NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, SEPTEMBER 7, 2017
2:00 P.M.

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

TELECONFERENCE LOCATION:
44600 INDIAN WELLS LANE, INDIAN WELLS, CA 92210

BOARD OF DIRECTORS

Paul Yost, M.D., Chair	Lee Penrose, Vice Chair
Supervisor Lisa Bartlett	Supervisor Andrew Do
Ria Berger	Ron DiLuigi
Dr. Nikan Khatibi	Alexander Nguyen, M.D.
Richard Sanchez	J. Scott Schoeffel

Supervisor Michelle Steel, Alternate

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Michael Schrader	Gary Crockett	Suzanne Turf

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

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

The Board Meeting Agenda and supporting documentation is available for review at CalOptima, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. The Board Meeting Agenda and supporting materials are also available online at www.caloptima.org. Board meeting audio is streamed live at https://caloptima.org/en/AboutUs/BoardMeetingsLive.aspx

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
    a. Program of All-Inclusive Care for the Elderly (PACE) Draft Policy Letter
    b. PACE Service Area Expansion Application
    c. State Medical Loss Ratio Audit of CalOptima
    d. Proposition 56 Supplemental Medi-Cal Payments
    e. Medicare Risk Adjustment Factor Score
    f. State Payments
    g. County Community Service Center
    h. J.D. Power Medicaid Study
    i. CalOptima-Hosted Meetings

PUBLIC COMMENTS

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

CONSENT CALENDAR

2. Minutes
    a. Approve Minutes of the August 3, 2017 Regular Meeting of the CalOptima Board of Directors
    b. Receive and File Minutes of the June 8, 2017 Meeting of the CalOptima Board of Directors' Provider Advisory Committee, and the June 22, 2017 Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee

REPORTS

3. Consider Further Actions Related to the Provision of Behavioral Health Services for CalOptima Medi-Cal Members

4. Consider Adoption of Resolution Approving Updated Human Resources Policies

5. Consider Authorizing Expenditures for CalOptima Staff Wellness Programs from Funding Received from CIGNA HealthCare for Calendar Year 2017

6. Consider Authorizing Employee and Retiree Group Health Insurance for Calendar Year 2018

7. Consider Actions Related to Reimbursement for Newborn Coverage

8. Consider Authorizing Amendment of Existing Contract with Verscend Technologies to Include Scope of Services Related to Review of Institutional and Professional Claims for All Lines of Business Covering the Period January 1, 2017 through February 28, 2018

9. Consider Actions Related to OneCare Connect Enrollment and Deemed Eligibility; Consider Amendments to Related Contracts and Policies

10. Consider Authorizing a Grant to the Orange County Health Care Agency, in Conjunction with the County's Whole Person Care Pilot, of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

12. Specific to the CalOptima PACE Program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services

13. Consider Authorizing Request for Waiver Allowing Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

14. Consider Extension of Deadline for Intergovernmental Transfer (IGT) Project with University of California, Irvine (UCI) Health's Observation Stay Pilot Program

15. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Events

16. Consider Chief Executive Officer Performance Review and Compensation *(to follow Closed Session)*

ADVISORY COMMITTEE UPDATES

17. Member Advisory Committee Update

18. Provider Advisory Committee Update

19. OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee Update

INFORMATION ITEMS

20. July 2017 Financial Summary

21. Compliance Report

22. Federal and State Legislative Advocates Report

23. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

CS 1 Pursuant to Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer)

CS 2 Pursuant to Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS
Agency Designated Representatives: (Paul Yost, M.D. and Lee Penrose)
Unrepresented Employee: (Chief Executive Officer)

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, October 5, 2017 at 2:00 p.m.

MEMORANDUM

DATE:	September 7, 2017
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee

Program of All-Inclusive Care for the Elderly (PACE) Draft Policy Letter
On August 30, the Department of Health Care Services (DHCS) released a draft policy letter with a revised review process and timeline affecting applications for PACE expansion and new PACE organizations. This draft letter supersedes the April DHCS policy document that your Board received at our May PACE Study Session. Of note, the draft policy letter would prohibit PACE organizations from fully delegating fundamental elements of the program. However, it would permit subcontracting specific services, such as transportation, and using Alternative Care Settings (ACS) to deliver some PACE services. Further, the letter states that, in County Organized Health System (COHS) counties, independent PACE organization applicants must have a letter of support from the COHS plan. Staff is in the process of analyzing the draft policy letter and will, in coordination with your Board, prepare a response within the given two-week comment period.

PACE Service Area Expansion (SAE) Application
Given that DHCS is accepting comments on the draft policy letter, it could take several months until policies are finalized. In the interest of time and in order to be responsive to community demand for PACE services, staff has begun the SAE application process for expanding CalOptima's PACE services to south Orange County using the ACS model. Your Board previously approved moving forward with the SAE application for south Orange County. If DHCS' final guidance results in policy changes, and your Board provides direction in response, we can either amend our SAE application or start a new one. We anticipate that the SAE application will take several weeks to complete, as it requires detailed information about how we plan to provide PACE services in the new area. Once we submit the SAE application, it can take approximately nine months for review and approval by both DHCS and the Centers for Medicare & Medicaid Services (CMS).

State Medical Loss Ratio (MLR) Audit of CalOptima
The state is planning to conduct MLR audits of all Medi-Cal managed care plans, including CalOptima, for the Expansion population (members who became eligible through the Affordable Care Act) beginning in the fall. Our state contract specifies that, for the Expansion population, CalOptima must have an MLR of no less than 85 percent, meaning that we must spend at least 85 cents of every dollar for medical services, or no more than 15 percent for administration. After CMS approves the audit methodology, the state will release it to the health plans.

Back to Agenda

Proposition 56 Supplemental Medi-Cal Payments
Effective in April, Proposition 56 increased the state tax on tobacco products. The tax is expected to generate approximately $1.3 billion in new Medi-Cal revenue for FY 2017–18. The state budget allocates a portion of these funds for supplemental payments to Medi-Cal providers. DHCS recently released guidance stating that some of those supplemental payments will flow through managed care plans to physicians who provide certain services to members. These payments will begin once DHCS obtains federal approval and will be retroactively effective, from July 1, 2017, to June 30, 2018. The California Association of Health Plans is working with the state on a disbursement methodology, and CalOptima is participating in this workgroup. We will update your Board and our provider community when more information is available.

Medicare Risk Adjustment Factor (RAF) Score
CalOptima budgeted for a decrease in FY 2017–18 Medicare revenue due to a decrease in RAF scores. CalOptima now anticipates that RAF scores for OneCare and OneCare Connect will be returning to prior levels. The improvement is the result of multiple efforts, including addressing provider coding issues, encouraging members to visit their doctors, and strengthening data compilation and submission to CMS.

State Payments
The state is holding capitation payments for dual eligible members in Medi-Cal from managed care plans. CalOptima has not received any payment for Medi-Cal services provided to duals for dates of service in May and after. According to a mid-August DHCS monthly payment call, the state expects to resolve its internal reconciliation issue in September, which may result in resumption of payments in November. The fiscal impact to CalOptima is approximately $16 million a month.

County Community Service Center
CalOptima continues to boost the service level at the County Community Service Center in Westminster. A full-time staff member has been on site since June. We are also expanding the draw of the center by adding classes to attract CalOptima members and the community at large. New in July was our weekly Mommy and Me classes, led in Vietnamese by staff from MOMS Orange County. This offering joins our regular monthly series on important health care topics. Coming in the fall are classes on care options for the chronically ill, respite care and care planning. Also in the works are regular classes focused on parenting, meditation and diabetes. CalOptima is promoting the center, including running ads for the monthly series and highlighting the center in our agency publications. Further, the center was recently discussed on VSTAR TV in an interview conducted with a CalOptima Vietnamese-speaking Customer Service supervisor.

J.D. Power Medicaid Study
Medicaid enrollees are more satisfied than commercial health plan members, according to the J.D. Power 2017 Medicaid Managed Care Special Report. The July report studied the experience of 2,145 Medicaid members in 36 states and Washington, D.C., and 35 CalOptima members were among those surveyed. The study measured overall satisfaction based on six factors: provider choice, coverage and benefits, customer service, cost, information and communication,

Back to Agenda

and claims processing. The Medicaid results were compared with J.D. Power's 2017 Member Health Plan Study for commercial plans. A press release summary of the report is here.

