Integrated Grievances, D-SNP Contractor must have the following:

1) Procedure to allow a Member, Member's authorized representative, or their provider to file a standard or expedited Integrated Grievance orally or in writing with D-SNP Contractor at any time.

2) Procedure to ensure D-SNP Contractor sends a written acknowledgement of an Integrated Grievance that is dated and postmarked within five (5) calendar days of receipt in accordance with Health and Safety Code (H&S) section 1368(a)(4)(A) and 28 California Code of Regulations (CCR) section 1300.68(d)(1) and 42 CFR section 422.629(g).

3) Procedure to resolve standard Integrated Grievances as expeditiously as the Member's health condition requires, but no later than 30 calendar days from receipt of the Integrated Grievances in accordance with 42 CFR section 422.630.

4) Procedure to resolve expedited Integrated Grievances within 24 hours in accordance with 42 CFR section 422.630.

5) Procedure to provide a written resolution to the Member for an Integrated Grievance within the resolution timeframe for a standard and expedited Integrated Grievance when:

a) The Member submits an Integrated Grievance in writing;

b) The Member requests a written response;

c) The Integrated Grievance is related to quality of care, coverage dispute, or disputed health care service involving medical necessity or experimental or investigational treatment; or

d) The Integrated Grievance is not resolved by the next business day, regardless of the type of Integrated Grievance or how it is filed.

6) Procedure to log and report all Integrated Grievances.

F. For Integrated Organization Determinations, D-SNP Contractor must have the following:

1) Procedure for D-SNP Contractor to consider both Medicare and Medi-Cal coverage criteria when making an Integrated Organization Determination.

2) Procedure to provide timely notice of standard Integrated Organization Determinations as expeditiously as the Member's health condition requires, and no later than 14 calendar days from when it receives the request in accordance with 42 CFR section 422.631(d)(2)(i)(B).

3) Procedure to provide notice to Members of their appeal rights and State Hearing rights for all fully or partially denied Integrated Organization Determinations.

4) Procedure to include the most current State Hearing form with the Integrated Organization Determination notice when the following requirements are met:

a) The denied Integrated Organization Determination is not for a Medicare-only service or benefit; and

b) The Integrated Organization Determination is relating to a denial, in whole or in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

5) For Knox-Keene licensed plans, a procedure to ensure compliance with H&S section 1367.01, including making Integrated Organization Determinations in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days from D-SNP Contractor's receipt of information reasonably necessary to make the Integrated Organization Determination, and no later than 14 calendar days from the receipt of request in accordance with

H&S section 1367.01(h)(1) and 42 CFR section 422.631(d)(2)(i)(B).

6) For Knox-Keene licensed plans, a procedure to inform Members of their rights to an IMR in accordance with the Knox-Keene Act, including but not limited to H&S sections 1368.03, 1370.4, and 1374.30, 28 CCR sections 1300.70.4 and 1300.74.30, and including verbatim language required by H&S section 1368.02(b), as well as the most recent IMR form, application instructions, the Department of Managed Health Care's (DMHC's) toll-free telephone number, and an envelope addressed to DMHC when the following requirements are met:

   a) The denied Integrated Organization Determination is for experimental or investigational therapy, or is a denial of urgent care or emergency service;

   b) The denied Integrated Organization Determination is not for a Medicare-only service or benefit; and

   c) The Integrated Organization Determination is relating to a denial, in whole or in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

7) Procedure to provide timely notice of expedited Integrated Organization Determinations as expeditiously as the Member's health condition requires, and no later than 72 hours from when D-SNP Contractor receives the request in accordance with 42 CFR section 422.631(d)(2)(iv).

8) Procedure to ensure deadlines for integrated organization determinations are not extended in accordance with H&S section 1367.01.

9) Procedure to ensure that prior to terminating, suspending, or reducing a previously approved item or service, D-SNP Contractor must provide Members with an integrated coverage decision letter at least ten (10) calendar days in advance of the effective date of the adverse organization determination in accordance with 42 CFR section 422.631(d)(2)(i)(A).

10) For Knox-Keene licensed plans, a procedure to ensure that D-SNP Contractor must not rescind or modify an integrated organization authorization after the Provider renders the health care service in good faith in accordance with H&S section 1371.8.

G. For Integrated Appeals, D-SNP Contractor must have the following:

1) Procedure to provide written acknowledgement of receipt of all Integrated Appeals within five (5) calendar days in accordance with 42 CFR section 422.629(g) and H&S section 1368(a)(4)(A).

2) Procedure to resolve standard Integrated Appeals as expeditiously as the Member's health condition requires but to not exceeding 30 calendar days from the date of receipt of the request in accordance with 42 CFR section 422.633(f)(1).

3) Procedure to inform Members of their rights to a State Hearing and include the most current State Hearing form when the following requirements are met:

a) The denied Integrated Appeal decision is not for a Medicare-only service or benefit; and

b) The Integrated Appeal relates to a denial, in whole or in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

4) For Knox-Keene licensed plans, a procedure to ensure that the Medi-Cal External Appeals processes are in accordance with DMHC's IMR System set forth in Article 5.55 of the Knox-Keene Act and the regulations promulgated thereunder.

5) For Knox-Keene licensed plans, a procedure to inform Members of their right to request an IMR in accordance with the Knox-Keene Act, including but not limited to H&S sections1368.03 and 1374.30, and 28 CCR section 1300.74.30, and including the verbatim language required by H&S section 1368.02, as well as 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:

a) The denied Integrated Appeal decision is not for a Medicare-only service or benefit; and

b) The Integrated Appeal is relating to a denial, in whole or in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

6) Procedure to resolve expedited Integrated Appeals within 72 hours of receipt of the Appeal in accordance with 42 CFR section 422.633(f)(2).

7) Procedure to ensure deadlines for Integrated Appeals of Medicare and Medi-Cal Services are not extended in accordance with APL 21-011.

8) Procedure to ensure D-SNP Contractor is obtaining all relevant information needed to make an Integrated Appeal decision within the required timeframes.

9) Procedure to ensure D-SNP Contractor continues the Member's benefits per 42 CFR section 422.632 while the Integrated Appeal is pending if all of the following are met:

a) The Member files a request to continue benefits within ten calendar days of notice of adverse integrated organization determination;

b) The integrated appeal involves the termination, suspension, or reduction of previously authorized services;

c) The services were ordered by an authorized provider; and

d) The period covered by the original authorization has not expired.

H. For a Reversal of Integrated Appeal Decisions, D-SNP Contractor must have the following:

1) Procedure to authorize or provide the service under dispute if D-SNP Contractor reverses its decision to deny, limit, or delay services that were not provided while the Appeal was pending within the following timeframes:

   a) As expeditiously as the Member's health condition requires and no later than 72 hours from the date it reverses its determination; or

   b) With the exception of a Medicare Part B drug, 30 calendar days after the date D-SNP Contractor receives the request for the Integrated Appeal; or

   c) For a Medicare Part B drug, seven (7) calendar days after the date D-SNP Contractor receives the request for the Integrated Appeal.

2) Procedure to authorize or provide the disrupted service(s) if a State Hearing officer reverses D-SNP Contractor's Integrated Appeal decision to deny, limit, or delay services that were not provided while the Appeal was pending, as expeditiously as the Member's health condition requires but no later than 72 hours of the date it receives notice reversing the determination in accordance with 42 CFR section 422.634(d)(2).

3) Procedure to effectuate decisions made by a Part C independent review entity, an administrate law judge or attorney adjudicator at the Office of Medicare Hearings and Appeals, or the Medicare Appeals Council to reverse D-SNP Contractor's decision under the same timelines applicable to other Medicare Advantage plans as specified in 42 CFR sections 422.618,422.619, and 422.634(d)(3).

4) For Knox-Keene licensed plans, the procedure to promptly implement the decision of an IMR that a disputed health care service is medically necessary in accordance with H&S section 1374.30.

21. Additional Guidance

A. For Marketing materials, D-SNP Contractor must include information about Medi-Cal Dental benefits. Additional details regarding this requirement are fully outlined in the 2026 CalAIM

Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

B. D-SNP Contractor must include information about Medi-Cal Dental benefits in any materials that provide Member information about D-SNP Dental Supplemental Benefits. Additional details regarding this requirement are fully outlined in the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

22. Noncompliance and Enforcement

DHCS may implement enforcement action to address Contractor's performance and compliance issues through monitoring and oversight activities. If DHCS finds the Contractor is noncompliant with any of the obligations set forth in the Contract, the D-SNP Policy Guide, or D-SNP Reporting Requirements, DHCS may require the Contractor to develop and submit a Corrective Action plan response designed to correct or resolve such noncompliance. Corrective Action includes specific identifiable activities or undertakings by the Contractor which address deficiencies or noncompliance. DHCS is not required to impose a Corrective Action plan on Contractor before any of the sanctions set forth in State and federal law. Noncompliance with this Contract may subject the Contractor to discontinuance of new enrollment, or termination of the Contract by DHCS.

GTC 307

Exhibit C
GENERAL TERMS AND CONDITIONS

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

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

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

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

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

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

7. TERMINATION FOR CAUSE: The State may terminate this Agreement and be relieved of any payments should D-SNP Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided.

GTC 307

Exhibit C
GENERAL TERMS AND CONDITIONS

In the event of such termination the State may proceed with the work in any manner deemed proper by the State. All costs to the State shall be deducted from any sum due to D-SNP Contractor under this Agreement and the balance, if any, shall be paid to D-SNP Contractor upon demand.

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

9. RECYCLING CERTIFICATION: D-SNP Contractor shall certify in writing under penalty of perjury, the minimum, if not exact, percentage of post- consumer material as defined in the Public Contract Code Section 12200, in products, materials, goods, or supplies offered or sold to the State regardless of whether the product meets the requirements of Public Contract Code Section 12209. With respect to printer or duplication cartridges that comply with the requirements of Section 12156(e), the certification required by this subdivision shall specify that the cartridges so comply (Public Contract Code Section12205).

10. NON-DISCRIMINATION CLAUSE: During the performance of this Agreement, D-SNP Contractor shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40*),* marital status, and denial of family care leave. D-SNP Contractor shall insure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. D-SNP Contractor shall comply with the provision*s* of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 8101 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 of Title 2 of the California Code of Regulations, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. D-SNP Contractor shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

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

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

GTC 307

Exhibit C
GENERAL TERMS AND CONDITIONS

13. COMPENSATION:
    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

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

15. ANTITRUST CLAIMS:

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

16. CHILD SUPPORT COMPLIANCE ACT:

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

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

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

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

1. Federal Equal Opportunity Requirements

A. D-SNP Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. D-SNP Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. D-SNP Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212). Such notices shall state D-SNP Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

B. D-SNP Contractor will, in all solicitations or advancements for employees placed by or on behalf of D-SNP Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

C. D-SNP Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of D-SNP Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

D. D-SNP Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act

of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

E. D-SNP Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

F. In the event of D-SNP Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this D-SNP Contract may be cancelled, terminated, or suspended in whole or in part and D-SNP Contractor may be declared ineligible for further federal and State contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

G. D-SNP Contractor will include the Provisions of Paragraphs A through G in every purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or

(38 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each vendor. D-SNP Contractor will take such action with respect to any purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event D-SNP Contractor becomes involved in, or is threatened with litigation by a vendor as a result of such direction by DHCS, D-SNP Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

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

3. Procurement Rules

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

4. Equipment Ownership / Inventory / Disposition

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

5. Subcontract Requirements

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

6. Income Restrictions

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

7. Audit and Record Retention

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

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder and the premises in which it is being performed. If any inspection or evaluation is made of the premises of D-SNP Contractor, D-SNP Contractor shall provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be

performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

It is mutually understood between the parties that this D-SNP Contract may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the D-SNP Contract were executed after that determination was made.

10. Intellectual Property Rights

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

11. Air or Water Pollution Requirements

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

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

B. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

12. Prior Approval of Training Seminars, Workshops or Conferences

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

13. Confidentiality of Information

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

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

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

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

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

F. As deemed applicable by DHCS, this Provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this D-SNP Contract or incorporated into this D-SNP Contract by reference.

14. Documents, Publications and Written Reports

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

15. Dispute Resolution Process

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

16. Financial and Compliance Audit Requirements

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

17. Human Subjects Use Requirements

By signing this D-SNP Contract, D-SNP Contractor agrees that if any performance under this D-SNP Contract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such

examinations are performed shall meet the requirements of 42 USC 263a (CLIA) and the regulations thereto.

18. Novation Requirements

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

19. Debarment and Suspension Certification

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

B. By signing this D-SNP Contract, D-SNP Contractor certifies to the best of its knowledge and belief, that it and its principals:

1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

2) Have not within a three-year period preceding this D-SNP Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

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

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

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

6) Will include a clause entitled, “Debarment and Suspension Certification’’ that essentially sets forth the provisions herein, in all

lower tier covered transactions and in all solicitations for lower tier covered transactions.

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

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

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

20. Smoke-Free Workplace Certification

A. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed.

B. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

C. By signing this D-SNP Contract, D-SNP Contractor certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

21. Covenant Against Contingent Fees

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

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

22. Payment Withholds

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

23. Performance Evaluation

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

24. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this D-SNP Contract, or to any benefit that may arise therefrom. This Provision shall not be construed to extend to this D-SNP Contract if made with a corporation for its general benefits.

25. Four-Digit Date Compliance

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

26. Prohibited Use of State Funds for Software

D-SNP Contractor certifies that it has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Contract for the acquisition, operation or maintenance of computer software in violation of copyright laws.

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

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

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

28. Alien Ineligibility Certification

By signing this D-SNP Contract, D-SNP Contractor certifies that he/she is not an alien that is ineligible for State and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 USC 1601, et. seq.)

29. Union Organizing

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

30. Contract Uniformity (Fringe Benefit Allowability)

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

31. Lobbying Restrictions and Disclosure Certification

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

A. Certification and Disclosure Requirements

1) Each person (or recipient) who requests or receives a contract, grant, or sub-grant, which is subject to 31 USC Section 1352, and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1, consisting of one page, entitled “Certification Regarding Lobbying”) that the recipient has not made, and will not make, any payment prohibited by Paragraph B of this provision.

2) Each recipient shall file a disclosure (in the form set forth in Attachment 2, entitled “Standard Form-LLL ‘disclosure of Lobbying Activities’”) if such recipient has made or has agreed to make any payment using non appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

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

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

a) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract, grant or sub-grant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

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

B. Prohibition

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

Exhibit E, Attachment 1
DEFINITIONS

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

1. **Aligned Enrollment** means, per 42 CFR section 422.2, the Enrollment in a D-SNP of a full-benefit Dual-Eligible Beneficiary whose Medi-Cal benefits are covered under a Medi-Cal managed care organization contract under section 1903(m) of the Social Security Act between California and D-SNP Contractor's MA organization, which is the parent organization, or another entity that is owned and controlled by D-SNP Contractor's parent organization.

2. **Applicable Integrated Plan** means, per 42 CFR section 422.561, the Medi-Cal managed care organization through which D-SNP Contractor, its parent organization, or another entity that is owned and controlled by its parent organization, covers Medi-Cal services for Dual-Eligible Beneficiaries enrolled with D-SNP Contractor and such Medi-Cal managed care organization.

3. **Care Coordination or Coordination of Care** means a process used by a person or team to assist Members in accessing Medicare and Medi-Cal Services, as well as social, educational, and other support services, regardless of the funding source for the services. It is characterized by advocacy, communication, and resource management to promote quality, cost effectiveness, and positive outcomes.

4. **Care Coordinator** means a clinician or other trained individual who is employed or contracted by the Member's primary care provider or D-SNP Contractor, serves on one (1) or more Interdisciplinary Care Teams (ICT), and coordinates and facilitates meetings and other activities of those ICTs, as well as participates in the Health Risk Assessment of each Member on whose ICT they serve.

5. **Caregiver** means, per CY 2024 Physician Fee Schedule (Final Rule), an adult family member or other individual who has significant relationship with, and who provides a broad range of assistance to a Member with a chronic or other health condition, disability, or functional limitation, and a family member, friend or neighbor who provides unpaid assistance to a Member with a chronic illness or disabling condition.

6. **Centers for Medicare & Medicaid Services (CMS)** means the federal agency responsible for management of the Medicare and Medicaid programs.

Exhibit E, Attachment 1
DEFINITIONS

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

8. **Covered Service(s)** means Care Coordination or Coordination of Care. This is the only service covered under this Contract.

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

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

11. **Dementia Care Specialists** means D-SNP care coordinators/managers trained in understanding Alzheimer's disease and related dementias, symptoms, and progression; understanding and managing behaviors and communication problems; understanding caregiver stress and its management; and connecting enrollees and caregivers to community resources.

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

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

14. **Dual-Eligible Beneficiary (or Enrollee)** means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and Part B of Title 42 of the United States Code (commencing with Section 1395j) and is also eligible for medical assistance under the Medi-Cal State Plan. This Contract is only for full-benefit Dual-Eligible Beneficiaries (QMB+, SLMB+, and other full-benefit Dual-Eligible Beneficiaries).

15. **Enrollment** means the process by which a beneficiary eligible for enrollment, as contained in Exhibit A, Attachment 1, Provision 8, and becomes a Member of the D-SNP Contractor’s D-SNP.

16. **Exclusively Aligned Enrollment** means that State Policy has limited a D-SNP’s membership to individuals with Aligned

Exhibit E, Attachment 1
DEFINITIONS

Enrollment.

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

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

B. Maintained by a provider to provide services on behalf of D-SNP Contractor.

18. **Grievance** means any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of D-SNP Contractor's or provider's operations, activities, or behavior, regardless of whether remedial action is requested.

19. **Integrated Appeal** means any of the procedures that deal with, or result from, adverse integrated organization determinations by D-SNP Contractor on the health care services the Member believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care services such that a delay would adversely affect the health of the Member, or on any amounts the Member must pay for a service. An Integrated Appeal is made by a Member in an Applicable Integrated Plan and is subject to the Integrated Reconsiderations procedures in 42 CFR sections 422.629, 422.633, and 422.634.