CalOptima-Hosted Meetings

- **Medi-Cal Expansion (MCE) Rate Meeting**
  In August, CalOptima held a special meeting with health networks to discuss MCE rates. It was well attended by CEOs, CFOs and other network representatives. The meeting included an overview of the rate development template, background on the rate development methodology, a review of the rate adjustment history and the future outlook of MCE rates. Health networks also had the opportunity to submit questions in advance. A robust list of 22 questions were answered during the session.
- **Data Workgroup**
  Recognizing our strategic goal to enhance partnerships, the Quality Analytics department in collaboration with CHOC Children's created a data workgroup to resolve health networks' questions about our Pay for Value and HEDIS programs. The workgroup held its first meeting in August at CalOptima. Clinical and quality staff as well as data analysts at all participating health networks and community clinics were invited. Turnout was good, with attendance by more than 20 staff from five participating health networks, and representatives from 10 community clinics and the Coalition of Orange County Community Health Centers. The agenda topics included immunization rates considering changes with the California Immunization Registry, physician focus groups and primary care provider mapping for well child visits. Attendees completed a brief survey after the meeting that showed a majority agreed the information was applicable and useful. Monthly meetings are planned.

Back to Agenda

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

August 3, 2017

A Regular Meeting of the CalOptima Board of Directors was held on August 3, 2017, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:01 p.m. Director DiLuigi led the Pledge of Allegiance.

ROLL CALL

Members Present: Paul Yost, M.D., Chair; Lee Penrose, Vice Chair; Supervisor Lisa Bartlett, Ria Berger, Ron DiLuigi, Supervisor Andrew Do, Dr. Nikan Khatibi, Alexander Nguyen, M.D., Scott Schoeffel

Members Absent: Richard Sanchez (non-voting)

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Richard Helmer, M.D., Chief Medical Officer; Nancy Huang, Interim Chief Financial Officer; Ladan Khamseh, Chief Operating Officer; Len Rosignoli, Chief Information Officer; Suzanne Turf, Clerk of the Board

Chair Yost announced the following changes to the agenda: the Board will consider Agenda Item 12, Consider Actions Related to the Provision of Behavioral Health Services for CalOptima Medi-Cal Members, and Agenda Item 13, Consider Chief Executive Officer and Chief Counsel Performance Reviews, after Closed Session.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader provided an update on health care reform, and noted that CalOptima staff will continue to work with other health plans through our associations to explore possible improvements to the Medicaid program that could be shared with Members of Congress. Given the unknown status of Medicaid, staff has been in communication with the City of Orange regarding an extension of the current six-year development agreement for the 505 City Parkway West building site that expires in 2020. An updated development agreement action plan including a proposed request for authority to pursue a development agreement extension with the City of Orange will be presented to the Board of Directors' Finance and Audit Committee for review and to the Board of Directors for consideration at a future meeting.

As a follow up to the Board study session on CalOptima's Program of All-Inclusive Care for the Elderly (PACE), a Request for Information (RFI) process was conducted for expanding access to PACE using the Alternative Care Setting model of satellite sites, and staff is in the process of analyzing the RFI results. Additionally, it is anticipated that final guidance from the Department of Health Care Services (DHCS) providing direction regarding delegation in PACE programs will be received in August, which will inform our analysis of the RFI results. An update on the RFI results

and proposed recommendations for CalOptima's PACE program will be presented to the Board for consideration at a future meeting.

PUBLIC COMMENTS

1. Jennifer Ida, Boehringer Ingelheim Pharmaceuticals – Oral re: request to review addition of Jardiance to CalOptima formulary.
2. Lori Aguirre, Bloom Behavioral Health – Oral re: Consider Actions Related to the Provision of Behavioral Health Services for CalOptima Medi-Cal Members.

CONSENT CALENDAR

2. Minutes

a. Approve Minutes of the June 1, 2017 Regular Meeting of the CalOptima Board of Directors

b. Receive and File Minutes of the May 11, 2017 Meeting of the CalOptima Board of Directors' Provider Advisory Committee, and the May 25, 2017 Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 9-0-0)***

REPORTS

3. Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisors Bartlett and Do did not participate in the discussion and vote on this item due to potential conflicts of interest based on campaign contributions under the Levine Act.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors: 1) Ratified an amendment to contract with American Logistics expanding the scope of work to include the Medi-Cal covered taxi services benefit, excluding services provided for members assigned to Kaiser Permanente, for nine months beginning July 1, 2017; 2) Authorized the Chief Executive Officer, with the assistance of legal counsel, to amend other existing contracts through no later than March 31, 2018 as necessary to ensure that qualifying Medi-Cal members have access to covered non-medical transportation services; and 3) Authorized the Chief Executive Officer to conduct a Request for Proposal process to solicit bids from vendors providing non-medical transportation for CalOptima Medi-Cal, effective April 1, 2018. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

Back to Agenda

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for University of California, Irvine (UCI) Observation Stay Pilot

It was noted for the record that the recommendation to extend the deadline for the parties to reach agreement on terms for the UCI Observation Stay Pilot Program will be continued to a future Board meeting.

At the May 4, 2017 Board meeting, an ad hoc composed of Directors Khatibi, Nguyen and Schoeffel was formed to make recommendations to the full Board on the expenditure of IGT 6 and 7 funds. On behalf of the ad hoc, Director Schoeffel reported that the ad hoc met on July 6, 2017 to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee recommended that the Board approve utilizing CalOptima's share of IGT 6 and IGT 7 funds, projected at approximately $22.1 million, to support programs addressing the following areas: opioid and other substance overuse; children's mental health; homeless health; and community grants to support program areas beyond those funded by IGT 5. Staff will present recommendations to the Board for consideration once a more detailed expenditure plan is developed and reviewed with our community stakeholders, including the Provider, Member, and OneCare Connect Member Advisory Committees.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors approved the recommended expenditure categories for IGT 6 and 7, and authorized the proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission. (Motion carried 9-0-0)***

5. Consider Ratifying Amendment to Agreement with the California Department of Health Care Services (DHCS)

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors ratified Amendment 01 to Agreement 16-93274 between CalOptima and the DHCS. (Motion carried 9-0-0)***

6. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute a Revised Amendment A03 or a new Amendment A04 to the Agreement with the California Department of Health Care Services for the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute a revised Amendment A03 or a new Amendment A04 to the PACE Agreement between DHCS and CalOptima, and until such Amendment is provided, authorized and directed the Chairman of the Board of Directors to provide assurances to the DHCS, with the assistance of legal counsel, of CalOptima's intent to comply with all applicable requirements. (Motion carried 9-0-0)***

Back to Agenda

7. Consider Authorizing Amendment of the Memorandum of Understanding Between Orange County Health Care Agency and CalOptima to Include Drug Medi-Cal Organized Delivery System

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to amend the current Memorandum of Understanding between the Orange County Health Care Agency and CalOptima for the provision of Drug Medi-Cal services as defined by the DHCS, effective no sooner than October 1, 2017. (Motion carried 9-0-0)***

8. Consider Adoption of Resolution Approving Updated Human Resources Policies

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors adopted Resolution No. 17-0803-01, Approving Updated Human Resources Policies GA.8037: Leave of Absence, and GA.8058: Salary Schedule. (Motion carried 9-0-0)***

9. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Event

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized up to $1,500 and staff participation in the World Refugee Day 2017 event in Anaheim on August 26, 2017, made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose, and authorized the Chief Executive Officer to execute agreements as necessary for the event and expenditures. (Motion carried 9-0-0)***

10. Consider Authorizing Non-Binding Agreement Between CalOptima, Inland Empire Health Plan, L.A. Care Health Plan, and the Regents of the University of California to Outline General Goals for Collaboration

Directors Nguyen and Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into a non-binding agreement involving CalOptima, Inland Empire Health Plan, and L.A. Care with the Regents of the University of California, a Constitutional Corporation, on behalf of the University of California Office of the President, UC Health and its Academic Medical and Clinical Enterprises in Southern California (UC), that outlines general goals for collaboration among the parties for a one-year term beginning July 1, 2017, with the option to renew for three two-year periods. (Motion carried 7-0-0; Directors Nguyen and Schoeffel absent)***

Back to Agenda

11. Consider Adoption of Resolution Approving CalOptima's Updated Policy No. AA.1217: Legal Claims and Judicial Review

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors adopted Resolution No. 17-0803-02, approving CalOptima's updated Policy No. AA.1217: Legal Claims and Judicial Review, to authorize CalOptima's Chief Executive Officer, with the assistance of legal counsel, to compromise any pending action if the amount to be paid from CalOptima's treasury does not exceed $50,000. (Motion carried 9-0-0)***

Agenda Items 12 and 13 were considered after Closed Session.

ADVISORY COMMITTEE UPDATES

14. OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC) Update

OCC MAC Vice Chair Patty Mouton provided an overview of the activities at the Committee meeting held on June 22, 2017, including an update on the Group Needs Assessment, an overview of OneCare Connect eligibility aid codes, a review of the Veteran's Administration Coordination of Health Care Benefits and the Orange County Strategic Plan on Aging.

15. Member Advisory Committee (MAC) Update

Patty Mouton, MAC Vice Chair, reported that the Committee received the following updates at the July 13, 2017 MAC meeting: initiative for screening of depression in adolescents, CalOptima community engagement, overview of ResCare Workforce Services, and the status of behavioral health services provided by Magellan.

16. Provider Advisory Committee (PAC) Update

The Board accepted the PAC update as presented.

INFORMATION ITEMS

The following Information Items were accepted as presented:
17. June 2017 and May 2017 Financial Summaries
18. Compliance Report
19. Federal and State Legislative Advocates Report
20. CalOptima Community Outreach and Program Summary

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 2:46 p.m. pursuant to:

CS 1 CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION. Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: (one case)

CS 2 Pursuant to Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer)

Back to Agenda

CS 3 Pursuant to Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS
Agency Designated Representatives: (Paul Yost, M.D. and Lee Penrose)
Unrepresented Employee: (Chief Executive Officer)

CS 4 Pursuant to Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Counsel)

CS 5 Pursuant to Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS
Agency Designated Representatives: (Paul Yost, M.D. and Lee Penrose)
Unrepresented Employee: (Chief Counsel)

The Board reconvened to open session at 5:46 p.m.

Vice Chair Penrose provided the following report related to CS 1: The Board authorized the Chief Executive Officer to enter into a transition agreement with Magellan, under which Magellan has committed to remaining contracted with CalOptima through the end of calendar year 2017.

There were no reportable actions taken related to CS 2 through CS 5.

12. Consider Actions Related to the Provision of Behavioral Health Services for CalOptima Medi-Cal Members

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

The following recommended actions were presented for consideration: 1) Authorize the Chief Executive Officer (CEO) to: (a) Amend, with the assistance of legal counsel, the Medi-Cal Contract with the existing managed behavioral health organization to transition to a percent of premium basis for compensation of Applied Behavior Analysis (ABA) services as part of a 180-day wind down period ending on December 31, 2017; (b) Integrate Medi-Cal covered Behavioral Health (BH), which includes Mental Health (MH) and ABA services, within CalOptima internal operations; (c) Establish a standard CalOptima provider fee schedule for MH and ABA services; (d) Enter into contracts, with the assistance of legal counsel, with MH and ABA providers; (e) Enter into an agreement, with the assistance of legal counsel, for after-hour coverage for CalOptima's behavioral health call center and triage services obtained in accordance with CalOptima's Procurement Policy; 2) Authorize reallocation of budgeted funds not to exceed $4.1 million from Medi-Cal administrative expenses for purchased services approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, to Medi-Cal medical and administrative expenses; and 3) Authorize unbudgeted expenditures of up to $2.5 million from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses.

Vice Chair Penrose suggested moving forward with Recommended Action 1.a., and continuing the remaining recommended actions to the September Board of Directors meeting for further study.

Back to Agenda

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized the Chief Executive Officer to amend, with the assistance of legal counsel, the Medi-Cal Contract with the existing managed behavioral health organization to transition to a percent of premium basis for compensation of ABA services as part of a 180-day wind down period ending on December 31, 2017; and continued recommended actions 1.b. through 3 to the September Board of Directors meeting for further study. (Motion carried 6-0-0; Supervisor Do, and Directors Berger and Schoeffel absent)***

Chair Yost added that in addition to providing staff with guidance as part of the recommended process, an ad hoc composed of Vice Chair Penrose, Supervisor Do, and Director Khatibi has been formed to further evaluate options going forward, including exploring the possibility of extending the Magellan relationship.

13. Consider Chief Executive Officer and Chief Counsel Performance Reviews and Compensation
This item was continued to a future Board of Directors meeting.

BOARD MEMBER COMMENTS
Chair Yost announced the formation of and appointments to the following ad hoc committees: 1) Compensation Ad Hoc – Chair Yost, Vice Chair Penrose, and Director DiLuigi; and 2) Legal Structure Ad Hoc – Chair Yost, Supervisor Do, and Director Schoeffel.

Supervisor Bartlett complemented staff on the CalOptima in the Community 2017 brochure.

ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 6:01 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: September 7, 2017

Back to Agenda

MINUTES

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

June 8, 2017

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, June 8, 2017, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Teri Miranti, PAC Chair, called the meeting to order at 8:04 a.m., and Member Jensen led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Teri Miranti, Chair; Suzanne Richards, MBA, FACHE, Vice Chair; Anjan Batra, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Jena Jensen; Pamela Kahn, R.N.; John Nishimoto, O.D.; George Orras, Ph.D., FAAP; Pamela Pimentel, R.N.; Jacob Sweidan, M.D.
Members Absent:	Alan Edwards, M.D.; Steve Flood; Mary Pham, Pharm.D, CHC; Barry Ross, R.N., MPH, MBA;
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Richard Helmer, M.D., Chief Medical Officer; Gary Crockett, Chief Counsel; Nancy Huang, Interim Chief Financial Officer; Michelle Laughlin, Executive Director, Network Operations; Phil Tsunoda, Executive Director, Public Policy and Public Affairs; Cheryl Meronk, Director, Strategic Development; Pshyra Jones, Director, Health Education and Disease Management; Cheryl Simmons, Staff to the Provider Advisory Committee

MINUTES

Approve the Minutes of the May 11, 2017 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the May 11, 2017 meeting. (Motion carried 11-0-0; Members Edwards, Flood, Pham and Ross absent)***

PUBLIC COMMENTS

No requests for public comment were received.

Back to Agenda

REPORTS

CEO AND MANAGEMENT REPORTS

Chief Medical Officer Update

Richard Helmer, M.D., Chief Medical Officer, presented on the CalOptima Community Network's (CCN) Performance: Quality and Financial Analysis. Dr. Helmer reviewed the CCN timeline from its inception in January 2015 to present. The presentation elicited much discussion among the PAC members and CalOptima staff regarding the overlap of physicians in CCN and the other networks. PAC members will solicit additional feedback from their constituents on this topic and share the comments with CalOptima staff.

Chief Financial Officer Update

Nancy Huang, Interim Chief Financial Officer, presented CalOptima's Financial Summary as of April 2017, including a report of the Health Network Enrollment for the month of April 2017. Ms. Huang summarized CalOptima's financial performance and current reserve levels.

Provider Network Operations Update

Michelle Laughlin, Executive Director, Provider Network Operations, invited PAC members to the OneCare Connect Town Hall for Physicians and Hospital Staff on June 20, 2017.

Federal and State Budget Update

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, provided an update on Prop 56 and the potential impact to FY 2017-18 State Budget and CalOptima. He noted that Governor Brown is proposing to allocate all of the new Prop 56 revenue for current and anticipated increases for general Medi-Cal expenditures.

INFORMATION ITEMS

Community Involvement

Cheryl Meronk, Director, Strategic Development, presented on CalOptima's involvement with the community and provided an update on Intergovernmental Transfer (IGT) funds received to date and allocated to provide enhanced benefits to existing Medi-Cal beneficiaries. She noted that $15 million was approved by the Board for community grants pending the completion of a Member Health Needs Assessment. Staff will request PAC input in the development of strategic community grant initiatives to help address identified needs.