20. **Integrated Grievance** means a dispute or complaint that would be defined and covered, for Grievances filed by a Member in a non-applicable integrated plan, under 42 CFR section 422.564 or 42 CFR sections 438.400 through 438.416. Integrated Grievances do not include Appeals procedures and QIO complaints, as described in 42 CFR section 422.564(b) and (c). An Integrated Grievance made a Member in an Applicable Integrated Plan is subject to the Integrated Grievance procedures in 42 CFR sections 422.629 and 422.630.

21. **Integrated Organization Determination** means an organization determination that would otherwise be defined and covered, for a non-Applicable Integrated Plan, as an organization determination under 42 CFR section 422.566, an adverse benefit determination under 42 CFR section 438.400(b), or an action under 42 CFR 431.201. An Integrated Organization Determination is made by a Member in an Applicable Integrated Plan and is subject to the Integrated Organization

Exhibit E, Attachment 1
DEFINITIONS

Determination procedures in 42 CFR sections 422.629, 422.631, and 422.634.

22. **Medi-Cal Managed Care Health Plan (MCP)** means a managed care health plan that contracts with DHCS for provision or arrangement of Medi-Cal benefits and services. For the purposes of this Contract, this includes Subcontracted Delegate Health Plans. A Subcontracted Delegate Health Plan is a health care service plan that is a subcontractor of a MCP that DHCS determines to have assumed the entire financial risk for all Medi-Cal Services provided to a Dual-Eligible Beneficiary that are covered under the applicable comprehensive risk contract of the MCP.

23. **Medi-Cal Fee-For-Service (FFS)** means the Med-Cal delivery system in which providers submit claims to and receive payments from DHCS for services covered under Medi-Cal and rendered to Medi-Cal recipients.

24. **Medi-Cal Services** means all services covered by the Medi-Cal program as identified in Exhibit H, which is attached to this Contract.

25. **Medically Necessary or Medical Necessity** means reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and Title 22 CCR section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

26. **Member** means any Dual-Eligible Beneficiary who is enrolled in with D-SNP Contractor.

27. **Service Area** means the county or counties that D-SNP Contractor is approved to operate in under the terms of this D-SNP Contract. A Service Area may have designated zip codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of this D-SNP Contract.

28. **State** means the State of California.

29. **Supplemental Benefits** means all of the following under Medicare Advantage definitions: Initial and Expansion Primarily Health Related Supplemental Benefits, Special Supplemental Benefits for the Chronically Ill, and Value Based-Insurance Design Model benefits.

Exhibit E, Attachment 1
DEFINITIONS

30. **Subcontracted Delegate Health Plan** means a health care service plan that is a subcontractor of a Medi-Cal MCP that DHCS determines to have assumed the entire financial risk for all Medi-Cal Services provided to a Member that is covered under the applicable comprehensive risk contract of the MCP.

31. **Working day(s)** mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

1. Governing Law

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

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

Any provision of this D-SNP Contract which is in conflict with current or future applicable federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the D-SNP Contract will be effective on the effective date of the statutes or regulations necessitating it and binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

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

C. All existing policy guidance issued by DHCS, including the D-SNP Policy Guide, can be viewed at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx and shall be complied with by D-SNP Contractor. All policy guidance issued by DHCS subsequent to the effective date of this D-SNP Contract must provide clarification of D-SNP Contractor's obligations pursuant to this D-SNP Contract, and may include instructions to D-

SNP Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial interpretation. In the event DHCS determines that there is an inconsistency between this D-SNP Contract and DHCS policy guidance, the D-SNP Contract shall prevail.

2. Entire Agreement

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

3. Amendment Process

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

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

4. Change Requirements

A. General Provisions

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

B. D-SNP Contractor's Obligation to Implement

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

5. Delegation of Authority

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

D-SNP Contractor will designate a single administrator; hereafter called the "Contractor's Representative." The Contractor's Representative, on behalf of the D-SNP Contractor, will make all determinations and take all actions as are appropriate to implement this D-SNP Contract, subject to the limitations of the D-SNP Contract, Federal and State laws and regulations. The Contractor's Representative may delegate their authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative will be empowered to legally bind the D-SNP Contractor to all agreements reached with DHCS. D-SNP Contractor shall designate Contractor’s Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Attachment 2, Provision 13, Notices.

6. Authority of the State

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

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

7. Fulfillment of Obligations

No covenant, condition, duty, obligation, or undertaking continued or made a part of this D-SNP Contract will be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this D-SNP Contract, or under law, notwithstanding such forbearance or indulgence.

8. Prohibition Against Novations

D-SNP Contractor must not enter any novation agreements without prior discussion with DHCS.

9. Obtaining DHCS Approval

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

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

B. Within 60 calendar days of receipt, DHCS must make all reasonable efforts to approve in writing the use of such material provided to DHCS pursuant to this Provision to provide D-SNP Contractor with a written explanation why its use is not approved or provide a written estimated date of completion of DHCS' review process. If DHCS does not complete its review of submitted material within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, D-SNP Contractor may elect to implement or use

the material at D-SNP Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Provision must not be construed to imply DHCS approval of any material that has not received written DHCS approval.

10. Program

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

11. Certifications

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

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

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

12. Notices

All notices to be given under this D-SNP Contract will be in writing and will be deemed given when sent via certified mail or electronic mail (email). DHCS and D-SNP Contractor will designate email addresses for notices sent via email. Notices sent via certified mail must be addressed to the following DHCS and D-SNP Contractor contacts:

California Department of Health Care Services Managed Care Operations Division Attn: Michelle Retke, Division Chief MS 4408 P.O. Box 997413 Sacramento, CA 95899-7413	Local Initiative Health Authority for LA County Attn: Martha Santana-Chin, CEO 1200 West 7th Street Los Angeles, CA 90017

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

13. Term

The D-SNP Contract is effective January 1, 2026, and continues in full force and effect through December 31, 2026.

14. Service Area

The Service Area covered under this D-SNP Contract is stated in Exhibit A, Provision 8, Coverage Area and Eligible Beneficiaries. All D-SNP Contract provisions apply separately to each county within the Service Area.

15. D-SNP Contract Extension

DHCS has the exclusive option to extend the term of this D-SNP Contract for any reason, in any county within the Service Area, with at least nine (9) months' written notice to D-SNP Contractor before the end of the D-SNP Contract term.

16. Termination for Cause and Other Terminations

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

A. DHCS-Initiated Terminations

1) DHCS will terminate this D-SNP Contract in the event that the Director determines that the health and welfare of Members is jeopardized by the continuation of the D-SNP Contract. Termination pursuant to the requirements in this Provision's Paragraph A.1) will be effective immediately upon the provision of written notice provided by DHCS to D-SNP Contractor.

2) Termination for Cause

a) DHCS may terminate this D-SNP Contract should D-SNP Contractor fail to perform the requirements of this Contract. In the event of such termination, DHCS may proceed with providing the services required under this D-SNP Contract in any manner deemed proper by DHCS.

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

c) Should DHCS terminate this D-SNP Contract for cause under this Provision's Paragraph A.2) of this D-SNP Contract, DHCS will provide D-SNP Contractor with at least 60 calendar days' notice prior to the effective date of termination, unless potential beneficiary harm requires a shorter notice period. D-SNP Contractor agrees that this notice provision is reasonable.

d) DHCS must terminate this D-SNP Contract under this Provision and pursuant to the provisions of Welfare and Institutions Code, Section 14197.7, and California Code of Regulations, Title 22, Section 53873.

B. D-SNP Contractor-Initiated Terminations

D-SNP Contractor may only terminate this D-SNP Contract when a change in contractual obligations is created by a State or federal change in the Medi-Cal program, or a lawsuit, that substantially alters the conditions under which the D-SNP Contractor entered into this D-SNP Contract, such that the D-SNP Contractor can demonstrate this to the satisfaction of DHCS.

C. Termination of Obligations

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

17. Disputes

D-SNP Contractor must comply with and exhaust the requirements of this Provision when it initiates a contract dispute with DHCS. This Provision (Disputes) does not apply to challenges to Corrective Action plans as described in Exhibit A, Provision 22, or any other contract compliance action initiated by DHCS. In addition to Exhibit C, Provision 6, Disputes, D-SNP Contractor also agrees to the following:

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

A. Disputes Resolution by Negotiation

D-SNP Contractor agrees to make best efforts to resolve all contractual issues by negotiation and mutual agreement at the DHCS Contracting Officer level before appealing to the DHCS Office of Administrative Hearings and Appeals (OAHA). D-SNP Contractor must exhaust OAHA's appeal process before filing a writ in Sacramento County Superior Court. During the negotiations to resolve Contractor's issues, DHCS and Contractor may agree, in writing, to an extension of time for continuing negotiations to resolve Contractor's dispute before the decision of the DHCS Contracting Officer is issued.

B. Notice of Dispute

1) Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to D-SNP Contractor, D-SNP Contractor must serve a written Notice of Dispute to the DHCS' Contracting Officer. D-SNP Contractor's failure to serve its Notice of Dispute within 30 calendar days from the date the alleged dispute arises or otherwise becomes known to D-SNP Contractor constitutes a waiver of all issues raised in D-SNP Contractor's Notice of Dispute.

2) The D-SNP Contractor's Notice of Dispute must include, based on the most accurate and substantiating information then available to the D-SNP Contractor, the following:

a) That it is a dispute subject to the procedures set forth in this Provision.

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

c) The names, phone numbers, functions, and conduct of each D-SNP Contractor, DHCS/State official or employee involved in or knowledgeable about the alleged issue that is the subject of the dispute.

d) The identification of any substantiating documents and the substances of any oral communications

that are relevant to the alleged conduct. Copies of all identified documents will be attached.

e) Copies of all substantiating documentation and any other evidence.

f) The factual and legal bases supporting Contractor's Notice of Dispute.

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

h) D-SNP Contractor's desired remedy.

3) The required documentation set forth above, in this Provision's Paragraph B.2), will serve as the basis for any subsequent appeal.

4) After D-SNP Contractor submits its Notice of Dispute with all accurate available substantiating documentation, D-SNP Contractor must comply with the requirements of Title 22, CCR, Section 53851(d) and must diligently continue performance of this D-SNP Contract, including compliance with contract requirements that are the subject of, or related to, D-SNP Contractor's Notice of Dispute.

5) If D-SNP Contractor requests and DHCS agrees, D-SNP Contractor's Notice of Dispute may be decided by an Alternate Dispute Officer (ADO). DHCS will designate an ADO who was not directly involved in the alleged conduct that prompted D-SNP Contractor's Notice of Dispute.

6) Any appeal of the DHCS Contracting Officer or ADO's decision to OAHA or a writ seeking review of OAHA's decision in Sacramento County Superior Court shall be limited to the issues and arguments set forth and properly documented in D-SNP Contractor's Notice of Dispute, that were not waived or resolved.

C. The DHCS Contracting Officer's or ADO's Decision

Any disputes concerning performance of this D-SNP Contract will be decided by the DHCS Contracting Officer or the ADO in a written decision stating the factual basis for the decision. Within 30 calendar

days of receipt of a Notice of Dispute, the Contracting Officer or the ADO shall either:

1) Find in favor of D-SNP Contractor, in which case the DHCS Contracting Officer or ADO may correct the earlier conduct which caused D-SNP Contractor to file a dispute; or

2) Deny D-SNP Contractor's dispute and, where necessary, direct the manner of future performance; or

3) Request additional substantiating documentation in the event the information in D-SNP Contractor's notification is inadequate to permit a decision to be made under Paragraphs B.2) or C.1) above. If the DHCS Contracting Officer or ADO determines that additional substantiating information is required, they will provide D-SNP Contractor with a written request identifying the issue(s) requiring additional substantiating documentation. D-SNP Contractor must provide that additional substantiating documentation no later than 30 calendar days from receipt of the request. Upon receipt of this additional requested substantiating information, the DHCS Contracting Officer or ADO shall have 30 calendar days to issue a decision. Failure to supply additional substantiating information requested by the DHCS Contracting Officer or ADO, or otherwise notify the DHCS Contracting Officer or ADO that no additional documents exist, within the time period specified above shall constitutes D-SNP Contractor’s waiver of issues raised in D-SNP Contractor’s Notice of Dispute.

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

D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

1) D-SNP Contractor will have 30 calendar days following the receipt of the DHCS Contracting Officer or ADO’s decision to appeal the decision to the Director, through the OAHA. All of D-SNP Contractor’s appeals are governed by Health and Safety Code, section 100171, except Government Code section 11511 will not apply.

2) All of D-SNP Contractor’s appeals must be in writing and be filed with the OAHA and a copy sent to the Chief Counsel of DHCS and the DHCS Contract Manager. D-SNP Contactor’s

appeal shall be deemed filed on the date it is received by the OAHA. D-SNP Contractor's appeal will be known as Statement of Disputed Issues and must specifically set forth the unresolved issue(s) that remain in dispute and issues that have not been waived because of D-SNP Contractor's failure to provide all substantiating documentation to DHCS, as specified in Paragraph C of this Provision, and include D-SNP Contractor's contentions as to those issues. Additionally, D- SNP Contractor's appeal will be limited to those issues raised in its Notice of Dispute filed pursuant to Paragraph B, Notification of Dispute that have not been resolved or waived.

3) D-SNP Contractor has the burden of proof of demonstrating that its position is correct and must show by a preponderance of evidence that:

   a) DHCS acted improperly such that it breached this Contract; and

   b) D-SNP Contractor sustained a cost impact directly related to DHCS' breach.

4) OAHA's jurisdiction is limited to issues and arguments raised in the Notice of Dispute that were not waived by the untimely filing of the Notice of Dispute or Statement of Disputed Issues, by D-SNP's Contractor's failure to provide all requested substantiating documentation requested by the DHCS Contracting Officer or ADO, or by D-SNP's Contractor failure to notify the DHCS Contracting Officer or ADO that no additional documents exist within the required timeframe as required in Paragraph C(3), or otherwise resolved by D-SNP Contractor and DHCS.

E. No Obligation to Pay Interest

If D-SNP Contractor prevails on its Notice of Dispute pursuant to a DHCS Contracting Officer's or ADO's decision, an OAHA decision, or an order or decision issued by the Sacramento County Superior Court or any California court of appeal, DHCS will not be required to pay interest on any amounts found to be due or owing to D-SNP Contractor arising out of the Notice of Dispute or any subsequent litigation.

F. D-SNP Contractor Duty to Perform

D-SNP Contractor must comply with all requirements of 22 CCR section 53851(d) and continue to perform all obligations under this D-SNP Contract, including continuing D-SNP Contract requirements that are the subject of, or related to, D-SNP Contractor's Notice of Dispute until there is a final decision from the DHCS Contracting Officer, the ADO or a decision on an appeal in Sacramento County Superior Court or any California Court of Appeal or the California Supreme Court.

G. Waiver of Claims

D-SNP Contractor waives all claims or issues if it fails to timely submit a Notice of Dispute with all substantiating documents within the timeframes set forth in Paragraph B of this Provision. D-SNP Contractor also waives all claims or issues set forth in its Notice of Dispute if it fails to timely submit all additional substantiating documentation within 30 calendar days at the DHCS Contracting Officer or ADO's request, or if it fails to notify the DHCS Contracting Officer or ADO, within 30 calendar days of DHCS Contracting Officer's or ADO's request, that no additional documents exist. D-SNP Contractor also waives all claims or issues set forth in its Notice of Dispute if it fails to timely appeal the DHCS Contracting Officer or ADO's decision in the manner and within the time specified in this Provision 18. D-SNP Contractor's waiver includes all damages whether direct or consequential in nature.

18. Audit

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

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

A. Books and Records

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

B. Records Retention

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

19. Inspection Rights

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

A. Through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, D-SNP Contractor must allow the DHCS, DHHS, the Comptroller General of the United States, DOJ Bureau of Medi-Cal Fraud, Department of Managed Health Care (DMHC), and other authorized State agencies, or their duly authorized representatives, including DHCS' external quality review organization contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this D-SNP Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, contracts, computers, or other electronic systems and facilities maintained by D-SNP Contractor pertaining to these services at any time during normal business hours. Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, and books of account, medical records, prescription files, laboratory results,

information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, D-SNP Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at D-SNP Contractor's sole expense.

B. Access Requirements and State's Right to Monitor

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

20. Confidentiality of Information

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

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

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

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

Contractor, the D-SNP Contractor:

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

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

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

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

21. Third-Party Tort and Workers' Compensation Liability

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

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

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

1) Member name.

2) Full 14-digit Medi-Cal number.

3) Social Security Number.

4) Date of birth.

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

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

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

D. If D-SNP Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of referrals, D-SNP Contractor must refer the request to the Third Party Liability and Recovery Division with the information contained in Paragraph B above, and provide the name, address and telephone number of the requesting party.

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

22. Records Related To Recovery for Litigation

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

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

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

privilege; and

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

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

23. Equal Opportunity Employer

D-SNP Contractor must comply with all applicable federal and State employment discrimination laws. D-SNP Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the D-SNP Contractor, state that it is an equal opportunity employer, and will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by DHCS, advising the labor union or workers' representative of the D-SNP Contractor's commitment as an equal opportunity employer and will post copies of the notice in conspicuous places available to employees and applicants for employment.

24. Discrimination Prohibitions

A. Member Discrimination Prohibition

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

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

1) Denying any Member case any Covered Services;

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

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

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

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

6) Failing to make Auxiliary Aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability;

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

8) D-SNP Contractor must take affirmative action to ensure that Members are provided Covered Services without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, except as needed to provide equal

access to Limited English Proficient (LEP) Members or Members with disabilities, or as medically indicated.

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

B. Discrimination Related to Health Status

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

25. Federal and State Nondiscrimination Requirements

D-SNP Contractor must comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; Titles I and II of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations issued under the above-listed statutes. D-SNP Contractor shall also comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, Sections 7405 and 11135 of the Government Code, Section 14029.91 of the Welfare and Institutions Code, and state implementing regulations.

26. Discrimination Grievances

D-SNP Contractor must process a grievance for discrimination as required by APL 25-005, and in accordance with federal and State nondiscrimination law as stated in 45 CFR section 84.7; 34 CFR section 106.8; 28 CFR section 35.107; and W&I Code section 14029.91(e)(4).

A. D-SNP Contractor must designate a discrimination grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements, and investigating

discrimination grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law.

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

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

1) The original discrimination grievance;

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

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

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

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

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

27. Nondiscrimination Notice and Notice of Availability

A. D-SNP Contractor must post (1) a DHCS-approved nondiscrimination notice, and (2) Notice of Availability in a conspicuously visible font size in English, the threshold languages, and at least the top 15 non-English languages in the State, and any other languages, as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and Notice of Availability shall include D-SNP Contractor's toll-free and TTY/TDD telephone number for obtaining these services, and shall be posted in the Member Services Guide/Evidence of Coverage, and in all Member information, informational notices, and materials critical to obtaining services targeted to Members, potential Members, applicants, and members of the public, in accordance with APL 25-005 and APL 22-002, 42 CFR section 438.10(d)(2)-(3), Section 1557 of the Affordable Care Act, and W&I Code section 14029.91(f) and 14029.92(c).

B. D-SNP Contractor's nondiscrimination notice must include all information required by W&I Code section 14029.91(e) and APL 25-005, any additional information required by DHCS, and must provide information on how to file a discrimination grievance with:

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

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

28. Small Business Participation and Disabled Veteran Business Enterprises (DVBE) Reporting Requirements

A. D-SNP Contractor must comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Public Contract Code section 10230.

B. If for this D-SNP Contract, D-SNP Contractor made a commitment to achieve small business participation, then D-SNP Contractor must annually and within 60 calendar days of receiving final payment under this D-SNP Contract report to DHCS the actual percentage of small business participation that was achieved per Government Code section 14841.

C. If for this D-SNP Contract, D-SNP Contractor made a commitment to achieve DVBE participation, then D-SNP Contractor must annually and within 60 calendar days of receiving final payment under this D-SNP Contract certify in a report to DHCS the following:

1) The total amount Contractor received under the Contract;

2) The name and address of the DVBE(s) that participated in the performance of the Contract;

3) The amount each DVBE received from Contractor;

4) That all payments under the Contract have been made to the DVBE; and

5) The actual percentage of DVBE participation that was achieved, per Mil. & Vets. Code section 999.5(d), and Government Code section 14841.

29. Word Usage

Unless the context of this D-SNP Contract clearly requires otherwise, (a) the plural and singular numbers is deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

30. Federal False Claims Act Compliance

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

employee handbook excerpts.

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)

2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.

4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. D-SNP Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA if done by DHCS.

   7.1 Specific Use and Disclosure Provisions. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

8. **Compliance with Other Applicable Law**

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

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

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

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

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

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

9. Additional Responsibilities of Business Associate

9.1 Nondisclosure. Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security.

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

9.2.2 Business Associate shall, at a minimum, utilize an industry-recognized security framework when selecting and implementing its security controls, and shall maintain continuous compliance with its selected framework as it may be updated from time to time. Examples of industry-recognized security frameworks include but are not limited to

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

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

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

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

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

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

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

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

9.3 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

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

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

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

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

the requirements of the subpart that apply to DHCS in the performance of such obligation.

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

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

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

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

18.1 Notice to DHCS.

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

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

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

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential data affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

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

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

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

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

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

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

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

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

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

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its subcontractors, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, D-SNP Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

DHCS Program Contract Manager	DHCS Privacy Office	DHCS Information Security Office
See the Scope of Work Exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

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

21. Termination

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

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

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

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

22. Miscellaneous Provisions

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

22.2. Amendment.

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

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

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

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

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

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

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

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

January 1, 2022 – December 31, 2026[i]
Updated May 22, 2024

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Acupuncture Services	Other Practitioners' Services and Acupuncture Services	Acupuncture services are limited to treatment performed to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.	**X**	
Audiological Services	Audiology Services	Audiological services are covered when provided by persons who meet the appropriate requirements	**X**	
Behavioral Health Treatment (BHT)	Preventive Services - EPSDT	The provision of medically necessary BHT services to eligible Medi-Cal members under 21 years of age as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate and state plan.	**X**[ii]	
Blood and Blood Derivatives	Blood and Blood Derivatives	A facility that collects, stores, and distributes human blood and blood derivatives. Covers certification of blood ordered by a physician or facility where transfusion is given.	**X**	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
California Children Services (CCS)	EPSDT	California Children Services (CCS) are services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.	X[iii]	
Certified Family Nurse Practitioner	Certified Family Nurse Practitioners' Services	A certified family nurse practitioner who provides services within the scope of their practice.	X	
Certified Pediatric Nurse Practitioner Services	Certified Pediatric Nurse Practitioner Services	Covers the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks; can also include primary care services.	X	
Childhood Lead Poisoning Case Management (Provided by the Local County Health Departments)	EPSDT	A case of childhood lead poisoning (for purposes of initiating case management) as a child from birth up to 21 years of age with one venous blood lead level (BLL) equal to or greater than 15 µg/dL, or two BLLs equal to or greater than 10 µg/dL that must be at least 30 and no more than 600 calendar days apart, the first specimen is not required to be venous, but the second must be venous.		X

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Chiropractic Services	Chiropractors' Services	Services provided by chiropractors, acting within the scope of their practice as authorized by California law, are covered, except that such services are limited to treatment of the spine by means of manual manipulation.	X[iv]	
Chronic Hemodialysis	Chronic Hemodialysis	Procedure used to treat kidney failure - covered only as an outpatient service. Blood is removed from the body through a vein and circulated through a machine that filters the waste products and excess fluids from the blood. The “cleaned” blood is then returned to the body. Chronic means this procedure is performed on a regular basis. Prior authorization required when provided by renal dialysis centers or community hemodialysis units.	X	
Community Based Adult Services (CBAS)		CBAS Bundled services: An outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to eligible Medi-Cal beneficiaries. CBAS Unbundled Services: Component parts of CBAS center services delivered outside of centers, under certain conditions.	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Community Health Workers	Preventive Services	Preventive services by unlicensed community health workers, promotores, and community health representatives to prevent disease, disability, and other health conditions or their progression.	X[v]	
Comprehensive Perinatal Services	Extended Services for Pregnant Women-Pregnancy Related and Postpartum Services	Obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided during pregnancy and up to 12 months following the last day of pregnancy.	X	
Dental Services (Covered under Medi-Cal)		Professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws, and associated structures; the use of drugs administered in-office, anesthetics, and physical evaluation; consultations; home, office, and institutional calls.	X[vi]	
Dyadic Services		Integrated physical and behavioral health screening and services for child, caregiver, and family.	X[5]	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Doula Services		Personal support by unlicensed providers to pregnant beneficiaries and their families throughout pregnancy, labor, and in the post-partum period.	X[5]	
Durable Medical Equipment	DME	Assistive medical devices and supplies. Covered with a prescription; prior authorization is required.	X	
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	EPSDT	Medicaid program's benefit for children and adolescents, providing a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children, and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act.	X	
Erectile and/or Sexual Dysfunction Drugs		Drugs for which the only FDA-approved indication is the treatment of sexual dysfunction or erectile dysfunction are not a benefit of the program. Drugs that are FDA-approved for the treatment of sexual dysfunction or erectile dysfunction in addition to one or more other indications, are a benefit only if the drug has is used for a FDA-approved indication outside of the treatment of sexual dysfunction or erectile dysfunction.		X

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Expanded Alpha-Fetoprotein Testing (Administered by Genetic Disease Branch of CDPH)		A simple blood test recommended for all pregnant women to detect if they are carrying a fetus with certain genetic abnormalities such as open neural tube defects, Down Syndrome, chromosomal abnormalities, and defects in the abdominal wall of the fetus.		X
Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances	Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes, and Other Eye Appliances	Eye appliances are covered on the valid prescription of a physician or optometrist.	X[vii]	
Federally Qualified Health Centers (FQHC) (Medi-Cal covered services only)	FQHC	Services described in 42 U.S.C. Section 1396d(a)(2)(C) furnished by an entity defined in 42 U.S.C. Section 1396d(l)(2)(B)).	X	
Hearing Aids	Hearing Aids	Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation including a hearing aid evaluation which must be	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		performed by or under the supervision of the above physician or by a licensed audiologist.		
1915(c) Home and Community- Based Waiver Services (Does not include EPSDT Services)		Provided and reimbursed as Medi-Cal covered benefits only: (1) For the duration of the applicable federally approved waiver, (2) To the extent the services are set forth in the applicable waiver approved by the HHS; and (3) To the extent the Department can claim and be reimbursed federal funds for these services.		X
Home Health Agency Services	Home Health Services- Home Health Agency	Covered as specified below when prescribed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and provided at the home of the beneficiary in accordance with a written treatment plan which the physician reviews every 60 days.	X	
Home Health Aide Services	Home Health Services- Home Health Aide	Covers skilled nursing or other professional services in the residence including part-time and intermittent skilled nursing services, home health aide services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Home Health Pharmacy Services-Total Parenteral and Enteral Nutrition under Medi-Cal Rx.	Home Health	Nutritional products medically necessary because of chronic illness or trauma for patients who cannot be sustained through oral feeding and when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food that are billed by a pharmacy on a pharmacy claim, including formula, pumps, tubing, and general sub-categories, as described in the Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).		X
Home Health Other Pharmacy Services-Total Parenteral and Enteral Nutrition	Home Health	Nutritional products medically necessary because of chronic illness or trauma for patients who cannot be sustained through oral feeding and when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food that are billed on medical and institutional claims as described in the Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL2	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		0-020.pdf).		
Hospice Care	Hospice Care	Covers services limited to individuals who have been certified as terminally ill in accordance with Title 42, CFR Part 418, Subpart B, and who directly or through their representative volunteer to receive such benefits in lieu of other care as specified.	X	
Hospital Outpatient Department Services and Organized Outpatient Clinic Services	Clinic Services and Hospital Outpatient Department Services and Organized Outpatient Clinic Services	A scheduled administrative arrangement enabling outpatients to receive the attention of a healthcare provider. Provides the opportunity for consultation, investigation, and minor treatment.	X	
Human Immunodeficiency Virus and AIDS drugs		Human Immunodeficiency Virus and AIDS drugs that are listed in the Medi-Cal Provider Manual		X

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Hysterectomy	Inpatient Hospital Services	Except for previously sterile women, a nonemergency hysterectomy may be covered only if: (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile, (2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and (3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.	X	
Indian Health Services (Medi- Cal covered services only)		Indian means any person who is eligible under federal law and regulations (25 U.S.C. Sections 1603c, 1679b, and 1680c) and covers health services provided directly by the United States Department of Health and Human Services,	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.		
Inpatient Hospital Services	Inpatient Hospital Services	Covers delivery services and hospitalization for newborns; emergency services without prior authorization; and any hospitalization deemed medically necessary with prior authorization.	X	
Laboratory, Radiological and Radioisotope Services	Laboratory, X-Ray and Laboratory, Radiological and Radioisotope Services	Covers exams, tests, and therapeutic services ordered by a licensed practitioner.	X[viii]	
Licensed Midwife Services	Other Practitioners' Services and Licensed Midwife Services	When provided by a licensed midwife, the following are covered Medi-Cal services: (1) Attendance at cases of normal childbirth and (2) The provision of prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn.	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Local Educational Agency (LEA) Services	Local Education Agency Medi-Cal Billing Option Program Services	LEA health and mental health evaluation and health and mental health education services, which include any or all of the following: (A) Nutritional assessment and nutrition education, consisting of assessments and non-classroom nutrition education delivered to the LEA eligible beneficiary based on the outcome of the nutritional health assessment (diet, feeding, laboratory values, and growth), (B) Vision assessment, consisting of examination of visual acuity at the far point conducted by means of the Snellen Test, (C) Hearing assessment, consisting of testing for auditory impairment using at-risk criteria and appropriate screening techniques as defined in Title 17, California Code of Regulations, Sections 2951(c), (D) Developmental assessment, consisting of examination of the developmental level by review of developmental achievement in comparison with expected norms for age and background, (E) Assessment of psychosocial status, consisting of appraisal of cognitive, emotional, social, and behavioral functioning and self-concept through tests, interviews, and behavioral evaluations and (F) Health education and anticipatory guidance		**X**

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		appropriate to age and health status, consisting of non- classroom health education and anticipatory guidance based on age and developmentally appropriate health education.		
Long Term Care (LTC) Facility Services		Medically necessary care in a LTC facility or setting, including the following: • Skilled Nursing Facility (SNF), including a distinct part or unit of a hospital; • Intermediate Care Facility (ICF); • Intermediate Care Facility for Developmentally Disabled (ICF/DD); • Intermediate Care Facility for Developmentally Disabled with Habilitative (ICF/DDH); • Intermediate Care Facility for Developmentally Disabled with Nursing (ICF/DDN); • Subacute facility; • Pediatric Subacute Facility.	*Prior to 1/1/2023:* **X**[ix,x,xi] *After 1/1/2023 for SNF (in all counties):* **X** *After 1/1/2024 for ICF/DD, ICF/DDH, ICF/DDN, Subacute, and Pediatric Subacute*: **X**	**X**[15]
Medi-Cal Substance Abuse Services	Substance Abuse Treatment Services	Medically necessary substance abuse treatment to eligible beneficiaries includes: counseling services and behavioral therapy related to the drugs and biologicals covered under the		**X**

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		SUPPORT Act.		
Medical Supplies	Medical Supplies	Supplies are medically necessary when prescribed by a licensed practitioner. Does not include medical supplies carved-out to Medi-Cal Rx that are billed by a pharmacy on a pharmacy claim including medical supplies described in the Medi-Cal Rx All Plan Letter (ALP 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).	**X**	
Medical & Non-Medical (NMT) Transportation Services	Transportation - Medical & Non-Medical Transportation (NMT) Services	Covers ambulance, litter van and wheelchair van medical transportation services when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care. NMT is transportation by private or public vehicle for beneficiaries who do not have another way to get to their appointment.	**X**	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Nurse Anesthetist Services	Other Practitioners' Services and Nurse Anesthetist Services	Covers anesthesiology services performed by a nurse anesthetist within the scope of his or her licensure.	X	
Nurse Midwife Services	Nurse-Midwife Services	An advanced practice registered nurse who has specialized education and training in both Nursing and Midwifery, is trained in obstetrics, and provides care for mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks.	X	
Optometry Services	Optometrists' Services	Covers eye examinations and prescriptions for corrective lenses.	X	
Organ and Bone Marrow Transplant Surgeries	Transplant	Medically necessary donor and recipient organ and bone marrow transplant surgeries for adult and pediatric transplant recipients and donors, including related services such as organ procurement and living donor care.	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Outpatient Mental Health	Outpatient Mental Health	Services provided by licensed health care professionals acting within the scope of their license for adults and children diagnosed with a mental condition as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Services include: • Preventive mental health services for potential mental health disorders not yet diagnosed • Behavioral health screenings and interventions • Mental health evaluation and treatment, including individual, group and family psychotherapy • Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition. • Outpatient services for purposes of monitoring drug therapy • Psychiatric consultation • Outpatient laboratory, drugs, supplies and supplements	X[xii]	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		• Mental health services for beneficiaries 21 years and over with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders • Mental health services for beneficiaries under age 21 regardless of level of distress or impairment or the presence of a diagnosis, unless the recipient meets the criteria for Specialty Mental Health Services		
Organized Outpatient Clinic Services	Clinic Services and Organized Outpatient Clinic Services	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in- home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	**X**	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Outpatient Heroin Detoxification Services	Outpatient Heroin Detoxification Services	Can cover various medications and treatments, allowing for day-to-day functionality for a person choosing to not admit as an inpatient. Routine elective heroin detoxification services are covered, subject to prior authorization, only as an outpatient service. Outpatient services are limited to a maximum period of 21 days. Inpatient hospital services shall be limited to patients with serious medical complications of addiction or to patients with associated medical problems which require inpatient treatment.		X
Part D Drugs		Drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act.		X
Personal Care Services	Personal Care Services	Services for categorically needy beneficiaries with a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services. Benefit known as In Home Supportive Services (IHSS).	X[14]	X[14]

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Pharmaceutical Services and Prescribed Drugs under Medi-Cal Rx	Pharmaceutical Services and Prescribed Drugs	Pharmacy benefits carved-out to Medi-Cal Rx, which are pharmacy benefits that are billed by a pharmacy on a pharmacy claim, including covered outpatient drugs and physician administered drugs, as described in the Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).		X
Other Pharmaceutical Services and Prescribed Drugs	Pharmaceutical Services and Prescribed Drugs	Covers Pharmacy benefits that are billed on medical and institutional claims, including physician administered drugs, other outpatient drugs, legend, non-legend and specialty drugs that are not carved-out to Medi-Cal Rx as discussed above, and further described in Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).	X	
Pharmacist Services	Pharmacist Services	Pharmacists in a community pharmacy setting furnishing specified categories of drugs (furnishing of naloxone, self-administered hormonal contraceptives, nicotine replacement therapy, HIV pre-exposure and post-exposure prophylaxis, and initiating and administrating	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		immunizations).		
Physician Services	Physician Services	Covers primary care, outpatient services, and services rendered during a stay in a hospital or nursing facility for medically necessary services. Can cover limited mental health services when rendered by a physician, and limited allergy treatments.	X	
Podiatry Services	Other Practitioners' Services and Podiatrists' Services	Medically necessary Office visits are covered. All other outpatient services are subject to the same prior authorization procedures that govern physicians, and are limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk. Services rendered on an emergency basis are exempt from prior authorization.	X	
Preventive Services	Preventive Services	All preventive services articulated in the state plan.	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Prosthetic and Orthotic Appliances	Prosthetic and Orthotic Appliances	All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts as prescribed by a licensed physician, podiatrist or dentist, within the scope of their license, are covered when provided by a prosthetist, orthotist or the licensed practitioner, respectively	**X**	
Physical Therapy and Occupational Therapy	Physical Therapy and Occupational Therapy	Physical therapy and occupational therapy are covered when provided by persons who meet the appropriate requirements	**X**	
Private Duty Nursing	EPSDT	Private duty nursing is the planning of care and care of clients by nurses, whether a registered nurse or licensed practical nurse for individuals under 21 years of age.	**X**[2]	
Rehabilitation Center Outpatient Services	Rehabilitative Services	A facility providing therapy and training for rehabilitation on an outpatient basis. The center may offer occupational therapy, physical therapy, vocational training, and special training.	**X**	
Rehabilitation Center Services	Rehabilitative Services	A facility which provides an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.	**X**	
Respiratory Care	Physician	A provider trained and licensed for respiratory	**X**	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Services	Services	care to provide therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities affecting the pulmonary system and aspects of cardiopulmonary and other systems.		
Rural Health Clinic Services	Rural Health Clinic Services	Services described in 42 U.S.C. Section 1396d(a)(2)(B) furnished by a rural health clinic as defined in 42 U.S.C. Section 1396d(l)(1).	**X**	
Scope of Sign Language Interpreter Services	Sign Language Interpreter Services	Sign language interpreter services may be utilized for medically necessary health care services	**X**	
Services provided in a State or Federal Hospital		California state hospitals provide inpatient treatment services for Californians with serious mental illnesses. Federal hospitals provide services for certain populations, such as the military, for which the federal government is responsible.		**X**
Specialty Mental Health Services		Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.		**X**[xiii]

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities	Special Rehabilitative Services	Specialized rehabilitative services are covered. Such service must include the medically necessary continuation of treatment services initiated in the hospital or short-term intensive therapy expected to produce recovery of function leading to either (1) a sustained higher level of self- care and discharge to home or (2) a lower level of care. Specialized rehabilitation service shall be covered.	X[9]	
Speech Pathology	Speech Pathology	Services are covered when provided by persons who meet the appropriate requirements.	X	
State Supported Services		State funded abortion services that are provided through a secondary contract.	X	
Swing Bed Services	Inpatient Hospital Services	Swing bed services is additional inpatient care services for those who qualify and need additional care before returning home.	X	
Targeted Case Management Services (provided by Local Governmental Agencies)	Targeted Case Management	Persons who are eligible to receive targeted case management services must consist of the following Medi-Cal beneficiary groups: (1) high risk children under the age of 21, (2) medically fragile individuals; (3) children with an Individualized Education Plan or Individualized Family Service Plan; (4) individuals at risk of institutionalization; (5) individuals in jeopardy of		X

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		negative health or psycho-social outcomes; and (6) individuals with a communicable disease. Targeted case management services must include at least one of the following service components: A documented assessment identifying the beneficiary's needs, development of a comprehensive, written, individual service plan, implementation of the service plan includes linkage and consultation with and referral to providers of service, assistance with accessing the services identified in the service plan, crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary, periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified or discontinued.		