2016 Group Needs Assessment

Pshyra Jones, Director, Health Education & Disease Management, presented the 2016 Group Needs Assessment (GNA). She noted that all health plans are required to conduct a GNA with the goal to improve health outcomes for members enrolled in Medi-Cal managed care by evaluating member health risks, identifying health needs, and prioritizing health education, cultural and linguistic services, and preventative health and quality improvement programs to improve member health outcomes.

Back to Agenda

ADJOURNMENT

There being no further business before the Committee, Chair Miranti adjourned the meeting at 10:10 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: August 10, 2017

Back to Agenda

MINUTES

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

June 22, 2017

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on June 22, 2017, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Patty Mouton called the meeting to order at 3:08 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Patty Mouton, Chair; Gio Corzo, Vice Chair; Ted Chigaros, Christine Chow, Josefina Diaz, Sandy Finestone, Sara Lee, George Crits, M.D. (non-voting)
Members Absent:	John Dupies, Donta Harrison, Erin Ulibarri (non-voting)
Others Present:	Michael Schrader, Chief Executive Officer; Dr. Donald Sharps, Medical Director; Candice Gomez, Executive Director, Program Implementation; Sesha Mudunuri, Executive Director, Operations; Belinda Abeyta, Director, Customer Service; Albert Cardenas, Associate Director, Customer Service; Becki Melli, Customer Service; Pamela Reichardt, Executive Assistant

MINUTES

Approve the Minutes of the May 25, 2017 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: ***On motion of Member Sandy Finestone, seconded and carried, the OCC MAC approved the minutes as submitted.***

PUBLIC COMMENT
There were no requests for public comment.

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer Update
Michael Schrader, Chief Executive Officer discussed Medi-Cal Expansion and how proposed changes may effect federal funding through 2023. CalOptima collaborated with plans across

Back to Agenda

California, and sent a joint letter to the Senate Leadership regarding the Senate's consideration of the American Health Care Act, the proposed reduction in federal funding for Medicaid, and the overall impact on health outcomes. CalOptima also sent separate letters to the U.S. Senators representing California highlighting its concerns regarding the impact of the health care bill being developed in the Senate.

Chief Medical Officer (CMO) Update
Dr. Helmer provided an update on CalOptima Community Network and palliative care. Dr. Helmer explained that palliative care is an approach of taking care of people that can improve the care of members, but it is not a specific benefit. Additional information on palliative care will be presented at a future meeting.

Federal and State Budget and Legislative Update
Phil Tsunoda, Executive Director, Public Affairs provided an update on Federal and State Legislative items. It was noted that the proposed state budget continues OneCare Connect through December 31, 2019.

INFORMATION ITEMS

OCC MAC Member Updates:
Chair Mouton announced that the CalOptima Board of Directors approved the recommended slate of candidates for OCC MAC at their June Board meeting, including Josefina Diaz, OneCare Connect Member/Family Member; Sara Lee, Members from Ethnic or Cultural Community; Sandy Finestone, Members with Disabilities; and Gio Corzo, Community Based Adult Services (CBAS) Provider. In addition, Gio Corzo was selected as Chair and Patty Mouton as Vice Chair for fiscal year 2017-18. Richard Santana, In Home Supportive Services (IHSS)/Union Provider will be joining the OCC MAC on July 27, 2017. Chair Mouton requested three volunteers to serve on the Nominations Ad Hoc Subcommittee to review the applications for the open family member seat. Members Sandy Finestone, Ted Chigaros and Christine Chow agreed to serve on this ad hoc.

Member Sara Lee requested that CalOptima staff present on mental health barriers at an upcoming meeting. Member Ted Chigaros will present on post-acute care at the next OCC MAC meeting.

OCC MAC Member Presentation - Orange County Strategic Plan for Aging
Member Christine Chow, Alzheimer's Orange County, presented the Orange County Strategic Plan for the Aging (OCSPA). By 2040, nearly one in four residents in Orange County will be over the age of 65, and the county needs to prepare for the growing numbers of older residents and the issues they face. OCSPA's strategy is to bring together cities, the county, non-profits, foundations, and corporate entities to create a structure to address issues and concerns faced by older residents. The short-term strategy is to "move the needle" over the next 18-months in key areas, such as: 1) food security; 2) health care; 3) elder abuse prevention; 4) transportation; and

Back to Agenda

5) housing. Long-term strategies are to explore larger funding strategies, keep current groups going and develop new 18-month goals.

Group Needs Assessment
Pshyra Jones, Director Health Education and Disease Management, presented the results of the 2016 Group Needs Assessment (GNA). The goal of the GNA is to improve health outcome for members enrolled in Medi-Cal managed care. CalOptima mailed 17,030 surveys with 64% of completed surveys from CalOptima adult Medi-Cal members, 36% completed by adults for CalOptima children with Medi-Cal, and 13% of completed surveys from Seniors and Persons with Disabilities (SPD). GNA results and next steps were reviewed with the Committee.

Veterans Administration Health Care Coordination of Benefits
Belinda Abeyta, Director of Customer, presented an overview of the Veterans Administration (VA) health care eligibility, level of benefits and reimbursement methodology when services provided at a VA facility and a non-VA facility. The member has the right to choose whether to use their VA health care benefits or their Medicare or Medi-Cal health plan benefits.

Member Trend for CalOptima Community Network 2016
Ana Aranda, Manager, Grievance and Appeals, presented the top grievance issues related to quality of service, quality of care and interventions for members assigned to the CalOptima Community Network (CCN).

OneCare Connect Cal MediConnect Aid Codes
Albert Cardenas, Associate Director, Customer Service, presented an overview on aid codes and their relationship to the level of benefits a member is eligible to receive under their Medi-Cal benefits.

ADJOURNMENT
Chair Mouton announced that the next OCC MAC Meeting is Thursday, July 27, 2017. Hearing no further business, the meeting adjourned at 4:30 p.m.

/s/ Eva Garcia for
Pamela Reichardt
Executive Assistant

Approved: July 27, 2017

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Further Actions Related to the Provision of Behavioral Health Services for CalOptima Medi-Cal Members

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400
Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to:
    a. Integrate Medi-Cal covered Behavioral Health (BH), which includes Mental Health (MH) and Applied Behavior Analysis (ABA) services, within CalOptima internal operations effective January 1, 2018;
    b. Establish a standard CalOptima provider fee schedule for MH and ABA services;
    c. Enter into contracts, with the assistance of legal counsel, with MH and ABA providers;
    d. Enter into an agreement, with the assistance of legal counsel, for after-hour coverage for CalOptima's behavioral health call center and triage services obtained in accordance with CalOptima's Procurement Policy;
2. Authorize reallocation of budgeted funds not to exceed $4.1 million from Medi-Cal administrative expenses for purchased services approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, to Medi-Cal medical and administrative expenses; and
3. Authorize unbudgeted expenditures of up to $2.5 million from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses.

Background

Medi-Cal MH/ABA Benefits. Behavioral Health services include MH, substance use disorder, and autism spectrum disorder behavioral health treatment (which includes ABA services). Outpatient mild-to-moderate MH services became a covered benefit for Medi-Cal managed care plans as of January 1, 2014. Beginning in September 2014, CalOptima started providing ABA services to Medi-Cal beneficiaries under the age of 21 under the Early and Periodic Screening, Diagnostic, and Treatment benefit. Like many Medi-Cal managed care plans, CalOptima has contracted with Managed Behavioral Health Organizations (MBHOs) to provide expertise and specialization in the management of behavioral health benefits, including ABA. CalOptima currently contracts with Human Affairs International of California, Inc., dba Magellan Healthcare (Magellan) as its MBHO serving Medi-Cal, OneCare, and OneCare Connect members.