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Transitional Inpatient Care Services	Nursing Facility and Transitional Inpatient Care Services	Focuses on transition of care from outpatient to inpatient. Inpatient care coordinators, along with providers from varying settings along the care continuum, should provide a safe and quality transition.	X	
Tuberculosis (TB) Related Services (Provided by the Local County Health Departments)	TB Related Services	Covers TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.		X

[i] Coverage and reimbursement of COVID-19 vaccines and administration are carved out of Medi-Cal managed care for all eligible populations and are exclusively covered and reimbursed through the State's fee-for-service delivery system by all applicable providers.
[ii] Benefit coverage is limited to only beneficiaries under 21 years of age for services rendered pursuant to EPSDT requirements.
[iii] California Children Services (CCS) covered in COHS counties with the exception of Ventura County (Gold Coast Health Plan). CCS not covered in Non-COHS counties and Ventura County.
[iv] Chiropractic coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities; 3) beneficiaries who are pregnant; 4) CCS beneficiaries; 5) beneficiaries enrolled in the PACE; 6) beneficiaries who receive services at an FQHC or RHC; and 7) beneficiaries in hospital outpatient settings. Chiropractic services are not available at Indian Health Clinics except for those in the exempt groups.
[v] Coverage of benefit subject to federal approval in the Medi-Cal State Plan.
[vi] Dental services are carved in to managed care for Health Plan of San Mateo.

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

[vii] The fabrication of eyeglasses lenses are carved out statewide to FFS Medi-Cal contracted optical laboratories, with the exception of specialty lenses (including lenses that exceed contract lab ranges), which remain the responsibility of the managed care plan.
[viii] Coverage and reimbursement of COVID-19 testing in school settings, to be carved out of managed care, covered and reimbursed through the state's Fee For Service delivery system.
[ix] Only covered for the month of admission and the following month in Non-COHS. Services covered in COHS.
[x] Services covered under managed care only in MLTSS Eligible Beneficiary Authorized Counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. IHSS benefits are not part of this covered service.
[xi] ICF-DD residents are exempt from managed care plan enrollment in Coordinated Care Initiative Counties.
[xii] Services provided by primary care physicians; psychiatrists; psychologists; licensed clinical social workers; or other specialty mental health provider. Solano County for Partnership Health plan (COHS) covers specialty mental health, and Kaiser GMC covers inpatient, outpatient, and specialty mental health services.
[xiii] Kaiser members in Solano and Sacramento counties carved into managed care until 7/1/2023.
[14] Personal care services benefit carved-in to SCAN Connections and SCAN Connections at Home, and members of those plans are not eligible for In Home Supportive Services (IHSS). For all other plans, the IHSS personal care services benefit is carved-out of Medi-Cal managed care and is administered and authorized by county agencies.
[15] Intermediate Care Facility for Developmentally Disabled (ICF/DD) – Continuous Nursing Care (ICF/DD-CN) Homes are not subject to the LTC Carve-In Policy

Report Title: **Approval of Human Resources Policies**
Date: **June 27, 2025**
Prepared By: **Terry Brown, *Chief Human Resources Officer, Human Resources***

1. Purpose / Desired Impact of the Report

To provide the Board with the opportunity to review and approve updated HR Policies. is to ensure that the organization remains compliant, effective, and aligned with its mission and strategic goals.

2. Background / Context

L.A. Care Policy HR-501 requires regular review and approval of HR policies, especially when substantial changes occur

3. Key Considerations / Analysis

Management Considerations:

Keeps policies current with changes in law, industry standards, and best practices.

- Aligns policies with the organization's mission, vision, and strategic objectives.
- Promotes ethical conduct and accountability.
- Ensures policies reflect current operations, technologies, and organizational structures
- Improves clarity and guidance for staff execution

4. Risk Area and Mitigation Activities

Risk Statement: **Known Key Risk:** ☐ Yes ☒ No ☐ Unknown

Not approving updated policies can lead to the following Risks:

- Outdated policies may fail to meet current legal or regulatory standards.
- Employees may act on incorrect or outdated guidance.
- Processes governed by outdated policies may no longer reflect current technology, tools, or best practices.
- Leaders and employees may base decisions on obsolete guidelines.

Impacted Area/Risk: Please select those areas impacted

☐ Claims	☒ Compliance	☒ Regulatory	☐ Vendor	☐ Community
☐ Financial	☐ Pharmacy	☐ Privacy	☐ Medicare	☐ Access
☐ Reputation	☐ Clinical	☐ IT	☐ SDOH	☒ Legal
☐ Member	☐ Provider	☐ InfoSec	☐ Contract	☒ Employee

Risk Mitigation Activities: N/A

5. Recommended Action / Decision Requested

Board Action Needed:

- ☐ For Information Only
- ☐ For Discussion with Board/Committee
- ☒ For Approval / Decision

Proposed Motion (if applicable): To approve the Human Resources Policies as presented

6. Next Steps / Timeline / Milestones

Once approved, policies will be upload to our online platform for employees to access.

7. Attachments / Supporting Materials / Presentations

- HR-101 Auto Allowance, Mileage Reimbursement, and Vehicle Damage Reimbursement
- HR-125 Sick Leave for Per Diem, Part-Time, and Non-Regular Employees
- HR-232 Bereavement Leave
- HR-310 Per Diem Employment Status
- HR-314 Seniority
- HR-323 Employee Recruitment Referral Bonus Program
- HR-606 Shift Premium
- HR-633 Monthly/ Quarterly Incentive Program
- HR-708 Internship Program- Retire policy and replace with SOP (Standard Operating Procedures)

Board of Governors
MOTION SUMMARY

Date: June 27, 2025 **Motion No. EXE A.0625**

Committee: Executive **Chairperson:** Ilan Shapiro, MD

Issue: L.A. Care Policy HR-501 requires that the Executive Committee annually review substantial changes to the Human Resources Policies.

Background: The revised policies are written to comply with changes to Regulatory, Legislative and Judicial changes, and reflect changes in L.A. Care's practices.

Policy Number	Policy	Section	Description of Modification
HR-101	Auto Allowance, Mileage Reimbursement, and Vehicle Damage Reimbursement	Benefits	Annual Review
HR-125	Sick Leave for Per Diem, Part-Time, and Non-Regular Employees	Benefits	Updated 4.1 due to expanded sick leave rights (AB2499) effective January 1, 2025 and added reference to CA Labor Code 246.5 (c) (1) et seq. to history and 4.3
HR-232	Bereavement Leave	Employee Relations	Annual Review
HR-310	Per Diem Employment Status	Employment	Updated section 3.5 to include Per Diem employees are eligible for and accrue paid sick leave pursuant to California law as set forth and described in HR-125.
HR-314	Seniority	Employment	Transferred to new template and update for clearer definitions. Also updated the seniority credits provided to Contingent Workers and Temporary Employee.
HR-323	Employee Recruitment Referral Bonus Program	Employment	Annual Review
HR-606	Shift Premium	Wage & Salary	Review; updated 3.2 that Shift premium is not included in base pay but paid as a separate line item; added 3.3 that Shift premium is paid as a separate line item for worked time; updated 3.4 that Shift premium is paid as a separate line item for non-worked time.

HR-633	Monthly/Quarterly Incentive Program	Wage & Salary	Review; Updated List of Departments eligible for Monthly/Quarterly Incentive Programs
HR-708	Internship Program	Learning & Development	Transferred to new template and retiring. Replacing policy with internal SOP

Member Impact: L.A. Care members will benefit from this motion by receiving more efficient service from L.A. Care staff members, who will be thoroughly versed on L.A. Care Human Resource policies

Budget Impact: None

Motion: **To approve the following Human Resources Policies as presented:**

- **HR-101 (Auto Allowance, Mileage Reimbursement, and Vehicle Damage Reimbursement)**
- **HR-125 (Sick Leave for Per Diem, Part-Time, and Non-Regular Employees)**
- **HR-232 (Bereavement Leave)**
- **HR-310 (Per Diem Employment Status)**
- **HR-314 (Seniority)**
- **HR-323 (Employee Recruitment Referral Bonus Program)**
- **HR-606 Shift Premium**
- **HR-633 Monthly/ Quarterly Incentive Program**
- **HR-708 Internship Program- Retire policy and replace with SOP (Standard Operating Procedures)**

	AUTO ALLOWANCE, MILEAGE REIMBURSEMENT, AND VEHICLE DAMAGE REIMBURSEMENT	**HR-101**

DEPARTMENT	HUMAN RESOURCES
Supersedes Policy Number(s)	6102

DATES					
Effective Date	10/1/1997	Review Date	~~12/26/2023~~5/8/2025	Next Annual Review Date	~~12/26/2024~~5/8/2026
Legal Review Date	~~12/26/2023~~4/10/2025	Committee Review Date	~~1/24/2024~~6/27/2025		

LINES OF BUSINESS

☐ Cal MediConnect ☐ L.A. Care Covered ☐ L.A. Care Covered Direct ☐ MCLA
☐ PASC-SEIU Plan ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

☐ PP – Mandated ☐ PP – Non-Mandated ☐ PPGs/IPA ☐ Hospitals
☐ Specialty Health Plans ☐ Directly Contracted Providers ☐ Ancillaries ☐ Other External Entities

ACCOUNTABILITY MATRIX

ATTACHMENTS

- ~~Professional License,~~ Automobile License and Liability Insurance Certification

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	**DIRECTOR**
NAME	Terry Brown	Sarah Viloria Diaz
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Senior Director, Human Resources, Total Rewards

AUTHORITIES

- HR-501 Executive Committee of the Board: HR Roles and Responsibilities
- California Welfare & Institutions Code Section 14087.9605
- L.A. Care By-Laws, Section 10.1 Purchasing, Hiring, Personnel etc.
- California Labor Code Section 2802

REFERENCES

AFS-027 TRAVEL EXPENSES

HISTORY

REVISION DATE	DESCRIPTION OF REVISIONS
1/25/2017	Revision
8/22/2018	Revision, no fault property damages increased from up to $250.00 to a maximum of $1,000.00
10/31/2023	Review; clarified processes; changed Monitoring and Reporting sections to standard verbiage
~~10/253/2024~~5/8/2025	Review

DEFINITIONS

1.0 OVERVIEW:

1.1 To ensure that employees at L.A. Care Health Plan (L.A. Care) whose jobs require travel are compensated appropriately for the use of their personal vehicles, ~~auto allowance, mileage,~~ and/or for property damages to their vehicles that are incurred while on official business.

2.0 DEFINITIONS:

~~Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.~~

2.1 N/A

3.0 POLICY:

~~**3.1**~~ L.A Care will compensate employees for the use of their personal vehicle when required to use it for official business.~~Employees who use their personal vehicles for official business purposes may be eligible for a mileage reimbursement.~~

~~Mileage reimbursement is based on the current IRS-defined business mileage rate and is provided to all employees who use their personal vehicles for official business purposes. Employees will be reimbursed for the total miles traveled for official business purposes. However, if an employee is traveling to a different location in lieu of traveling to the employee's regularly assigned office location, the employee will be reimbursed for the total miles traveled less the number of miles the employee typically drives to and from the employee's home residence to the employee's regularly assigned office location.~~

~~**3.2**~~

~~**3.2.1** Officers receiving a monthly auto allowance as compensation for the expense of using their personal vehicles for official business purposes are not eligible for mileage reimbursement.~~

~~**3.3** Reimbursement for other expenses related to driving for official business purposes, such as toll road fees and parking fees, may be requested by officers and employees.~~

~~**3.4** Costs associated with the regular operation of a vehicle including but not limited to fuel, automobile repairs, and insurance are non-reimbursable. The reimbursement of such expenses incurred from the use of personal vehicles for official business purposes is expected to be covered by the auto allowance or mileage reimbursement.~~

~~**3.5**~~**3.1** ~~To the extent that the auto allowance or mileage reimbursement is insufficient to cover the necessary expenses incurred by the employees' use of personal vehicles~~

~~for official business purposes, employees are to immediately advise their supervisors and their Human Resources Business Partner (HRBP) so that further review may be conducted to ensure that employees are being appropriately reimbursed for such expenses.~~

~~3.6~~3.2 Property damages to an employees' personal vehicle that are incurred without fault or cause on the part of the employees while using their personal vehicle while on official business may be compensated by L.A. Care.

~~3.7 All employees using their personal vehicles for official business purposes must sign the "Professional License, Automobile License and Liability Insurance Certification" form when hired and/or prior to use of personal vehicles for official business purposes. This form certifies that the employees will maintain their state issued driver's license and automobile insurance in current, valid, active status while employed in a position that requires driving on official business.~~

4.0 PROCEDURES:

4.1 All employees using their personal vehicles for official business purposes must sign the "Automobile License and Liability Insurance Certification" form when hired and/or prior to use of personal vehicles for official business purposes. This form certifies that the employees will maintain their state issued driver's license and automobile insurance in current, valid, active status while employed in a position that requires driving on official business.

4.2 Auto Allowance

~~4.1~~

~~4.1.1~~4.2.1 The Auto Allowance is a taxable benefit and is added to each officer's or eligible employees' paycheck. ~~subject to required taxes.~~

~~4.2~~4.3 Mileage Reimbursement

~~4.2.1~~4.3.1 Mileage Reimbursement is available for employees who use their personal vehicles for official business purposes but do not receive an auto allowance.

~~4.2.2~~4.3.2 The rate of reimbursement is based on the current IRS-defined business mileage rate.

~~4.2.3~~4.3.3 Employees will be reimbursed for the total miles traveled for official business purposes, less the number of miles the employees typically drive to and from the employees' ~~home~~ residence to the employees' regularly assigned office location.

~~4.2.4~~4.3.4 The mileage reimbursement is non-taxable and is provided on a separate check through the travel reimbursement system.

~~4.2.5~~4.3.5 Please refer to AFS-027 Travel Expenses for more information.

~~4.3~~4.4 Other Reimbursements

~~4.3.1~~4.4.1 Officers and employees may also request reimbursement through the travel reimbursement system for other expenses related to driving for official business purpose such as toll road fees and parking fees.

~~4.3.2 Costs associated with the regular operation of a vehicle, including but not limited to fuel, automobile repairs, and insurance, are non-reimbursable. The reimbursement of such expenses incurred from the use of personal vehicles for official business purposes is expected to be covered by the auto allowance or mileage reimbursement.~~

~~4.3.3~~4.4.2 To the extent that the auto allowance or mileage reimbursement is insufficient to cover the necessary expenses incurred by the employees' use of personal vehicles for official business purposes, employees are to immediately advise their supervisor and their HRBP so that further review may be conducted to ensure that employees are being appropriately reimbursed for such expenses.

~~4.3.4~~4.4.3 Please refer to AFS-027 Travel Expenses for more information.

~~4.4~~4.5 Driver's License and Insurance

~~4.4.1~~4.5.1 All employees who are required to ~~drive, or~~drive or use~~are using~~ their personal vehicles for official business purposes, must maintain valid driver's licenses, car registration, and automobile liability insurance.

~~4.4.2~~4.5.2 Employees must sign the "~~Professional License, Automobile~~ License and Liability Insurance Certification" form. Their responsibility is to maintain valid driver's licenses, car registration, and automobile liability insurance for as long as the employee is in a position that requires the employee to travel to offsite locations for work~~drive for official business purposes~~, as well as the requirement to advise their supervisors of any change in status, including but not limited to the lapse or revocation of either. They must have at least the minimum required automobile liability insurance coverage as required by state law.

~~4.4.3~~4.5.3 Employees must sign the "~~Professional License, Automobile~~ License and Liability Insurance Certification" form when hired and/or prior to use of personal vehicles for official business purposes. Employees may also be required to re-sign the "~~Professional License, Automobile~~ License and Liability Insurance Certification" form to reaffirm this acknowledgement from time to time.

~~4.5~~4.6 Travel Reimbursement System

~~4.5.1~~4.6.1 The travel reimbursement system is used to log information related to employees' use of personal vehicles for official business purposes.

~~4.5.2~~4.6.2 Employees must log all mileage for official business purposes.

~~4.5.3~~4.6.3 Employees must also retain all receipts for any reimbursement requested related to driving for official business purposes, such as toll road receipts and receipts for parking fees. Employees must submit such receipts upon request.

~~4.5.4~~4.6.4 Employees must obtain their supervisor's approval prior to submitting such receipts to Accounts Payable.

~~4.5.5~~4.6.5 Please refer to AFS-027 Travel Expenses for more information.

~~4.6~~4.7 Property damages to an employees' personal vehicle incurred without fault or cause on the part of the employees while using their personal vehicle while on official business may be compensated for up to $1,000.00 or the amount of the employees' insurance deductible, whichever is the lesser amount. This requires approval from Human Resources.

~~5.0~~ MONITORING:

~~5.1~~5.0 Human Resources shall review its policies routinely to ensure they are updated appropriately and have processes in place to ensure the appropriate required steps are taken under this policy

~~6.0~~ REPORTING:

~~6.1~~6.0 Any suspected violations to this policy should be reported to your Human Resources Business Partner or the Human Resources Department.

7.0 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.

~~Professional License,~~ Automobile License and Liability Insurance Certification

For employees who are required to ~~maintain their professional licenses and/or~~ drive ~~their personal automobiles~~ for official business purposes

I understand that as part of my job responsibilities, I am required to drive ~~my personal automobile~~ for business purposes, therefore:

I hereby certify that I will maintain my driver's license, car registration, and automobile liability ~~insurance~~ insurance in current, valid, active status while employed at L.A. Care Health Plan. I certify that I have at least the minimum required automobile liability insurance as required ~~in California~~by state law. If there is any change in the status of my driver's license, registration, or insurance, including but not limited to the revocation or lapse of either, I hereby certify that I will inform my Supervisor and I will not drive my automobile for business purposes.

I understand that failure to comply with this procedure may result in my termination of employment.

_____ _____

Name (Please Print)

Signature Date

~~**Professional License,**~~ **Automobile License and Liability Insurance Certification**

For employees who ~~are required to maintain their professional licenses and/or~~ drive their personal automobiles for official business purposes

~~I understand that as part of my job responsibilities, I am required to drive my personal automobile for business purposes, therefore:~~

I hereby certify that I will maintain my driver's license, car registration, and automobile liability insurance in current, valid, active status while employed at L.A. Care Health Plan. I certify that I have at least the minimum required automobile liability insurance coverage as required by state law~~in California~~. If there is any change in the status of my driver's license, registration, or insurance, including but not limited to the revocation or lapse of either, I hereby certify that I will inform my Supervisor and I will not drive my automobile for business purposes.

I understand that failure to comply with this procedure may result in my termination of employment.

_____

_____ _____

Name (Please Print)

Signature Date

	SICK LEAVE FOR PER DIEM, PART-TIME, AND NON-REGULAR EMPLOYEES	**HR-125**

DEPARTMENT	HUMAN RESOURCES
Supersedes Policy Number(s)	

DATES					
Effective Date	7/1/2015	Review Date	~~5/14/2024~~12/11/2024~~6~~/12/2025	Next Annual Review Date	~~5/14/2025~~12/11/2~~025~~6/12/2026
Legal Review Date	~~1/18/2024~~5/13/2025	Committee Review Date	~~5/22/2024~~6/27/2025		

LINES OF BUSINESS

- ☐ Cal MediConnect
- ☐ L.A. Care Covered
- ☐ L.A. Care Covered Direct
- ☐ MCLA
- ☐ PASC-SEIU Plan
- ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

- ☐ PP – Mandated
- ☐ PP – Non-Mandated
- ☐ PPGs/IPA
- ☐ Hospitals
- ☐ Specialty Health Plans
- ☐ Directly Contracted Providers
- ☐ Ancillaries
- ☐ Other External Entities

ACCOUNTABILITY MATRIX

ATTACHMENTS

- HR-114 Paid Time Off

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	**DIRECTOR**
NAME	Terry Brown	Sarah Viloria Diaz
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Sr. Director, Human Resources, Total Rewards

AUTHORITIES

- California Labor Code §245 *et seq.*
- CA Labor Code 246.5 (c) (1) *et seq.*
- City of Los Angeles Sick Leave Ordinance No. 184320, Municipal Code Chap. XVIII, Art. 7, §187.04

REFERENCES

- HR-114, "Paid Time Off"

HISTORY

REVISION DATE	DESCRIPTION OF REVISIONS
7/1/2015	New Policy
1/24/2018	Revision
5/9/2019	Review
4/17/2020	Changed Monitoring and Reporting sections to standard verbiage
8/17/2023	Clarified definition of Eligible employees
10/5/2023	Updated 3.4 to allow employees to accrue 80 hours or 10 days from one calendar year based on SB616, effective 1/1/2024; added 4.3 - Accrued, unused time is paid out at the time of employee separation or when employee transfers to a position eligible for PTO, effective 1/1/2024
5/14/2024	Expanded 4.1 on how sick leave may be used; Updated 3.1 to reflect 80 hours to be consistent with 3.4
~~12/11/2024~~	~~Updated 4.1 due to expanded sick leave rights (AB2499) effective 1/1/2025~~
5/13/2025	Updated 4.1 due to expanded sick leave rights (AB2499) effective 1/1/2025 and ~~A~~added reference to CA Labor Code 246.5 (c) (1) *et seq.* to history and 4.3

DEFINITIONS

1.0 OVERVIEW:

1.1 Under California's Paid Sick Leave Law, California Labor Code §245 et seq. and City of Los Angeles Sick Leave Ordinance No. 184320, Municipal Code Chap. XVIII, Art. 7, Section 187.04, L.A. Care Health Plan (L.A. Care) will provide paid sick leave to employees subject to this policy, consistent with California law and the City of Los Angeles Ordinance, who work 30 or more days in California within a year of hire and have successfully completed 90 days of employment.

2.0 DEFINITIONS:

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

2.1 **Employee -** For the purposes of this policy, "Employee" means "per diem, part-time employees regularly scheduled less than 30 hours per week, student interns, or temporary employees who are employees of L.A. Care and on the payroll as such."

2.1.1 Full-time and part-time employees who are in regular or ALD status positions and are scheduled to work 30 or more hours per week accrue PTO, as covered under HR-114, "Paid Time Off," and therefore are not covered under this policy.

3.0 POLICY:

3.1 Beginning January 1, 2018, or the first day of employment if hired after January 1, 2018, per diem, part-time regularly scheduled less than 30 hours per week employees, student workers and temporary employees with no benefits, shall accrue one hour of sick time for every 30 hours worked, provided that accruals will stop when the Eemployee's sick leave balance reaches 80 hours or ten days, whichever is greater. Employees will not resume accruing sick leave under this policy until enough sick leave has been used to reduce the accumulated hours below the maximum level, at which time the accrual will begin again.

3.2 Employees may use accrued paid sick time beginning with their 90th day of employment.

3.3 Employees may use up to a maximum of 48 hours (six days) of paid sick leave in each calendar year of employment.

3.4 Accrued, unused sick time under this policy will carry over from one calendar year to the next. However, an Eemployee's accrued paid sick leave balance may not exceed 80 hours or ten days, whichever is greater.

4.0 PROCEDURES:

4.1 Leave under this policy may be used in connection with the diagnosis, care or treatment of an existing health condition for, or the preventive care of, an Eemployee, an Eemployee's family member (i.e., biological, adopted, or foster child, stepchild, legal ward or a child to whom the Eemployee stands in loco parentis; an Eemployee's biological, adoptive, or foster parent, stepparent, or legal guardian of an Eemployee or the Eemployee's spouse or registered domestic partner, or a person who stood in loco parentis when the Eemployee was a minor child; spouse; registered domestic partner; grandparent; grandchild; and sibling) as defined in California Labor Code §§245.5 and 246.5, or for any individual related by blood or affinity whose close association with the Eemployee is the equivalent of a family relationship, pursuant to the City of Los Angeles Sick Leave Ordinance No. 184320, Municipal Code Chap. XVIII, Art. 7, Section 187.04. Sick leave may also be used by Eemployee who are the victims of a qualifying act of violence, which may include domestic violence, sexual assault, ~~or~~ stalking, or any act, conduct, or pattern that includes a) bodily injury or death to another individual; b) exhibiting, drawing, or brandishing a firearm or other dangerous weapon; or c) a reasonably perceived or actual threat to use force against another individual to cause physical injury or death, regardless of whether anyone is arrested for, prosecuted for, or convicted of committing any crime, to seek safety and support, or to assist ~~family members~~ the Eemployee's child, parent, grandparent, grandchild, sibling, spouse, or domestic partner as defined under the California Family Rights Act or a designated person~~.~~ who are victims of such acts, when they need time off to appear in legal proceedings, obtain restraining orders, relocate, enroll children in a new school or child care, access ~~to~~ legal services, seek medical attention or ~~for~~ medical treatment, provide care to a family member who is recovering from injuries caused by a qualifying act of violence, to seek, obtain, or provide childcare or care to a care-dependent adult if the childcare or care is necessary to ensure the safety of the child or dependent adult as a result of the qualifying act of violence, to obtain services or counseling, or to participate in safety planning related to the violent act. Sick leave may also be used for bereavement leave within three (3) months of the death of an ~~employee~~Employee's family member.

4.2 Employees requesting time off under this policy should provide as much advance notice to their supervisor as practicable.

~~4.2~~4.3 L.A. Care shall not deny an Employee's right to use accrued sick days or discriminate in any manner against an Employee for using sick days, attempting to exercise the right to use accrued sick days, or otherwise exercising rights under The Healthy Workplaces, Healthy Families Act of 2014 ("HWHFA"). Reference CA Labor Code 246.5 (c)(1) et seq.

~~4.3~~4.4 Accrued, unused time under this policy is paid out at the time of separation from employment or transfer to a position in which they become eligible for PTO.

~~4.4~~4.5 Sick leave under this policy may run concurrently with leave taken under other applicable policies as well as under local, state or federal law, including leave taken pursuant to the California Family Rights Act (CFRA) or the Family and Medical Leave Act (FMLA).

~~4.5~~4.6 Sick leave is paid at the E~~e~~mployee's base rate in effect at the time the Sick leave hours are used.

~~4.6~~4.7 Employees may make either an oral request or submit a request through the automated time record system to use paid sick leave (Code: SICKAB1522) for a qualifying reason.

~~4.7~~4.8 Employees must inform their supervisor in a timely manner if they did not use their previously approved sick leave. Employees must complete a Time Exception Report for adjustments after the ~~time card~~timecard has been approved and locked in the automated time record system.

~~5.0~~ MONITORING:

~~5.1~~5.0 Human Resources shall review its policies routinely to ensure they are updated appropriately and have processes in place to ensure the appropriate required steps are taken under this policy.

~~6.0~~ REPORTING:

~~6.1~~6.0 Any suspected violations to this policy should be reported to your Human Resources Business Partner or the Human Resources Department.

7.0 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.

	BEREAVEMENT LEAVE	HR-232
DEPARTMENT	HUMAN RESOURCES	
Supersedes Policy Number(s)	102	

DATES					
Effective Date	11/6/1997	Review Date	~~6/15/2023~~5/22/2025	Next Annual Review Date	~~6/15/2024~~5/22/2026
Legal Review Date	~~5/26/2023~~4/10/2025	Committee Review Date	~~6/28/2023~~6/25/2025		

LINES OF BUSINESS

☐ Cal MediConnect ☐ L.A. Care Covered ☐ L.A. Care Covered Direct ☐ MCLA
☐ PASC-SEIU Plan ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

☐ PP – Mandated ☐ PP – Non-Mandated ☐ PPGs/IPA ☐ Hospitals
☐ Specialty Health Plans ☐ Directly Contracted Providers ☐ Ancillaries ☐ Other External Entities

ACCOUNTABILITY MATRIX

ATTACHMENTS

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	DIRECTOR
NAME	Terry Brown	Jyl Russell
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Senior Director, Business Supp Svcs, Learning Experience and Organizational Excellence~~Senior Director, Business Support Services and Organizational Effectiveness~~

AUTHORITIES
➢ HR-501, "Executive Committee of the Board: HR Roles and Responsibilities" ➢ California Welfare & Institutions Code §14087.9605

REFERENCES
➢ HR-112, Leave of Absence policy

HISTORY	
REVISION DATE	**DESCRIPTION OF REVISIONS**
11/10/2016	Revision
4/25/2018	Revision. Changed policy name from "Bereavement Pay" to "Bereavement Leave", changed policy number from HR-102 to HR-232, and moved policy from Benefits section to Employee Relations. Added miscarriage/still birth to eligible events.
09/18/2020	Review
6/15/23	Revision: AB1949 signed into law by Governor Newsom on September 29, 2022. Indicate that eligible employees will receive up to 5 days of bereavement leave (3 paid and 2 unpaid) and that employees may use PTO for any unpaid bereavement time off.
~~10/18/24~~5/22/2025	Annual Review

1.0 OVERVIEW:

1.1 L.A. Care Health Plan (L.A. Care) provides ~~paid~~ bereavement leave to eligible employees to attend to matters associated with a death of the Eeligible ~~e~~Employee's immediate family members.

2.0 DEFINITIONS:

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

~~**2.1 Leave of Absence (LOA)** – is a specific period of time, whether paid (receiving Paid Time Off), or unpaid, when an employee is away from the job for a valid reason approved by the supervisor or mandated by Federal or State law.~~

2.2~~2~~.1 Eligible Employee ~~–~~ is an ~~E~~employee~~s must have~~who has been employed by L.A. Care for thirty (30) days and ~~. This~~ includes ~~L.A. Care~~ temporary ~~employees~~, full-time, part time ~~employees~~, per diem ~~or~~ and "assignment with limited duration" (ALD) employees~~.~~

3.0 POLICY:

3.1 Bereavement leave is available to all Eligible Employees. **~~NOT TRUE SEE 3.2 BELOW.~~**

3.1.1 Eligibility begins upon 30 days from ~~on~~ the date of hire; ~~**This is interesting because it says above that an Eligible Employee must have been employed for 30 days**~~

3.1.2 An Eligible Employee qualifies for up to five scheduled work~~ing~~ days ~~or 40 hours~~ of bereavement leave per event. Eligible employees are compensated up to; ~~the first~~ three scheduled work days. The ~~or 24 hours are paid. The~~ additional two scheduled ~~work days~~workdays may be taken ~~or 16 hours, the Eligible Employee may~~ a~~s~~use paid time off ("PTO"), sick leave, or unpaid time off. **~~How does this apply to part time employees? Is the 5 days, or 40 hours ….~~**

3.1.3 An Eligible Employee that requires additional leave time outside of five scheduled work~~ing~~ days ~~or 40 hours~~ may use paid time off ("PTO"), sick leave, or ~~or~~ unpaid time off with supervisory approval;

~~**3.1.4** Employees are eligible for leave under this policy for an employee's pregnancy that ends in a miscarriage or stillbirth.~~

3.2 Non-eligible employees "who have been employed for less than 30 days" are not eligible ~~may request up to five unpaid working days or 40 hours~~ for bereavement leave to attend to matters associated with the death of an immediate family member.

Non-eligible employees that require ~~additional~~ time off~~leave time outside of the five working days or 40 hours~~ may request ~~additional~~ time off with supervisory approval.

3.3 For purposes of this policy, immediate family is limited to the following relationships by blood, marriage, adoption, or domestic partnership:

3.3.1 Parent of Eligible Employee;

3.3.2 Current spouse of Eligible Employee and parents of current spouse;

3.3.3 Domestic partner of Eligible Employee and parents of domestic partner;

3.3.4 Child (born or unborn) of Eligible Employee, current spouse (e.g. step-child), or domestic partner;

3.3.5 Siblings of Eligible Employee, current spouse, or domestic partner;

3.3.6 Aunts and uncles of Eligible Employee, current spouse, or domestic partner;

3.3.7 Nieces and nephews of Eligible Employee, current spouse, or domestic partner;

3.3.8 Grandparent or grandchild of Eligible Employee, current spouse, or domestic partner;

3.3.9 Current son-in-law of Eligible Employee;

3.3.10 Current daughter-in-law of Eligible Employee;

3.3.11 Stepparent or legal guardian of Ee~~e~~ligible Ee~~e~~mployee.

4.0 PROCEDURES:

4.1 Eligible Ee~~e~~mployees may take bereavement leave in a single block of time or intermittently within three (3) months of the employee's family member's death. All time off in connection with the death of a family member, as defined above, should be scheduled with the Eligible Ee~~e~~mployee's supervisor. The employee must obtain approval from ~~his/her~~ their supervisor if additional time off is necessary. Additional days requested will be paid through PTO, if PTO hours are available. Otherwise, the additional time off will be unpaid.

4.2 Employees must record their bereavement hours through the time management system in current use.

4.2.1 Family relationship of the deceased must also be specified under the comments section in the time management system in current use.

4.3 The Company reserves the right to request supporting documentation of the need for bereavement leave within thirty (30) days of the employee's first day of leave, which can include a death certificate, a published obituary, or a written verification of death, burial, or memorial services from a mortuary, funeral home, burial society, crematorium, religious institution, or government agency.

4.4 Bereavement pay is not included in the calculation of overtime pay.

4.5 The Company will make reasonable efforts to safeguard the employee's privacy with respect to a request for bereavement leave.

~~**5.0**~~ **MONITORING:**

~~**5.1**~~**5.0** Human Resources reviews its policies routinely to ensure they are updated appropriately and has processes in place to ensure the appropriate required steps are taken under this policy.

~~**6.0**~~ **REPORTING:**

~~**6.1**~~**6.0** Employees are encouraged to request leave under this policy without fear of retaliation. Any suspected violation of this policy should be reported to your Human Resources Business Partner.

7.0 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.