Medi-Cal MH/ABA MBHO. Between January 1, 2014 and December 31, 2016, CalOptima contracted with College Health IPA (CHIPA) and its subcontractor Beacon Health Options as its Medi-Cal MBHO. Effective January 1, 2017, the Medi-Cal MH/ABA services were transitioned to Magellan. Magellan was selected as the new MBHO through a 2016 request for proposal (RFP) process that focused on identifying a delivery model that could cover Behavioral Health services for CalOptima's

Back to Agenda

Medi-Cal, OneCare, and OneCare Connect members. On September 1, 2016, the Board authorized a contract with Magellan, effective January 1, 2017, for the full scope Medi-Cal covered mild to moderate mental health and ABA services. Specialty mental health services, including inpatient psychiatric services, remain the responsibility of the Orange County Health Care Agency. In addition, substance use disorder treatment services remain as a carve-out benefit under Drug Medi-Cal. CalOptima provides the coordination of care and service across levels of care (including participating on interdisciplinary care teams), quality initiatives, and oversight. The Board also authorized a separate contract with Magellan for Medicare Behavioral Health services for CalOptima's Medicare Advantage (OneCare) and Cal-MediConnect (OneCare Connect) members.

Magellan Contract. The CalOptima-Magellan contract includes a provision allowing for the reset of reimbursement rates for ABA services based on changes to the Medi-Cal membership or the penetration rate for ABA services. In accordance with the contract, Magellan requested an adjustment to the ABA rates based on the increased Medi-Cal member utilization trends. The parties were unable to reach an agreement when on June 28, 2017, CalOptima received a rescission notice from Magellan asserting the right to rescind the Medi-Cal MBHO Contract effective June 30, 2017, rather than providing the 180-notice of termination provided for in the contract. Subsequently, Magellan entered into a "Settlement Agreement and Order" with the Department of Managed Health Care under which Magellan agreed to provide MBHO as set forth in the Medi-Cal Contract from July 1, 2017 through August 30, 2017.

On August 3, 2017, the Board authorized an amendment to the Magellan contract to transition to a percent of premium basis for compensation of ABA services as part of a 180-day wind down period of the contract ending on December 31, 2017. And while staff sought Board authorization to bring administration of the behavioral health benefit in-house, before the Board considered that option, the Chair appointed an ad hoc comprised of Supervisor Do, Vice Chair Penrose, and Director Khatibi to consider available options, including the possibility of extending the current contract with Magellan beyond December 31, 2017.

Discussion

Ahead of the CalOptima Board's August meeting, staff assessed various options for providing MH and ABA services to Medi-Cal members after the transition date with the intent of keeping the provider network intact to mitigate disruptions to services. The network includes over 530 provider contracts that comprises over 800 MH and 300 ABA providers. Following the August CalOptima Board meeting, the ad hoc has met, considered options, and provided direction to staff, including continuing discussions with Magellan. As of the time for finalization and distribution of meeting materials for the September 7, 2017 CalOptima Board meeting, no agreement had been reached with Magellan.

Consequently, the ad hoc has considered various options for moving forward, including considering contracting with another MBHO who responded to the 2016 RFP, issuing a new RFP, contracting with the previous MBHO, outsourcing certain services, or integrating administration of MH and ABA services into CalOptima operations. After considering these options, in the event that agreement with Magellan cannot be reached, the recommended approach is to implement a model in which coordination and management of MH and ABA services are integrated into CalOptima operations rather than utilizing a vendor/partner for Medi-Cal MH/ABA services as the approach that will best

mitigate disruption to Medi-Cal members. While the proposal is to bring administration of this benefit in-house, services will continue to be provided by private sector providers. At this time, no recommendation is being made on the separate contract with Magellan for services for CalOptima's OneCare and OneCare Connect members, though staff may return with further recommendations on this contract at a future date.

Incorporate MH and ABA Services into CalOptima Operations. In order to integrate MH and ABA services into its operations, CalOptima staff developed a clinical and operational work plan. New infrastructure and resources are necessary to meet this timeframe as well ensure compliance with the Mental Health Parity and Addiction Equity Act, and other regulatory and accreditation requirements. The work plan includes:

1. Develop and implement member transition plan:
    - Send regulatory notices to members regarding change in MBHO;
    - Transition dedicated BH phone number from Magellan to CalOptima;
    - Conduct telephonic outreach to high risk members;
    - Develop reports to monitor open authorizations and member access to care; and
    - Continue to inform community stakeholders, including but not limited to, CalOptima advisory and quality committee members, community-based organizations, and regulatory agencies.
2. Development of a MH and ABA provider network that meets all credentialing and access and availability standards:
    - Establish a MH services provider network to include psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists; and
    - Establish an ABA provider network to include Qualified Autism Service (QAS) providers, including Board Certified Behavioral Analysts (BCBAs), and other licensed professionals in the field; and
    - Establish a standard CalOptima provider fee schedule for MH and ABA services. and
    - Conduct provider meetings to ensure information is disseminated and questions and concerns are addressed.
3. Rely on Magellan's credentialing files in accordance with the National Committee for Quality Assurance (NCQA) guidelines and re-credential the practitioner when they are due.
4. Build infrastructure (staff and systems) to support the following areas:
    - Expand Customer Service to include BH and triage services:
        - Establish specialized customer service unit for BH services;
        - Contract with an external vendor, with the assistance of legal counsel, that has experience with behavioral health services for 24/7/365 referral and after-hours call center support;
    - Ensure adequate resources to process claims timely due to the anticipated increased volume of MH/ABA claims received after the transition period;
    - Incorporate handling of behavior health services provider complaints into existing system;
    - Implement Clinical Operations for BH Utilization Management and Case Management:
        - Perform initial MH screening, determine level of care needs, routine appointment assistance and participation in interdisciplinary care teams;

        - Develop authorization processes for ABA services and psychological testing;
    - Integrate MH and ABA treatment protocols and clinical guidelines into the electronic clinical support system and operations to support decisions;
    - Expand BHI resources for ABA services:
        - Implement process to review prior authorizations for ABA services; and
        - Conduct clinical case management and progress reports;
    - Implement MH/ABA Quality Improvement processes and complete impact analysis of MH/ABA transition on NCQA Accreditation.
5. Hire and train additional clinical and operational staff required to support MH/ABA member needs.
6. Develop and implement reporting and analytic capabilities to meet operational, regulatory and accreditation requirements.

Continued Implementation Efforts. CalOptima staff will continue to identify, develop and/or revise policies and procedures, quality program descriptions, and utilization management program descriptions. Further transition plans as developed as well as policies and programs requiring CalOptima Board approval or ratification will be presented at subsequent meetings.

Fiscal Impact

The fiscal impact for the recommended actions to fund the cost to integrate Medi-Cal covered MH and ABA services internally is projected to be $6.6 million. Management proposes to make a reallocation of budgeted funds approved in the CalOptima FY 2017-18 Operating Budget on June 1, 2017. Funding not to exceed $4.1 million will be reallocated from Medi-Cal administrative costs for Purchased Services to:

- $1.2 million to Medical Management; and
- $2.9 million to Administrative Costs.

In addition, Management requests up to $2.5 million from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses among the following budget categories: Medical Management, Salaries, Wages and Benefits, Professional Fees, Purchased Services, Printing, Postage and Other Operating Expenses.

Rationale for Recommendation

The CalOptima/Magellan contract will terminate on December 31, 2017. Beginning January 1, 2018, it is critical to ensure continuity of care and access to services for CalOptima members with behavioral health needs. CalOptima staff reviewed multiple options and concluded that, based on the available solutions, the best option is to integrate administration of MH and ABA services into CalOptima operations, with the services continuing to be provided by private sector providers. With the wind down period extending through December 2017, the transition team, consisting of all affected areas' leadership continues to believe that transitioning administration of the behavioral health benefit into CalOptima operations is the best option to minimize any further disruption to members' care. This approach will allow CalOptima to organize care around the needs of our members and work closely with the provider community to provide members with appropriate care.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation: Consider Further Actions Related to the Provision of Behavioral Health Services for Medi-Cal Members
2. Board Action dated August 3, 2017, Consider Actions Related to Provision of Behavioral Health Services for Medi-Cal Members

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

Back to Agenda

Consider Further Actions Related to the Provision of Behavioral Health Services for Medi-Cal Members

Board of Directors Meeting

September 7, 2017

Richard Helmer, M.D., Chief Medical Officer

Ladan Khamseh, Chief Operating Officer

Donald Sharps, M.D., Medical Director

Back to Agenda

Agenda

- Background of Behavioral Health Services
- Status of Magellan Contract
- Considerations, Recommendations and Rationale
- Transition Planning
- Fiscal Impact
- Recommended Actions

Back to Agenda

Background

- CalOptima is responsible for Behavioral Health (BH) services for Medi-Cal, OneCare and OneCare Connect
- BH services include:
  - Mental Health (MH)
  - Substance Use Disorder (SUD)
  - Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD)
- For Medi-Cal, CalOptima has been responsible for:
  - MH benefit since January 1, 2014
  - ASD Behavioral Health Treatment benefit since September 15, 2014
- Orange County Health Care Agency is responsible for specialty MH services and SUD through Drug Medi-Cal

Back to Agenda

Background (Cont.)