	PER DIEM EMPLOYMENT STATUS	HR-310

DEPARTMENT	HUMAN RESOURCES
Supersedes Policy Number(s)	

DATES					
Effective Date	4/1/2006	Review Date	~~9/20/2024~~6/16/2025	Next Annual Review Date	~~9/20/2025~~6/16/2026
Legal Review Date	10/11/2024	Committee Review Date	~~10/23/2024~~6/27/2025		

LINES OF BUSINESS

- ☐ Cal MediConnect
- ☐ L.A. Care Covered
- ☐ L.A. Care Covered Direct
- ☐ MCLA
- ☐ PASC-SEIU Plan
- ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

- ☐ PP – Mandated
- ☐ PP – Non-Mandated
- ☐ PPGs/IPA
- ☐ Hospitals
- ☐ Specialty Health Plans
- ☐ Directly Contracted Providers
- ☐ Ancillaries
- ☐ Other External Entities

ACCOUNTABILITY MATRIX

Enter department here	Enter policy §§ here		

ATTACHMENTS

- Enter all attachments here (e.g., desktop procedures/job aids, templates, reports, letters)

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	DIRECTOR
NAME	Terry Brown	Darren Lee
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Deputy Chief Human Resources Officer

AUTHORITIES
➢ Enter all authorities here. Authorities include all legal, regulatory, contractual, or accreditation requirements.

REFERENCES
➢ Enter all references, including policies and procedures, here.

HISTORY	
REVISION DATE	DESCRIPTION OF REVISIONS
9/20/2024	Transferred into new policy template
6/16/2025	Updated section 3.5 to include Per Diem employees are eligible for and accrue paid sick leave pursuant to California law as set forth and described in HR-125.

1.0 OVERVIEW:

1.1 It is the policy of L.A. Care to support a Per Diem employment classification, one which consists of an individual who works intermittently, primarily as a staff replacement or to supplement staffing.

2.0 DEFINITIONS:

2.1 Per Diem - an employment status which receives a higher flat hourly rate of pay in lieu of benefits and is not eligible for merit increases, organizational incentives, accumulation of Paid Time Off (PTO), or participation in any non-legally mandated health and welfare benefit.

3.0 POLICY:

3.1 Per Diem employees shall not normally be hired into a regularly scheduled budgeted position.

3.2 Per Diem employees are eligible for overtime pay and other differentials as regular benefit eligible employees, as well as legally mandated benefits including participation in L.A. Care's retirement plan, Worker's Compensation, State Mandated sick leave, and State Disability benefits.

3.3 Per Diem employees are paid for required in-service and staff meeting time.

3.4 Per Diem employees do not accrue Paid Time Off (PTO) benefits and are not eligible for tuition reimbursement benefits, transportation incentives, merit increases, holiday pay, ~~paid bereavement leave,~~ jury duty, health and welfare benefits, or to participate in the annual incentive program unless otherwise specified herein or required by applicable law.

~~3.4~~3.5 Per Diem employees are eligible for and accrue paid sick leave pursuant to California law as set forth and described in HR-125.

~~3.5~~3.6 Per Diem employees will receive an annual performance evaluation as defined by L.A. Care policy.

4.0 PROCEDURES:

4.1 As business need dictates, employees may request to transfer from a Per Diem position to an available budgeted position.

4.2 As business need dictates, an employee changing from a Per Diem position to a benefit eligible position shall:

4.2.1 Begin accruing Paid Time Off (PTO) benefits from the effective date of the change, subject to the terms and conditions of L.A. Care's PTO Policy HR-114.

4.2.2 Be eligible to participate in health and welfare benefit plans beginning the first of the month following the employment status change, if the employee meets eligibility.

4.2.3 Shall not receive credit for their service as a Per Diem employee, except for retirement vesting, which is based on the original hire date.

4.3 When a benefit eligible employee requests to transfer to a Per Diem position, the following will apply:

4.3.1 Unused, accrued PTO shall be cashed out at the time of conversion at the base hourly rate in effect before the date of conversion.

4.3.2 Participation in any health and welfare benefit plans shall cease at the end of the month of the effective date of the status change. Eligibility for continuation of health benefits will be offered through COBRA.

4.4 Employment shall remain at the mutual consent of the employee and L.A. Care, and may be terminated by the employee or L.A. Care at any time, with or without cause, or advance notice.

~~5.0~~ MONITORING:

~~5.1~~5.0 Human Resources reviews its policies routinely to ensure they are updated appropriately and has processes in place to ensure the appropriate required steps are taken under this policy.

~~6.0~~ **REPORTING:**

~~6.1~~6.0 Any suspected violations to this policy should be reported to your Human Resources Business Partner.

7.0 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time with or without notice.

	SENIORITY Updated to show comments from Sarah	**HR-314**

DEPARTMENT	HUMAN RESOURCES
Supersedes Policy Number(s)	6214

DATES					
Effective Date	10/16/2006	Review Date	~~4/1/2014~~11/7/2025	Next Annual Review Date	~~4/1/2015~~11/7/2026
Legal Review Date	1/3/2025	Committee Review Date	6/27/2025		

LINES OF BUSINESS

☐ Cal MediConnect ☐ L.A. Care Covered ☐ L.A. Care Covered Direct ☐ MCLA
☐ PASC-SEIU Plan ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

☐ PP – Mandated ☐ PP – Non-Mandated ☐ PPGs/IPA ☐ Hospitals
☐ Specialty Health Plans ☐ Directly Contracted Providers ☐ Ancillaries ☐ Other External Entities

ACCOUNTABILITY MATRIX

Enter department here	Enter policy §§ here		

ATTACHMENTS

- ~~Enter all attachments here (e.g., desktop procedures/job aids, templates, reports, letters)~~

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	**DIRECTOR**
NAME	Terry Brown	Sarah Viloria Diaz~~Edward Topps~~
DEPARTMENT	Human Resources	Human Resources~~Human Resources~~Talent Strategy & HR ~~Technology~~
TITLE	Chief Human Resources Officer	Senior Director, Human Resources Total Rewards ~~Senior Director, Talent Strategy and Human Resources Technology~~

AUTHORITIES
➢ HR-501, "Executive Committee of the Board: HR Roles and Responsibilities" ➢ California Welfare & Institutions Code §14087.9605 ➢ L.A. Care By-Laws, §10.1 Purchasing, Hiring, Personnel etc.~~Enter all authorities here. Authorities include all legal, regulatory, contractual, or accreditation requirements.~~

REFERENCES
➢ ~~Enter all references, including policies and procedures, here.~~

HISTORY	
REVISION DATE	DESCRIPTION OF REVISIONS
~~7/14/2020~~	~~Review~~
5/8/2025~~July 2021~~	Transferred to new template and ~~Review and~~ update for clearer definitions. Also updated the seniority credits provided to Contingent Workers and ~~L.A. Care~~ Temporary ~~staff.~~Employee.
~~9/25/2024~~	~~Review~~

1.0 OVERVIEW:

1.1 To clarify how seniority is ~~determined~~determined, and the impact seniority has on specific L.A. Care benefits**.**

2.0 DEFINITIONS:

~~**Temporary Personnel Conversion – are individuals hired from a Temporary Agency during an assignment with L.A. Care.Contingent Worker – Consultants, Contractors, Temporary employees through a third party vendor and are not on L.A. Care payroll.**~~

2.1 ~~**L.A. Care Employee – Any employee on L.A. Care's payroll with employment status as Regular, Temporary, Limited Duration, Per Diem.**~~**Regular Employee** – Regular employees are hired without a predetermined end date to

employment. Employees are eligible for employer-sponsored ~~benefits, and~~benefits and are also eligible for merit increase and incentive payouts.

2.2 Temporary Employee - Temporary employees are those who have been hired by L.A. Care for a temporary assignment and are on L.A. Care ~~Payroll, and~~Payroll and are ineligible for merit increase and incentive payouts. Employees may be eligible for employer-sponsored benefits.

2.3 Assignment with Limited Duration (ALD) Employee – ALD employees are hired, with a date of employment between one (1) and two (2) years, to complete a major project and/or implement a program. Employees are eligible for employer-sponsored ~~benefits, and~~benefits and are also eligible for merit increase and incentive payouts.

2.4 Contingent -Worker – Consultants, Contractors, Clinical Residents (unpaid) Temporary employees who are engaged through a ~~third party~~third-party vendor and are not on L.A. Care ~~payroll, and~~payroll and are ineligible for merit increase and incentive payouts. ~~Contingent Workers are not eligible for employer-sponsored benefits.~~

~~**2.1**~~

3.0 POLICY:

~~3.~~**3.1.** Seniority within L.A. Care begins to accrue on the date an employee first reports to work as a Regular, ~~or~~ ALD, or Temporary Eemployee ~~in any status other than "temporary~~contingent worker~~" status,~~ and continues to accrue until the employee's services are officially terminated.

~~4.~~**3.2.** Seniority, as recorded by L.A. Care, is the basis for ~~determining~~:

~~3.~~**3.2.1.** Eligibility for Paid Time ~~Off (~~Off (PTO) and other L.A. Care sponsored benefits, if eligible.

~~4.~~**3.2.2.** Eligibility for health, welfare, tuition reimbursement, and retirement benefits, if eligible.

~~5.~~**3.2.3.** Promotion and transfer where performance, qualifications and all other relevant factors of eligible candidates are entirely equal.

3.2.4. Reduction in workforce which will be based on performance, competency, qualifications, and~~,~~ when all relevant factors are equal, on seniority. Seniority will be considered when management determines that all other factors are equal with respect to two or more employees.

~~6. Tuition Reimbursement eligibility period.~~

~~3.3.~~ 3.3. Unless otherwise required by law, e~~E~~mployees will not accrue seniority while on any unpaid Leave of Absence (LOA). Service dates are adjusted based on the length of time of the unpaid LOA.

3.4. Seniority credit is reinstated when an employee voluntarily resigns and subsequently returns ~~to regular status~~as a regular or ALD employee within six (6) months from the date of separation.

3.5. ~~Effective _____, t~~Temporary E~~e~~mployees on L.A. Care payroll will be given seniority credit for all time spent working for L.A. Care in excess of 30 calendar days.

3.6. Contingent W~~w~~orkers hired through L.A. Care directly before October 1, 2019~~_____~~, will be given seniority credit for all time spent working for L.A. Care in excess of 30 calendar days.

3.7. Effective October 1, 2019~~_____~~, C~~c~~ontingent ~~w~~Workers hired through L.A. Care directly~~,~~ will not be given seniority credit.

~~3.4.~~

~~3.5. Effective October 1, 2005, temporary employees hired through a Temporary Agency while still on assignment with L.A. Care will be given seniority credit for all time spent working for L.A. Care in excess of 30 calendar days. The seniority credit will be used to determine eligibility for health and welfare benefits, PTO accrual rate and retirement plans.~~

3.8. Adjustment to the service date of a C~~temporary employee~~contingent W~~w~~orker who has converted to regular or limited duration status~~,~~ does not waive the ~~I~~introductory p~~P~~eriod or the performance review date as determined by the actual date of hire.

~~3.6.~~ Adjustment to the seniority date of a ~~c~~Contingent W~~w~~orker who has converted to regular or ~~limited duration~~ALD status~~,~~ may have impact to their merit or incentive eligibility.

3.9.

Employment as a Regular, ALD and/or Temporary employee is at-will and cannot be changed unless in writing and signed by the ~~[Insert Title, e.g., President/CEO] of L.A. Care.~~

3.10. Chief Executive Officer (CEO) or the Chairman of the Board of Governors of L.A Care

4.0 MONITORING:

Human Resources shall review its policies routinely to ensure they are updated appropriately and have processes in place to ensure the appropriate required steps are taken under this policy.

5.0 REPORTING:

5.1 Any suspected violations to this policy should be reported to your HRBP or the HR Department.

6. .0

6.0 RESERVATION OF RIGHTS:

3.7.

6.1 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time with or without notice.

	EMPLOYEE ~~RECRUITMENT~~ REFERRAL BONUS PROGRAM	**HR-323**

DEPARTMENT	HUMAN RESOURCES
Supersedes Policy Number(s)	6108, 106

DATES					
Effective Date	~~5/30/1996~~4/19/2024	Review Date	~~4/26/2019~~~~4/19/24~~~~9/25/2024~~5/22/2025	Next Annual Review Date	~~4/26/2020~~~~4/20/2026~~~~9/25/2025~~5/22/2026
Legal Review Date	~~4/15/2019~~4/18/2025	Committee Review Date	~~4/22/2019~~6/27/2025		

LINES OF BUSINESS

☐ Cal MediConnect ☐ L.A. Care Covered ☐ L.A. Care Covered Direct ☐ MCLA
☐ PASC-SEIU Plan ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

☐ PP – Mandated ☐ PP – Non-Mandated ☐ PPGs/IPA ☐ Hospitals
☐ Specialty Health Plans ☐ Directly Contracted Providers ☐ Ancillaries ☐ Other External Entities

ACCOUNTABILITY MATRIX

ATTACHMENTS

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	**DIRECTOR**
NAME	Terry Brown	~~Edward Topps~~~~Michelle Li~~Darren Lee
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	~~Sr. Director, Human Resources Talent Acquisition & HRIS~~Deputy Chief Human Resources Officer

AUTHORITIES

- HR-501, "Executive Committee of the Board: HR Roles and Responsibilities"
- California Welfare & Institutions Code §14087.9605.

REFERENCES

HISTORY

REVISION DATE	DESCRIPTION OF REVISIONS
7/1/2006~~4.19.2024~~	Revision
April 2014~~4.19.2024~~	Review
4/22/2019~~4.19.2024~~	Revision, policy moved from Benefits to Employment department; policy number changed from HR-106 to HR-323; 90-day time limit added for referrals; procedure for referring candidates to the CSC department added.
~~9/25/2024~~5/22/2025	~~Revision~~Annual Review

DEFINITIONS

~~Please visit the L.A. Care intranet for a comprehensive list of definitions used in policies: http://insidelac/ourtoolsandresources/departmentpoliciesandprocedures~~

1.0 OVERVIEW:

1.1 L.A. Care Health Plan (L.A. Care) provides a monetary incentive to ~~Eligible~~ eligible ~~Employees~~ employees for referring qualified applicants who are subsequently hired to fill vacant positions.

2.0 DEFINITIONS:

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

2.1 **Eligible Employees -** all L.A. Care employees with the exception of ~~the Leadership Team Members,~~Officers, ~~all~~ Directors and above, and all Human Resources Staff. ~~, and hiring~~ Hiring Managers are ineligible when ~~the~~ a referral is made for a vacancy that exists within their respective department(s) or any cross-matrixed teams that work on projects with the Hiring Manager's team(s).~~.~~

2.2 **Eligible Applicants -** all external applicants who are referred to Eligible Positions through the employee referral portal in Success Factors Employee Central ~~and/or validated by Human Resources staff~~ with the exception of any applicant who currently works for L.A. Care from a temporary employment agency or as a contracted staff person prior to the official application date.

2.3 **Eligible Positions -** all vacant regular status positions in L.A. Care, with the exception of those identified for student workers, interns, temporary, volunteers, and/or ~~or~~ residents. Additionally, Call Center Representatives are addressed separately below in section 4.4 of this policy.

~~**2.3**~~

3.0 POLICY:

~~**3.1** L.A. Care is committed to hiring qualified candidates who represent the culturally diverse population of Los Angeles County and the members we serve at a reasonable cost with as much efficiency as possible.~~

~~**3.2** This Recruitment Referral Bonus Program is administered by the Human Resources Department who maintains all related records~~The Human Resources Department will administer an Employee Referral Bonus Program whereby eligible employees who refer an applicant for an open position and that applicant is hired, shall receive a referral bonus. The referral incentive may be subject to change by position at the discretion of the ~~Director, Talent Acquisition~~Chief of Human Resources based on ability to recruit, market conditions, and other circumstances.

3.1 ~~Referral Bonus Amount. Employees will receive a referral bonus of $[x] for each successful hire. All applicable taxes will be deducted from the referral bonus.~~

4.0 PROCEDURES:

4.1 When a position becomes vacant, an Eligible Employee may refer an applicant to Human Resources for consideration. Referrals must be made through the employee referral portal within Success Factors Employee Central. ~~In addition, there must be a validation vetted process performed by the Human Resources Department.~~ An applicant must list the referring applicant in their electronic application in the appropriate field.

4.2 If the Eligible Applicant is hired within 90 days of being referred into an Eligible Position, the Eligible Employee who made the referral will receive the employee referral bonus in two separate installments.

4.3 The Eligible Employee who makes the referral receives half of the bonus at the time of the Eligible Applicant's hire (normally reflected in their paycheck two weeks later). If the new employee is successful in his/her new position and ~~stays~~ remains employed at least six months, then the Eligible Employee who made the referral receives the second half of the referral bonus (normally reflected in their paycheck two weeks later), provided the Eligible Employee remains actively employed as of this date.

4.4 The Eligible Employee who makes the referral of a Customer Solutions Center (CSC) Call Center Representative (all levels) receives half of the referral bonus three months after the Eligible Employee's hire (normally reflected in their paycheck two weeks later), provided the Eligible Employee remains actively employed as of this date. The second half of the bonus will be given once the Eligible Applicant completes an additional six months of employment (normally reflected in their paycheck two weeks later), provided the Eligible Employee remains actively employed as of this date.

~~**4.4** Any and all referral bonuses are considered non-discretionary wages, will be subject to applicable taxes and withholdings. Further, it will be included in the employee's regular rate of pay for overtime calculations.~~

~~5.0~~ MONITORING:

~~5.1~~**5.0** Human Resources reviews its policies routinely to ensure they are updated appropriately and has processes in place to ensure the appropriate required steps are taken under this policy.

~~6.0~~ REPORTING:

~~6.1~~**6.0** Any suspected violations to this policy should be reported to your Human Resources Business Partner. [Suggestion: Any misrepresentation or attempt to manipulate the program may result in disqualification and potential disciplinary action.]

7.0 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.