- Use of primary care providers (PCPs) for mild behavioral health issues and to support self-management and early identification

- Use of Managed Behavioral Health Organization (MBHO) to provide mild to moderate MH and all ABA services to members:
  - January 2014–December 2016: CHIPA/Beacon (Medi-Cal only)
  - January 2017–Present: Magellan (all populations including OneCare and OneCare Connect)

Back to Agenda

Status of Magellan Contract

- Contract includes provision allowing reset of reimbursement rates for ABA services based on:
  - Changes to Medi-Cal membership or
  - Penetration rate for ABA services

- On August 3, 2017, the Board authorized an amendment to adjust ABA rates

- Magellan will continue to provide MBHO services through December 31, 2017
  - No current agreement to extend contract beyond December 31, 2017

Back to Agenda

Considerations

- Average number of members receiving services
  - MH Services = 6,700 members per month
  - ABA Services = 1,800 members per month
- Previous transition for ABA in past two years
  - Regional Center of Orange County (RCOC) to CalOptima
  - Beacon
  - Magellan
- Contingency strategies considered for transition effective January 1, 2018:
  1. Contract with an MBHO who responded to RFP in 2016
  2. Issue a new RFP
  3. Contract with the previous MBHO
  4. Integrate MH and ABA services into CalOptima operations

Back to Agenda

Recommendation

- Integrate administration of MH and ABA services into CalOptima operations with services continuing to be provided by a network of private-sector providers beginning January 1, 2018

Back to Agenda

Rationale to Integrate MH and ABA Services

- Utilize existing CalOptima capabilities
  - Network contracting and relations
  - Customer service
  - Behavioral Health Integration department
  - Claims
  - Quality improvement/Credentialing
  - Grievance and appeals
- Minimize disruption to members that would occur with new vendor
- Provide increased opportunities to integrate BH services with medical care in the future

Back to Agenda

Transition Planning

- Workgroups have been in place since July 1, 2017

Network Development	Operations
Provider Contracting	Claims
Credentialing	Customer Service
Provider Directory	Grievance and Appeals
Rate Development	Utilization and Care Management
Provider Engagement	Reporting (internal, regulatory, accreditation)

Back to Agenda

Transition Planning (Cont.)

- Clinical and operational work plan developed that includes:
  - Member transition plan
  - Provider communication plan
  - MH and ABA provider network development
  - Credentialing process
  - Building infrastructure
  - Staff hiring and training
  - Reporting and analysis capabilities
  - Development or revision of:
    - Policy and procedures
    - Quality program descriptions
    - Utilization management program descriptions

Back to Agenda

ABA Providers

- Rates
  - Reference vendor rates for other plans
  - Ensure consistency with State funding for Medi-Cal

- Provider engagement
  - Establish provider information sharing workgroup
  - Continue CalOptima participation in RCOC vendor meetings

Back to Agenda

ABA Supervision Model

- Levels of ABA providers
  - Top level: Board Certified Behavioral Analysts (BCBA)
  - Mid level:
    - Current Medi-Cal Guidance
      - Board Certified, non-licensed associate Behavioral Analysts (BCaBA) (minimum bachelor's level)
    - Industry trend
      - Master's level, licensed provider
  - Paraprofessionals: non-licensed individuals with 40 hours of training (minimum high school graduate)

- Ensure appropriate care for children in their homes

Back to Agenda

Clinical Staffing Requirements

Title	Service Type	Requirements	FTE	Responsibilities
Manager, BH (Clinical)	MH	Licensed MH professionals	1	Oversee the clinical operation of CalOptima BH line
Clinician, BH	MH	Licensed MH professionals	6	Complete telephonic BH assessments; determine BH level of care needs
Member Liaison Specialist (BH)	MH	High School Diploma; BH experience	7	Care management support; assist members in navigating BH system of care and linking to BH services
Manager, BH (BCBA)	ABA	BCBA or BCBA-D	1	Oversee the clinical operation of ABA services
Care Manager (BCBA)	ABA	BCBA	3	Review and process request for authorization of ABA services; utilization management
Member Liaison Specialist (Autism)	ABA	High School Diploma; ABA experience	1	Care management support; assist member in linking to ASD-related services
		Total	**19**	

Back to Agenda

BCBA = Board Certified Behavior Analyst

Strategic Clinical Staffing Process

- Sequenced hiring beginning September 2017
  1. Managers
  2. Core staff to support transition
  3. All other staff

- Full staffing by January 1, 2018

Back to Agenda

Recruiting and On-Boarding

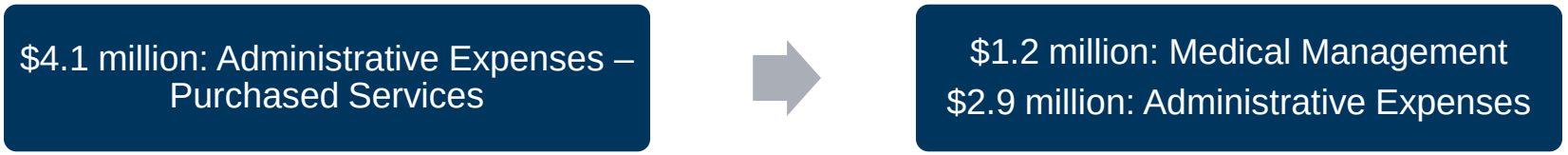
- Recruiting
  - Positions posted
  - Cultural and linguistic competencies
  - Screening and interviews being conducted
  - Identified potential new hires
  - Offers contingent on Board action

- On-boarding
  - Training specific for BH transition being developed
    - BH coordination
    - Managed care principles
  - CalOptima University for general orientation

Back to Agenda

Fiscal Impact

- Estimated cost
  - ➢ $4.1 million: Funded through budget reallocation under FY 2017–18 Medi-Cal Operating Budget



  - ➢ $2.5 million: Unbudgeted expenditures funded from existing reserves for one-time, transition-related contingency funds for Medi-Cal medical and administrative expenses
    - ▪ Distributed among the following budget categories: Medical Management, Salaries, Wages and Benefits, Professional Fees, Purchased Services, Printing, Postage, Other Operating Expenses

Back to Agenda

Recommended Actions

1. Authorize the Chief Executive Officer to:
   a. Integrate Medi-Cal covered Behavioral Health (BH), which includes Mental Health (MH) and Applied Behavior Analysis (ABA) services, within CalOptima internal operations, effective January 1, 2018;
   b. Establish a standard CalOptima provider fee schedule for MH and ABA services;
   c. Enter into contracts, with the assistance of legal counsel, with MH and ABA providers; and
   d. Enter into an agreement, with the assistance of legal counsel, for after-hours coverage for CalOptima's behavioral health call center and triage services obtained in accordance with CalOptima's Procurement Policy.

Back to Agenda

Recommended Actions (Cont.)

2. Authorize reallocation of budgeted funds not to exceed $4.1 million from Medi-Cal administrative expenses for purchased services approved in the CalOptima FY 2017–18 Operating Budget on June 1, 2017, to Medi-Cal medical and administrative expenses.

3. Authorize unbudgeted expenditures of up to $2.5 million from existing reserves for one-time, transition-related contingency funds for Medi-Cal medical and administrative expenses.