L.A. Care HEALTH PLAN	**SHIFT PREMIUM**	**HR-606**

DEPARTMENT	HUMAN RESOURCES
Supersedes Policy Number(s)	

DATES					
Effective Date	11/15/2021	Review Date	~~11/7/2021~~5/6/2025	Next Annual Review Date	~~11/7/2022~~5/6/2026
Legal Review Date	4/9/2025	Committee Review Date	~~11/15/2021~~6/16/2025		

LINES OF BUSINESS

☐ Cal MediConnect ☐ L.A. Care Covered ☐ L.A. Care Covered Direct ☐ MCLA
☐ PASC-SEIU Plan ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

☐ PP – Mandated ☐ PP – Non-Mandated ☐ PPGs/IPA ☐ Hospitals
☐ Specialty Health Plans ☐ Directly Contracted Providers ☐ Ancillaries ☐ Other External Entities

ACCOUNTABILITY MATRIX

ATTACHMENTS

- HR-606 Shift Premium Procedures

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	**DIRECTOR**
NAME	Terry Brown	Sarah Viloria Diaz
DEPARTMENT	Human Resources	Human Resources Total Rewards
TITLE	Chief Human Resources Officer	Senior Director

AUTHORITIES
➢ HR-501, "Executive Committee of the Board: HR Roles and Responsibilities"
➢ California Welfare & Institutions Code §14087.9605

REFERENCES

HISTORY	
REVISION DATE	**DESCRIPTION OF REVISIONS**
10/06/2006	Revision
April 2014	Review
05/24/2017	Revision
11/7/2021	Revision
~~11/18/2024~~5/6/2025	Review; updated ~~4.1~~ 3.2 that Shift premium~~s~~ is ~~are~~ not included in base pay but paid as a separate line item; added 3.3 that Shift premium is paid as a separate line item for worked time; updated 3.4 ~~4.2~~ that Shift premium is ~~pay is~~ paid as a separate line item ~~included in~~ for non-worked time.

1.0 OVERVIEW:

1.1 Shift premium pay is to provide fair and equitable premium pay for staff regularly assigned to work alternate shifts to perform services after standard operating hours.

2.0 DEFINITIONS:

2.1 Standard Operating Hours: L.A. Care's business operation hours of 8:00 a.m. to 5:00 p.m. Pacific Time (PT).

2.2 Evening Shift Hours: Regularly assigned shift hours which starts ~~on or after~~between 3:00 p.m. and 6:59pm.

2.3 Night Shift Hours: Regularly assigned shift hours which start ~~on or after~~between 7:00 p.m. and midnight.

3.0 POLICY:

3.1 To ensure consistency within its competitive markets, L.A. Care may pay a shift premium to non-exempt and exempt employees who are regularly scheduled shifts after Ss~~s~~tandard Oo~~e~~perating Hh~~h~~ours, if they meet all of the eligibility requirements for shift premium pay.

~~4.0 PROCEDURES:~~

3.2 Shift premium pay is paid as a separate line item, and not included in the base regular rate.

~~4.1~~3.3 Shift premium is paid as a separate line item for worked time, such as regular, and overtime for non-exempt employees.~~pay is included in for the computation of overtime pay for non-exempt employees.~~

~~4.2~~3.4 Shift premium is paid as a separate line item ~~pay is not included in pay~~ for non-worked time such as Paid Time Off, Jury Duty or Bereavement Leave.

3.5 Rates are determined on prevailing market, internal equity and ~~as defined as well as~~ at the discretion of the organization ~~discretion.~~.

~~4.3~~

3.6 To be eligible, the employee must be regularly assigned to evening or night shift hours.~~a position must meet all of the following conditions:~~ Positions eligible for this program will be assigned position codes with "(After Hours-Evening)" or "(After Hours – Nights) in the title.

~~4.4~~

3.7 Employees who are not regularly assigned to such shifts but are covering a single shift are not eligible for the shift premium pay.

~~4.4.1 Be regularly assigned to evening shift hours and/or night shift hours.~~

~~4.5 Any department with eligible positions will refer to these procedures document for implementation.~~

~~5.0~~4.0 MONITORING:

~~5.1~~4.1 Hours worked will be tracked in the official timekeeping system of L.A. Care.

~~5.2~~4.2 For accuracy in shift premium pay, non-exempt employees will be required to clock in at the beginning of the shift and clock out at the end of the shift.

~~6.0~~ **REPORTING:**

~~6.1~~**5.0** Any missed punches will need to be reported to employee's direct supervisor immediately for adjustment in L.A. Care's timekeeping system.

~~7.0~~**6.0** L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.

L.A. Care Customer Solution Center (CSC)
Call Center After Hours~~Alternate~~ Shift Premium Pay Program

Effective Date

May 3, 2021

Updated April 15, 2025

Objective

The objective of the L.A. Care CSC ~~Alternate~~ After Hours Shift Premium Pay Program is to provide fair and equitable premium pay for staff assigned to work alternate shifts to perform after hours Call Center Support services.

Eligibility

To be eligible to participate in this program staff must meet all of the following conditions:

1. Be regularly assigned to an alternate work shift; evening or nights.
2. Evening shift is defined as start time ~~on or after~~between 3:00pm and 6:55pm
3. Night shift is defined as start time ~~on or after~~between 7:00 p.m. and midnight.
4. Be assigned full time to the Customer Solution Center department in one of the following title(s):
    - Customer Solution Call Center Representative II
5. Receive prior written approval to participate by the Senior Director, Customer Solution ~~Call~~ Center and Director, Call Center Solution Center.
6. Be assigned to provide timely after hour services.
7. Team members will perform all Call Center after hours services for members.

Compensation

Participants in the After Hours program will receive an alternate shift premium which will be paid as a premium pay.

Evenings:

- Regular full time Customer Solution Center Service Representative II: additional $0.50 per hour ~~per hour worked~~

Nights:

- Regular full time Customer Solution Center Service Representative II: additional $0.75 per hour ~~per hour worked~~

Procedures

- Positions eligible for this program will be assigned position codes with “(After Hours-Evening)” or “(After Hours – Nights) in the title.

Example: Customer Solution Center Service Representative II (After Hours-Evenings).

- Should an employee transfer to a non-program participating position, they will no longer receive the After Hours Program shift premium pay for alternate shifts.

- Management will work with their Human Resources Business Partner to remove the premium pay from their position.

~~Shift premium pay will be included in a participating employee's hourly rate of pay for purposes of calculating overtime, paid sick leave, and other approved leaves as required by law.~~

- Shift premium is paid as a separate line item and not included in the base regular rate.

- Shift premium is paid as a separate line item for worked time, such as regular and overtime for non-exempt employees.

- Shift premium is paid as a separate line item for non-worked time such as Paid Time Off, Jury Duty or Bereavement Leave.

~~Shift premium pay is included in the computation of regular and overtime pay for non-exempt employee.~~

~~Shift premium is included in pay for non-worked time such as Paid Time off, Jury Duty or Bereavement Leave.~~

- ~~Please~~ R~~r~~efer to HR-606 Shift policy for additional information.

L.A. Care reserves the right to modify, rescind, delete or add to this program at any time, with or without notice.

Reviewed and Approved:

Name	Date
Robert Martinez, Senior Director, Customer Solution~~s Call Center~~ Center	
Terry Brown, Chief Human Resources Officer	

L.A. Care Utilization Management
After Hours ~~Alternate~~ Shift Premium Pay Program
Procedures

Effective Date

August 1, 2019

Updated April 15~~1~~, 2025

Objective

The objective of the L.A. Care After Hours ~~Alternate~~ Shift Premium Pay Program is to provide fair and equitable premium pay for staff assigned to work alternate shifts to perform utilization management clinical and non-clinical interventions needed for after hour services.

Eligibility

To be eligible to participate in this program staff must meet all of the following conditions:

1. Be regularly assigned to an alternate work shift; evening or nights.
2. Evening shift is defined as start time ~~on or after~~between 3:00pm and 6:59pm.
3. Night shift is defined as start time ~~on or after~~between 7:00 p.m. and midnight.
4. Be assigned full time to the Utilization Management department in one of the following titles:
    - Authorization Technician I
    - Authorization Technician II
    - Authorization Technician III
    - Lead Authorization Technician
    - Supervisor, Authorization Technician
    - Utilization Management Nurse Specialist LVN II
    - Utilization Management Nurse Specialist RN
    - Utilization Management Admissions Liaison RN II
5. Receive prior written approval to participate by the Senior Director, Utilization Management or Director, Utilization Management ~~Services~~.
6. Be assigned to provide timely authorization for medically necessary care for after hour services.
7. Clinical team members will perform all clinical interventions and Non-clinical team members will be responsible for all non-clinical interventions and assist in the transfer of members.

Compensation

Participants in the After Hours program will receive an alternate shift premium which will be paid as a premium pay (pro-rated based on assigned FTE).

Evenings:

- Hourly or Per Diem Registered Nurses: additional $2.00 per hour ~~worked~~.
- Regular full time Registered Nurse: additional $4,160 (annualized rate)
- Hourly or Per Diem Licensed Vocational Nurse: additional $1.50 per hour ~~worked~~.
- Regular full time Licensed Vocational Nurse: additional $3,120 (annualized rate)
- Regular full time Authorization Technicians and Lead Authorization Technicians: additional $0.50 per hour ~~worked~~.
- Regular full time Supervisor, Authorization Technician: additional $1,040 (annualized rate)

Nights:

- Hourly or Per Diem Registered Nurses: additional $4.00 per hour ~~worked~~.
- Regular full time Registered Nurse: additional $8,320 (annualized rate)
- Hourly or Per Diem Licensed Vocational Nurse: additional $2.50 per hour ~~worked~~.
- Regular full time Licensed Vocational Nurse: additional $5,200 (annualized rate)
- Regular full time Authorization Technicians and Lead Authorization Technicians: additional $0.75 per hour ~~worked~~
- Regular full time Supervisor, Authorization Technician: additional $1560 (annualized rate)

Procedures

- Positions eligible for this program will be assigned position codes with "(After Hours - - Evening)" or "(After Hours – - Nights) in the title.

  Example: Utilization Management Nurse Specialist RN II (After Hours-Evenings).

- Should an employee transfer to a non-program participating position, they will no longer receive the After Hours Program shift premium pay for alternate shifts.

- Management will work with their Human Resources Business Partner to remove the premium pay from their position.

- Shift premium is paid as a separate line item and not included in the base regular rate.

- Shift premium is paid as a separate line item for worked time, such as regular and overtime for non-exempt employees.

- Shift premium is paid as a separate line item for non-worked time such as Paid Time Off, Jury Duty or Bereavement Leave.

- Refer to HR-606 Shift policy for additional information.

- ~~Shift premium pay will be included in a participating employee's hourly rate of pay for purposes of calculating overtime, paid sick leave, and other approved leaves as required by law.~~

L.A. Care reserves the right to modify, rescind, delete or add to this program at any time, with or without notice.

Reviewed and Approved:

Name	Date
~~Jean Giggers~~Tara Nelson, Senior Director, Utilization Management ~~Services~~	~~9/18/2019~~
Terry Brown, Chief Human Resources Officer	

	MONTHLY/QUARTERLY INCENTIVE PROGRAMS	HR-PR-633
DEPARTMENT	HUMAN RESOURCES	
Supersedes Policy Number(s)	HR-610, HR-611, HR-612, HR-613, HR-614, HR-615, HR-616, HR-627	

DATES					
Effective Date	1/25/2017	Review Date	~~10/16/2017~~5/8/2025	Next Annual Review Date	~~10/16/2018~~5/8/2026
Legal Review Date	2/15/2019	Committee Review Date	~~2/25/2019~~6/27/2025		

LINES OF BUSINESS

☐ Cal MediConnect ☐ L.A. Care Covered ☐ L.A. Care Covered Direct ☐ MCLA
☐ PASC-SEIU Plan ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

☐ PP – Mandated ☐ PP – Non-Mandated ☐ PPGs/IPA ☐ Hospitals
☐ Specialty Health Plans ☐ Directly Contracted Providers ☐ Ancillaries ☐ Other External Entities

ACCOUNTABILITY MATRIX

ATTACHMENTS

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	DIRECTOR
NAME	Terry Brown	Sarah Viloria Diaz
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Sr. Director, Human Resources Total Rewards

AUTHORITIES
➢ HR-501, "Executive Committee of the Board: HR Roles and Responsibilities" ➢ California Welfare & Institutions Code §14087.9605

REFERENCES

HISTORY	
REVISION DATE	DESCRIPTION OF REVISIONS
1/25/2017	New Policy
9/21/2017	Revision which allows CEO to approve financial incentive bonus Incentive requirements for Sales and Marketing department updated
5/8/2025	Review; Updated List of Departments eligible for Monthly/Quarterly Incentive Programs

DEFINITIONS

1.0 OVERVIEW:

1.1 The monthly/quarterly incentive program is intended to recognize and reward eligible employees in production or sales-based positions who exceed pre-determined department performance standards.

2.0 POLICY:

2.1 Certain production and sales-based positions may be eligible for a monthly or quarterly incentive.

~~2.1~~2.2 Department standards will be reviewed and approved by the respective department director and the Chief Human Resources Officer ("CHRO") on an annual fiscal year basis ~~in order to~~to align with L.A. Care Health Plan's ("L.A. Care") strategic goals and business needs.

~~2.2~~2.3 The awarding of monthly/quarterly incentive program is not automatic and requires annual authorization from the Board of Governors.

~~2.3~~2.4 L.A. Care reserves the right to make modifications to this program or cancel the program at any time, with or without notice.

3.0 DEFINITIONS:

~~Whenever a word or term appears capitalized in this procedure, the reader should refer to the "Definitions" below.~~

3.1 N/A

4.0 PROCEDURES:

4.1 Eligibility:

4.1.1 In order to be eligible for the monthly/quarterly incentive program, an employee must hold a L.A. Care position that has been identified as eligible under this program. In addition, the employee must have obtained any required certification and/or licensing, as required by the position's job description.

4.1.2 Employee performance will be evaluated on a monthly basis based on pre-approved production standards as determined by the respective department and approved by the department director and the CHRO.

4.1.3 A new employee will become eligible for the monthly/quarterly incentive program on the first of the month following successful completion of three continuous months of employment at L.A. Care. Temporary employees that transition to a ~~full time~~full-time regular position will be eligible to participate in the monthly/quarterly incentive program on the first day of the month following successful completion of three continuous months of employment in the same position at L.A. Care.

4.1.3.1 Sales ~~and Marketing~~ staff are eligible for sales incentive at the time of hire with no waiting period.

4.1.4 If an employee transfers from a non-~~production based~~production-based position to a ~~production based~~production-based position, he or she will be eligible to participate in the monthly/quarterly incentive program on the first of the month following successful completion of three continuous months of employment in the production based position at L.A. Care.

4.1.4.1 Sales ~~and Marketing~~ staff are eligible for sales incentive at the time the employee transfers into the department with no waiting period.

4.1.5 If an employee transfers from a ~~production based~~production-based position to a non-~~production based~~production-based position, he or she will be eligible for a pro-rated payout for production goals that were met in the ~~production based~~production-based position. Such employees will then be eligible for a pro-rated share of the annual incentive bonus based upon their time in the non-~~production based~~production-based position.

4.1.6 Temporary or per diem employees are not eligible to participate in the monthly/quarterly incentive program.

4.1.7 The payout amounts for the monthly/quarterly incentive program will vary from department to department, are subject to department budget approval and must meet the specific metrics defined by the awarding department in conjunction with the CHRO.

4.1.8 The actual incentive amount that is awarded on monthly or quarterly basis will depend on the degree to which incentive criteria is met.

4.1.9 In order to be eligible for the monthly/quarterly incentive payout, an employee may not be on any form of disciplinary action (i.e. verbal, written, final or performance improvement plan) during the month of eligibility. An employee on corrective action may become eligible for the monthly incentive/quarterly payout on the first day of the month following the restriction period noted on the corrective action.

4.1.9.1 Sales ~~and Marking~~ staff may be eligible for the monthly/quarterly incentive regardless of disciplinary action plan as determined by management.

4.1.10 Any production work that is completed during overtime is excluded from the overall calculation of the monthly incentive payout.

4.1.10.1 Sales ~~and Marketing~~ staff are eligible to receive sales incentive for sales made during overtime.

~~for sales made during overtime.~~

4.1.11 Eligibility for participation in the monthly/quarterly incentive program will be determined on a monthly or quarterly basis. Supervisors, managers and directors are responsible for reviewing and approving employee eligibility on a monthly or quarterly basis.

4.1.12 An eligible employee must be actively employed and not on an approved leave of absence at the time the incentive payout is disbursed, to the extent permitted by law.

4.1.12.1 Sales ~~and Marketing~~ staff will receive the sales incentive for all sales made regardless of employment status at the time of payout.

4.1.13 The incentive payout is considered taxable income.

4.1.14 Employees may be eligible to participate in the monthly/quarterly incentive program in addition to other L.A. Care ~~incentive based~~incentive-based programs at the discretion and approval of the Chief Executive Officer (CEO).

4.2 Performance Objectives

4.2.1 Eligible employees must exceed their department's pre-established performance objectives in order to qualify for the incentive payout.

4.3 Monthly/Quarterly Incentive Management & Evaluation

4.3.1 Supervisors, managers, and directors are responsible for updating standards that support the service areas alignment with the Chief Executive Officer's strategic initiatives on an annual basis.

4.3.2 L.A. Care reserves the right to withhold incentive payouts if supervisors, managers, and/or directors do not provide updated department standards on a yearly basis.

4.3.3 Supervisors, managers and/or directors are required to provide every employee with a copy of the pre-determined department standards and are responsible for ensuring that employees review the incentive policy and related desktop procedures.

4.3.4 Supervisors, managers and directors are required to complete monthly or quarterly performance records that will assist in monitoring employee performance. These reports may be used to inform changes made to future performance metrics.

4.3.5 Supervisors, managers and/or directors must submit monthly/quarterly incentive goal worksheets to the Total Rewards Department in Human Resources by 5:00 p.m. on the ~~first~~ Friday prior to the scheduled pay date.~~of every month. Worksheets submitted after 5:00 p.m. on the first Friday of every month will be processed on the next regularly scheduled pay date.~~

4.4 Monthly Incentive Plan Pre-Approved Units and Departments

Monthly Incentive Plan	
Units	Department
Information Services Help Desk Unit	I~~nformation~~ T~~echnology~~ Executive Administration
~~Member Services~~Customer Solution Call Center~~ Unit~~	~~Member Services~~Customer Solution Call Center
Sales ~~and Marketing Unit~~	Product Sales ~~and Marketing~~

~~4.5 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.~~

5.0 MONITORING:

~~5.1~~ Department standards will be reviewed and approved by the respective department director and the CHRO on an annual fiscal year basis.

6.0 REPORTING:

~~6.1~~ Any suspected violations to this policy should be reported to your Human Resources Business Partner.

7.0 ~~5~~ L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.