Back to Agenda

CalOptima's Mission

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
12. Consider Actions Related to the Provision of Behavioral Health Services for CalOptima Medi-Cal Members

Contact
Ladan Khamseh, Chief Operating Officer, (714) 246-8400
Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400

Recommended Actions
1. Authorize the Chief Executive Officer (CEO) to:
    a. Amend, with the assistance of legal counsel, the Medi-Cal Contract with the existing managed behavioral health organization to transition to a percent of premium basis for compensation of ABA services as part of a 180-day wind down period ending on December 31, 2017~~;~~
    ~~b. Integrate Medi-Cal covered Behavioral Health (BH), which includes Mental Health (MH) and Applied Behavior Analysis (ABA) services, within CalOptima internal operations;~~
    ~~c. Establish a standard CalOptima provider fee schedule for MH and ABA services;~~
    ~~d. Enter into contracts, with the assistance of legal counsel, with MH and ABA providers;~~
    e. ~~Enter into an agreement, with the assistance of legal counsel, for after-hour coverage for CalOptima's behavioral health call center and triage services obtained in accordance with CalOptima's Procurement Policy;~~

Continued to 9/7/2017 Board Meeting

~~2. Authorize reallocation of budgeted funds not to exceed $4.1 million from Medi-Cal administrative expenses for purchased services approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, to Medi-Cal medical and administrative expenses; and~~
~~3. Authorize unbudgeted expenditures of up to $2.5 million from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses.~~

Background

Medi-Cal MH/ABA Benefits. Behavioral Health services include MH, substance use disorder, and autism spectrum disorder behavioral health treatment (which includes ABA services). Outpatient mild-to-moderate MH services became a covered benefit for Medi-Cal managed care plans as of January 1, 2014. Beginning in September 2014, CalOptima started providing ABA services to Medi-Cal beneficiaries under the age of 21 under the Early and Periodic Screening, Diagnostic, and Treatment benefit. Like many Medi-Cal managed care plans, CalOptima has contracted with Managed Behavioral Health Organizations (MBHOs) to provide expertise and specialization in the management of behavioral health benefits, including ABA. CalOptima currently contracts with Human Affairs International of California, Inc., dba Magellan Healthcare (Magellan) as its MBHO serving Medi-Cal, OneCare, and OneCare Connect members.

Medi-Cal MH/ABA MBHO. Between January 1, 2014 and December 31, 2016, CalOptima contracted with College Health IPA (CHIPA) and its subcontractor Beacon Health Options as its Medi-Cal

Back to Agenda

MBHO. Effective January 1, 2017, the Medi-Cal MH/ABA services were transitioned to Magellan. Magellan was selected as the new MBHO through a 2016 request for proposal (RFP) process that focused on identifying a delivery model that could cover Behavioral Health services for CalOptima's Medi-Cal, OneCare, and OneCare Connect members. On September 1, 2016, the Board authorized a contract with Magellan, effective January 1, 2017, for the full scope Medi-Cal covered mild to moderate mental health and ABA services. Specialty mental health services, including inpatient psychiatric services, remain the responsibility of the Orange County Health Care Agency. In addition, substance use disorder treatment services remain as a carve-out benefit under Drug Medi-Cal. CalOptima provides the coordination of care and service across levels of care (including participating on interdisciplinary care teams), quality initiatives, and oversight. The Board also authorized a separate contract with Magellan for Medicare Behavioral Health services for CalOptima's Medicare Advantage (OneCare) and Cal-MediConnect (OneCare Connect) members.

Magellan Contract. The CalOptima-Magellan contract includes a provision allowing for the reset of reimbursement rates for ABA services based on changes to the Medi-Cal membership or the penetration rate for ABA services. In accordance with the contract, Magellan requested an adjustment to the ABA rates based on the increased Medi-Cal member utilization trends. The parties were unable to reach an agreement when on June 28, 2017, CalOptima received a rescission notice from Magellan asserting the right to rescind the Medi-Cal MBHO Contract effective June 30, 2017, rather than providing the 180-notice of termination provided for in the contract. Subsequently, Magellan entered into a "Settlement Agreement and Order" with the Department of Managed Health Care under which Magellan agreed to provide MBHO as set forth in the Medi-Cal Contract from July 1, 2017 through August 30, 2017.

Discussion

CalOptima staff assessed various options for providing MH and ABA services to Medi-Cal members after the transition date with the intent of keeping the provider network intact to mitigate disruptions to services. The network includes over 530 provider contracts that comprises over 800 MH and 300 ABA providers.

These options included considering contracting with another MBHO who responded to the 2016 RFP, issuing a new RFP, contracting with the previous MBHO, outsourcing certain services, or integrating MH and ABA services into CalOptima operations. After considering these options, staff recommends implementing a model in which coordination and management of MH and ABA services are integrated into CalOptima operations rather than utilizing a vendor/partner for Medi-Cal MH/ABA services as the approach that will best mitigate disruption to Medi-Cal members. At this time, no recommendation is being made on the separate contract with Magellan for services for CalOptima's OneCare and OneCare Connect members, though staff may return with further recommendations on this contract at a future date.

Magellan and CalOptima continued discussions on options for moving forward, with the proposal that Magellan transition to a percent of premium arrangement from CalOptima for the ABA services during a July 1, 2017 through December 31, 2017 transition period. Staff is recommending that your Board authorize integration of administration of Medi-Cal MH and ABA services within CalOptima internal operations and authorize the amendment of the Magellan Contract for the percent of premium

Back to Agenda

arrangement from July 1, 2017 through the December 31, 2017 transition end date. While the proposal is to bring administration of this benefit in-house, services will continue to be provided by private sector providers.

Transition Plan to Incorporate MH and ABA Services into CalOptima Operations. In order to transition MH and ABA services into its operations, CalOptima staff developed a clinical and operational work plan. New infrastructure and resources are necessary to meet this timeframe as well ensure compliance with the Mental Health Parity and Addiction Equity Act, and other regulatory and accreditation requirements. The transition plan includes:

1. Development of a MH and ABA provider network that meets all credentialing and access and availability standards:
    - Establish a MH services provider network to include psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists;
    - Establish an ABA provider network to include Qualified Autism Service (QAS) providers, including Board Certified Behavioral Analysts (BCBAs), and other licensed professionals in the field;
2. Rely on Magellan's credentialing files in accordance with the National Committee for Quality Assurance (NCQA) guidelines and re-credential the practitioner when they are due.
3. Build infrastructure (staff and systems) to support the following areas:
    - Expand Customer Service to include BH and triage services:
        - Contract with an external vendor, with the assistance of legal counsel, that has experience with behavioral health services for 24/7/365 referral and after-hours call center support;
    - Ensure adequate resources to process claims timely due to the anticipated increased volume of MH/ABA claims received after the transition period;
    - Incorporate handling of behavior health services provider complaints into existing system;
    - Implement Clinical Operations for BH Utilization Management and Case Management:
        - Perform initial MH screening, determine level of care needs, routine appointment assistance and participation in interdisciplinary care teams;
        - Develop authorization processes for ABA services and psychological testing;
    - Integrate MH and ABA treatment protocols and clinical guidelines into the electronic clinical support system and operations to support decisions;
    - Expand BHI resources for ABA services:
        - Implement process to review prior authorizations for ABA services; and
        - Conduct clinical case management and progress reports;
    - Implement MH/ABA Quality Improvement processes and complete impact analysis of MH/ABA transition on NCQA Accreditation.
4. Hire and train additional clinical and operational staff required to support MH/ABA member needs.
5. Implement reporting and analytic capabilities to meet operational, regulatory and accreditation requirements.

Back to Agenda

Continued Implementation Efforts. CalOptima staff will continue to identify and develop or revise policies and procedures, quality program descriptions, and utilization management program descriptions. Further transition plans as developed as well as policies and programs requiring CalOptima Board approval or ratification will be presented at subsequent meetings.

Fiscal Impact

Magellan Medi-Cal Contract Amendment for ABA Services

There is no fiscal impact based on the recommended action to transition to a percent of premium agreement for ABA services for the period of July 1, 2017, through December 31, 2017. Under the CalOptima FY 2017-18 Operating Budget approved on June 1, 2017, Staff budgeted for the increased ABA provider capitation expenses. Staff anticipates the budgeted funds will be sufficient to transition to the proposed payment methodology with Magellan.