	INTERNSHIP PROGRAM	HR-708
DEPARTMENT	HUMAN RESOURCES	
Supersedes Policy Number(s)		

DATES							
Effective Date	8/22/2018	Review Date	8/22/2018	Next Annual Review Date		Legal Review Date	

LINES OF BUSINESS

☐ Cal MediConnect ☐ L.A. Care Covered ☐ L.A. Care Covered Direct ☐ MCLA
☐ PASC-SEIU Plan ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

☐ PP – Mandated ☐ PP – Non-Mandated ☐ PPGs/IPA ☐ Hospitals
☐ Specialty Health Plans ☐ Directly Contracted Providers ☐ Ancillaries ☐ Other External Entities

ACCOUNTABILITY MATRIX

ATTACHMENTS

- Interview Rubric Form

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	DIRECTOR
NAME	Terry Brown	Jackie Tham
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Senior Director, Center for Organizational Excellence

AUTHORITIES

- HR-501 Executive Committee of the Board: HR Roles and Responsibilities
- California Welfare & Institutions Code Section 14087.9605

REFERENCES

HISTORY

REVISION DATE	DESCRIPTION OF REVISIONS

DEFINITIONS

Please visit the L.A. Care intranet for a comprehensive list of definitions used in policies:
http://insidelac/ourtoolsandresources/departmentpoliciesandprocedures

1.0 OVERVIEW:

1.1 To organize and standardize L.A. Care Health Plan's (L.A. Care) Internship Program. This program provides students with a meaningful learning experience applicable to their field of study. This policy is intended to provide a guide for submitting Internship applications to Human Resources Department and to outline the responsibilities of each department in relation to Interns.

1.2 The purpose of the Internship Program is to provide training similar to that which would be given in an educational environment, and is designed and intended solely for the benefit of Interns by providing participants with a meaningful educational and training experiences in a public health plan. This program strives to ensure that every Intern has a valuable, meaningful and productive experience at L.A. Care.

2.0 DEFINITIONS:

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

2.1 **Intern -** A student from a Qualifying Educational Institution selected to participate in L.A. Care's Internship Program who is brought in to gain experience in his/her field of study for a defined period of time.

2.2 **Qualifying Educational Institution -** A regionally or nationally accredited college or university.

2.3 **Internship Program -** A program that allows Interns to gain experience in his/her field of study or satisfy educational requirements. The Internship Program is designed and intended solely for the benefit of Interns by providing the participants with meaningful educational and training experience in areas of their study that also correspond to L.A. Care's operations.

2.4 **Clinical Internship -** A program that allows students to gain experience in specific health related disciplines (i.e., medicine, pharmacy, nursing, etc.), while satisfying an educational requirement as a condition of the program. The Clinical Internship Program is designed and intended solely for the benefit of students by providing the participants with meaningful educational and training experience in areas of study that correspond to L.A. Care's clinical operations, such as nursing and pharmacy. These internships must remain unpaid as a condition of the internship and the Affiliation Agreement (when applicable).

2.5 **Affiliation Agreement -** An agreement between L.A. Care and a Qualifying Educational Institution that specifies the requirements for an Intern to receive academic credit.

3.0 POLICY:

3.1 The Center for Organizational Excellence (COE) Learning and Development (L&D) is responsible for overseeing both Internship Program and Clinical Internship, and appropriately placing Interns in accordance with the purpose of the underlying program and this policy

3.2 The COE L&D is responsible for outreach, education, and efforts to seek applicants for both the Internship Program and Clinical Internships, via Internship postings, onsite outreach conversations with university/organizational staff and other appropriate means.

3.3 All Interns, participating in either the Internship Program or a Clinical Internship, and that are receiving academic credit, must have an executed Affiliation Agreement signed between L.A. Care and the Qualifying Educational Institution prior to the start of the Internship.

3.4 For reasons of supervision, safety, security, and/or morale, and to avoid any potential conflicts, family members or relatives will not be placed in an Internship Program or Clinical Internship under the direct supervision of one another, nor will they be placed in the same department or service area if the work may create or pose actual or potential conflicts of interests as described in Employment of Relatives policy (HR-304). Additionally, no family member or relative of a potential Intern shall participate in, influence or make a decision relating to his or her participation in L.A. Care's Internship Program or Clinical Internship.

3.5 Participating Interns are not intended to and shall not displace regular, part-time or other employees at L.A. Care. Interns' work complement, and does not displace, the work of paid L.A. Care employees while providing significant educational benefit to the Interns.

3.6 Participation in the Internship Program or Clinical Internship shall not guarantee an Intern employment at L.A. Care upon the conclusion of the program. An internship at L.A. Care shall not be construed as an expectation or commitment on the part of L.A. Care to provide an Intern with paid employment at L.A. Care.

3.7 Participating Interns may be offered a stipend for their participation in the Internship Program. Interns shall not be entitled to compensation, salary or benefits from L.A. Care.

4.0 PROCEDURES:

4.1 The Human Resources Information Systems (HRIS) will be used to track placement and completion of an Intern's participation in Internship Program or Clinical Internship.

4.2 Any department that wishes to add an Intern shall submit an Intern request ticket via the COE L&D SharePoint site. The following information must be included on the requisition ticket:

4.2.1 Title of host department requesting Intern, including name of department director;

4.2.2 Hours (per week) of expected training which cannot exceed 29 hours per week and estimated duration of Internship, including estimated start and end date;

4.2.3 Brief description of expected learning opportunities and schedule of training hours;

4.2.4 Comments to include additional requests or stipulations;

4.2.5 Acknowledgement that host department has read and agreed to the terms and conditions of the L.A. Care Internship Program or Clinical Internship policy.

4.3 Requests for Interns will be routed to the COE L&D via SharePoint:

4.3.1 COE L&D will review all requests and prioritize based on the department that would benefit the Intern based on their field of study;

4.3.2 COE L&D will approve or deny all requests. Requests for Interns are reviewed and approved on a first come first serve basis; and

4.3.3 Once placement has been approved by COE L&D, a requisition will be initiated via the HRIS.

4.4 COE L&D will be responsible for:

4.4.1 Providing departments with information regarding the Internship Program and Clinical Internships, and training on adherence to the terms of Affiliation Agreement(s);

4.4.2 Coordination of interviews and placement in host department;

4.4.3 Maintaining periodic meetings with Interns to ensure positive and meaningful experience;

4.4.4 Coordinating monthly participating Intern meetings and activities;

4.4.5 On-site orientation and training;

4.4.6 Internship experience interview and feedback survey.

4.5 Human Resources Talent Acquisition and Business Support Services will be responsible for:

4.5.1 Overseeing the onboarding process including background check, and any other required paperwork;

4.5.2 Initial onboarding and training;

4.5.3 Applicable onboarding documentation to begin Internship Program or Clinical Internship.

4.5.4 Completion of procedures which include: Human Resources exit interview, and final Internship Program/Clinical Internship evaluation.

4.6 The host department will be responsible for:

4.6.1 Adhering to the Internship Program or Clinical Internship curriculum, training schedule and reporting requirements as defined by the Affiliation Agreement;

4.6.2 Oversight and management of the Intern's experience and day to day training/educational activities;

4.6.3 Creating and managing Intern daily activities and training schedule;

4.6.4 Providing department resources, supplies, workstation, etc.;

4.6.5 Creating initial footprints ticket for workstation setup.

4.7 All host departments will adhere to an open enrollment period for requesting Interns:

4.7.1 Spring enrollment dates are as follows:

4.7.1.1 Open request period, October 1st – November 30th;

4.7.1.2 Research Period, November 16th – January 31st;

4.7.1.3 Targeted start date February 1st.

4.7.2 Summer enrollment dates are as follows:

4.7.2.1 Open request period, March 1st – April 30th;

4.7.2.2 Research Period, April 16th – May 31st;

4.7.2.3 Targeted start date June 1st.

4.7.3 Fall enrollment dates are as follows:

4.7.3.1 Open request period, June 1st – July 30th;

4.7.3.2 Research Period, July 16th –August 31st;

4.7.3.3 Targeted start date September 1st.

4.7.4 COE L&D can choose Interns from previous applications if a suitable match could not be located or if a hold was placed on a prior Internship's start date.

4.8 The COE L&D team will determine which L.A. Care departments would most benefit from an Internship Program or Clinical Internship through research and survey information and will prioritize those roles for matching Interns.

4.9 Interviews must be attended by the host department's hiring manager and at least one COE L&D representative. An interview rubric hiring form must be completed and submitted to COE L&D for placement in the Intern file.

4.10 Interns will be required to attend department and training orientation prior to the start of their program. An Internship Program and/or Clinical Internship orientation will be administered during the applicable seasonal cohort. All Interns will be required to complete the following training:

4.10.1 Code of Conduct

4.10.2 CMC Awareness

4.10.3 Cyber Security Awareness

4.10.4 Deficit Reduction Act: False Claims and Employee Protections Training

4.10.5 Fraud and Abuse Awareness

4.10.6 HIPAA: General Awareness

4.10.7 Information Security

4.10.8 Building Safety Training

4.11 The Internship Program and/or Clinical Internship orientation is intended to educate and inform about organizational policies, procedures, Code of Conduct that Interns are expected to adhere to while at L.A. Care.

4.12 Upon notification of an Intern's first day, the host department will be responsible for notifying facilities, payroll (when applicable for stipend) and IT for coordination of work stations, stipend and system access prior to an Interns' first day.

4.13 Each new Intern will receive an in-depth review of host department functions and activities. The host department is responsible for detailing which activities the Intern

will perform. Such department review is considered a dual effort between the host department and COE L&D. COE L&D will complete all requested documentation from Intern's educational institution.

4.14 Interns are required to meet with an onsite field instructor when required by the Affiliation Agreement. COE L&D will schedule a one hour bi-weekly meeting with all Interns to review progress of the internship and to answer any questions/concerns to ensure that all assigned work and documentation will be completed on schedule.

4.15 Interns are required to submit bi-weekly reflection journals that may be reviewed and discussed during bi-weekly meetings with the COE L&D team.

4.16 Interns are required to attend quarterly participant meetings that may include presentations from L.A. Care leadership, guest speakers, vendor/provider community partners and field outings to L.A. Care's family resource centers.

4.17 Each Intern will have a file saved in COE L&D's, password protected network drive consisting of a resume, interview rubric, reflection journals, short bio (when provided) and feedback from field instructors, and an experience survey.

4.18 COE L&D will send each Intern a notification email to complete an experience survey within 30 days of the conclusion of the Internship Program or Clinical Internship.

4.19 Interns participating in the Internship Program or Clinical Internships may be terminated by either Party any time, with or without cause.

5.0 MONITORING:

5.1 COE L&D is responsible for coordinating and supervising the Internship Program to ensure the program's policies and procedures are followed and to maintain the integrity of the program's effectiveness.

6.0 REPORTING:

6.1 Any suspected violations to this policy should be reported to your Human Resources Business Partner.

7.0 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.

INTERNSHIP PROGRAM
STANDARD OPERATING PROCEDURE

1.0 OVERVIEW:

1.1 To organize and standardize L.A. Care Health Plan's (L.A. Care) paid Internship Program. This program provides students with a meaningful learning experience applicable to their field of study. This Standard Operating Procedure is intended to provide a guide for submitting Internship applications to the Human Resources Department and to outline the responsibilities of each host department in relation to Interns.

1.2 The purpose of the Internship Program is to provide college students with work experience related to their academic focus. This program strives to ensure that every Intern has a valuable, meaningful and productive experience at L.A. Care. In addition, the program is designed to create a pipeline of talent.

2.0 DEFINITIONS:

Whenever a word or term appears capitalized in this procedure, the reader should refer to the "Definitions" below.

2.1 **Intern -** A student currently enrolled in a Qualifying Educational Institution selected to participate in L.A. Care's Internship Program who is brought in to gain experience in their field of study for a defined period of time.

2.2 **Qualifying Educational Institution -** A regionally or nationally accredited college or university.

2.3 **Clinical Internship -** A program that allows students to gain experience in specific health related disciplines (i.e., medicine, pharmacy, nursing, etc.), while satisfying an educational requirement as a condition of the program. The Clinical Internship Program is designed and intended solely for the benefit of students by providing the participants with meaningful educational and training experience in areas of study that correspond to L.A. Care's clinical operations, such as nursing and pharmacy. These internships must remain unpaid as a condition of the internship and the Affiliation Agreement (when applicable).

2.4 **Affiliation Agreement -** An agreement between L.A. Care and a Qualifying Educational Institution that specifies the requirements for an Intern to receive academic credit.

3.0 PROCESS:

3.1 Talent Acquisition is responsible for overseeing the paid Internship Program and appropriately placing Interns in accordance with the purpose of the underlying program and this Standard Operating Procedure.

3.2 Talent Acquisition is responsible for the outreach, education, and efforts to recruit applicants for the paid Internship Program.

3.3 For reasons of supervision, safety, security, and/or morale, and to avoid any potential conflicts, family members or relatives will not be placed in an Internship Program or Clinical Internship under the direct supervision of one another, nor will they be placed in the same department or service area if the work may create or pose actual or potential conflicts of interests as described in Employment of Relatives policy (HR-304). Additionally, no family member or relative of a potential Intern shall participate in, influence or make a decision relating to his or her participation in L.A. Care's Internship Program or Clinical Internship.

3.4 Participating Interns are not intended to and shall not displace regular, part-time or other employees at L.A. Care. Interns' work complements, and does not displace, the work of paid L.A. Care employees while providing significant work experience benefit to the Interns.

3.5 Participation in the Internship Program or Clinical Internship shall not guarantee an Intern employment at L.A. Care upon the conclusion of the program. An internship at L.A. Care shall not be construed as an expectation or commitment on the part of L.A. Care to provide an Intern with paid employment at L.A. Care.

4.0 PROCEDURES:

4.1 The Human Resources Information Systems (HRIS) will be used to track placement and completion of an Interns' participation in Internship Program or Clinical Internship.

4.2 Any department that wishes to add an Intern shall submit an Intern request ticket via the Talent Acquisition JIRA portal. The following information must be included on the requisition ticket:

4.2.1 Title of host department requesting Intern, including name of department director;

4.2.2 Hours (per week) of expected training which must be a minimum of 12 hours and cannot exceed 20 hours per week.

4.2.3 Brief description of expected projects and tasks, and schedule of training hours;

4.2.4 Comments to include additional requirements

4.2.5 Acknowledgement that host department has read and agreed to the terms and conditions of the L.A. Care Internship Program or Clinical Internship guidelines.

4.3 Requests for Interns will be routed to the Talent Acquisition JIRA portal:

4.3.1 Talent Acquisition will review all requests and prioritize based on the department that would benefit the Intern based on their field of study;

4.3.2 Talent Acquisition will approve or deny all requests. Requests for Interns are reviewed and approved on a first come first serve basis; and

4.3.3 Once placement has been approved by Talent Acquisition, a requisition will be initiated via the HRIS.

4.4 Talent Acquisition will be responsible for:

4.4.1 Providing departments with information regarding the Internship Program;

4.4.2 Coordination of interviews and placement in host department;

4.4.3 Maintaining periodic meetings with Interns to ensure a positive and meaningful experience;

4.4.4 Coordinating monthly participating Intern meetings and activities;

4.4.5 Internship feedback survey for managers and Interns.

4.4.6 Overseeing the onboarding process including background check, and any other required paperwork;

4.4.7 Initial onboarding;

4.4.8 Applicable onboarding documentation to begin Internship Program;

4.5 The host department will be responsible for:

4.5.1 Adhering to the Internship Program , training schedule;

4.5.2 Oversight and management of the Intern's experience and day to day training/educational activities;

4.5.3 Creating and managing Intern daily activities and training schedule;

4.5.4 Providing department resources, supplies, workstation, etc.;

4.5.5 Creating initial JIRA User Profile Form ticket for workstation setup.

4.6 All host departments will adhere to an open enrollment period for requesting Interns:

4.6.1 Spring enrollment dates are as follows:

4.6.1.1 Open request period, October 1st – November 30th;

4.6.1.2 Research Period, November 16th – January 31st;

4.6.1.3 Targeted start date February 1st.

4.6.2 Summer enrollment dates are as follows:

4.6.2.1 Open request period, March 1st – April 30th;

4.6.2.2 Research Period, April 16th – May 31st;

4.6.2.3 Targeted start date June 1st.

4.6.3 Talent Acquisition can choose Interns from previous applications if a suitable match could not be located or if a hold was placed on a prior Internship's start date.

4.6.4 At the discretion of L.A. Care internship program schedule may be adjusted and if needed will be done with consideration made to the academic calendar.

4.7 The Talent Acquisition team will ensure that the host department has a meaningful assignment.

4.8 Interviews must be attended by the host department's hiring manager and at least one Talent Acquisition representative. An interview rubric hiring form must be completed and submitted to Talent Acquisition for placement in the Intern file.

4.9 Interns will be required to attend department and training orientation prior to the start of their program. An Internship Program orientation will be administered during the applicable seasonal cohort. All Interns will be required to complete the following training:

4.9.1 Code of Conduct

4.9.2 CMC Awareness

4.9.3 Cyber Security Awareness

4.9.4 Deficit Reduction Act: False Claims and Employee Protections Training

4.9.5 Fraud and Abuse Awareness

4.9.6 HIPAA: General Awareness

4.9.7 Information Security

4.10 The Internship Program orientation is intended to educate and inform about organizational policies, procedures, Code of Conduct that Interns are expected to adhere to while at L.A. Care.

4.11 Upon notification of an Intern's first day, the host department will be responsible for notifying facilities, payroll (when applicable for stipend) and IT for coordination of workstations, stipend and system access prior to an Intern's first day.

4.12 Each new Intern will receive an in-depth review of host department functions and activities. The host department is responsible for detailing which activities the Intern will perform. Such department review is considered a dual effort between the host department and Talent Acquisition.

4.13 Interns may attend meetings that may include presentations from L.A. Care leadership, guest speakers, vendor/provider community partners and field outings to L.A. Care's family resource centers.

4.14 Interns participating in the Internship Program may be terminated by either Party any time, with or without cause.

5.0 MONITORING:

5.1 Talent Acquisition is responsible for coordinating and supervising the Internship Program to ensure the program's policies and procedures are followed and to maintain the integrity of the program's effectiveness.

6.0 REPORTING:

6.1 Any suspected violations of this procedure should be reported to your Human Resources Business Partner.

6.2 L.A. Care reserves the right to modify, rescind, delete, or add to this procedure at any time, with or without notice.