BH Services Integration

The fiscal impact for the recommended actions to fund the cost to integrate Medi-Cal covered MH and ABA services internally is projected to be ~~$5.5~~ $6.6 million. Management proposes to make a reallocation of budgeted funds approved in the CalOptima FY 2017-18 Operating Budget on June 1, 2017. Funding not to exceed $4.1 million will be reallocated from Medi-Cal administrative costs for Purchased Services to:

Rev. 8/3/17

- $1.2 million to Medical Management; and
- $2.9 million to Administrative Costs.

In addition, Management requests up to $2.5 million from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses among the following budget categories: Medical Management, Salaries, Wages and Benefits, Professional Fees, Purchased Services, Printing, Postage and Other Operating Expenses.

Rationale for Recommendation

Upon receipt of the notice of rescission from Magellan, it was critical to ensure continuity of care and access to services for CalOptima members with behavioral health needs. CalOptima staff reviewed multiple options and concluded that, based on the available solutions, the best option was to integrate administration of MH and ABA services into CalOptima operations, with the services continuing to be provided by private sector providers. With the proposed wind-down period extending through December 2017, the transition team, consisting of all affected areas' leadership continues to believe that transitioning administration of the behavioral health benefit into CalOptima operations is the best option to minimize any further disruption to members' care. This approach will allow CalOptima to organize care around the needs of our members and work closely with the provider community to provide members with appropriate care.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments

1. PowerPoint Presentation: Consider Actions Related to the Provision of Behavioral Health Services for Medi-Cal Members
2. Board Action dated September 1, 2016, Consider Authorization of Contract with a Managed Behavioral Health Organization (MBHO) Effective January 1, 2017 and Contract with Consultant to Assist with MBHO Contract Implementation; Consider Authorization of Extension of Current Behavioral Health Contracts

/s/ Michael Schrader — **Authorized Signature**

08/01/2017 — **Date**

Back to Agenda

12. Consider Actions Related to the Provision of Behavioral Health Services for Medi-Cal Members

Board of Directors Meeting

August 3, 2017

Richard Helmer, M.D., Chief Medical Officer

Ladan Khamseh, Chief Operating Officer

Back to Agenda

Agenda

- Background
- Current State
- Considerations and Recommendations
- Implementation Planning
- Recommended Actions

Back to Agenda

Background

- CalOptima is responsible for Behavioral Health (BH) services for Medi-Cal, OneCare, and OneCare Connect
- BH services include:
  - Mental Health (MH)
  - Substance Use Disorder (SUD)
  - Autism Spectrum Disorder or Applied Behavioral Analysis (ABA)
- CalOptima responsible for:
  - Mental health health benefits since January 1, 2014
  - Autism Spectrum Disorder Behavioral Health Treatment benefit beginning September 15, 2014
- Orange County Health Care Agency responsible for specialty MH services and SUD through Drug Medi-Cal

Back to Agenda

Background (Cont.)

- Primary care providers and community resources for mild to moderate behavioral health issues and to support self-management and early identification

- Use of Managed Behavioral Health Organizations (MBHO) to provide mild to moderate BH services to members:
  - September 2014 – December 2016: CHIPA/Beacon (Medi-Cal only)
  - January 2017 – Present: Magellan (all populations including OneCare and OneCare Connect)

Back to Agenda

Status of Magellan Contract

- Contract includes provision allowing reset of reimbursement rates for ABA services based on:
  - Changes to Medi-Cal membership; or
  - Penetration rate for ABA services
- Magellan requested adjustment to the ABA rates; parties could not reach agreement
- Magellan subsequently agreed to provide MBHO services through December 31, 2017

Back to Agenda

Considerations and Recommendations

- Contingency strategies considered for transition effective January 1, 2018:
  1. Contract with an MBHO who responded to RFP in 2016
  2. Issue a new RFP
  3. Contract with the previous MBHO

- Average number of members receiving services:
  - BH Services = 6,700 members per month
  - ABA Services = 1,800 members per month

- Previous transition for ABA in last two years
  - RCOC to CalOptima
  - Beacon
  - Magellan

- Recommendation to mitigate member disruption:
  - Integrate administration of MH and ABA services into CalOptima operations with services continuing to be provided by network of private sector providers

Back to Agenda

Transition Implementation Planning

- Clinical and operational workplan developed
- Workgroups have been in place to ensure services during July 1 – December 31, 2017 transition:

Network Development	Operations
Provider Contracting	Claims
Credentialing	Customer Service
Provider Directory	Grievance and Appeals
Rate Development	Utilization & Care Management
	Reporting (internal, regulatory, accreditation)

Back to Agenda

Fiscal Impact

- Total estimated cost: Not to exceed $6.6 million
  - $4.1 million: Funded through budget reallocation under FY 2017-18 Medi-Cal Operating Budget

$4.1 million: Administrative Expenses – Purchased Services

$1.2 million: Medical Management
$2.9 million: Administrative Expenses

  - $2.5 million: Unbudgeted expenditures funded from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses
    - Distributed among the following budget categories: Medical Management, Salaries, Wages and Benefits, Professional Fees, Purchased Services, Printing, Postage, Other Operating Expenses

Rationale to Integrate MH and ABA Services

- Utilize existing CalOptima capabilities
  - Network contracting and relations
  - Customer service
  - Behavioral Health Integration Department
  - Claims
  - Quality improvement
  - Grievance and appeals
- Minimize disruption to members that would occur with new vendor
- Provide increased opportunities to integrate BH services with medical care in the future

Back to Agenda

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to:
   a. Amend, with the assistance of legal counsel, the Medi-Cal Contract with the existing managed behavioral health organization to transition to a percent of premium basis for compensation of ABA services as part of a 180-day wind down period ending on December 31, 2017;
   b. Integrate Medi-Cal covered Behavioral Health (BH), which includes Mental Health (MH) and Applied Behavior Analysis (ABA) services, within CalOptima internal operations;
   c. Establish a standard CalOptima provider fee schedule for MH and ABA services;
   d. Enter into contracts, with the assistance of legal counsel, with MH and ABA providers; and
   e. Enter into an agreement, with the assistance of legal counsel, for after-hour coverage for CalOptima's behavioral health call center and triage services obtained in accordance with CalOptima's Procurement Policy;

Back to Agenda

Recommended Actions (Cont.)

2. Authorize reallocation of budgeted funds not to exceed $4.1 million from Medi-Cal administrative expenses for purchased services approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, to Medi-Cal medical and administrative expenses; and

3. Authorize unbudgeted expenditures of up to $2.5 million from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Authorization of Contract with a Managed Behavioral Health Organization (MBHO) Effective January 1, 2017 and Contract with Consultant to Assist with MBHO Contract Implementation; Consider Authorization of Extension of Current Behavioral Health Contracts with College Health Independent Practice Association and Windstone Behavioral Health

Contact

Richard Helmer, Chief Medical Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:
    a. Enter into contract within 30 days with Magellan Health, Inc. to provide behavioral health services for CalOptima Medi-Cal, OneCare, and OneCare Connect members effective January 1, 2017, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.
    b. Contract with a consultant(s) in an amount not to exceed $50,000, to assist with the implementation of the Behavioral Health MBHO contract.
    c. Extend the current contracts with College Health Independent Practice Association (CHIPA) and Windstone Behavioral Health (Windstone) for up to six months, if necessary; and
2. Direct the CEO to return to the Board with further recommendations in the event that a contract is not finalized with Magellan within 30 days.

Background

Like many managed care plans, CalOptima has used Managed Behavioral Health Organizations (MBHOs) to provide expertise and specialization in the management of behavioral health benefits. Behavioral Health is a covered benefit for CalOptima's Medi-Cal and managed Medicare beneficiaries. CalOptima also provides Behavioral Health Treatment (BHT) services to Medi-Cal beneficiaries under the age of 21 under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. CalOptima currently contracts with CHIPA for the provision of Medi-Cal Managed Care Plan covered behavioral health and BHT services. This contract commenced January 1, 2014, was amended September 15, 2014 to include BHT services, and currently expires on December 31, 2016.

In addition, CalOptima contracts with Windstone to provide behavioral health services for members enrolled in CalOptima's OneCare and OneCare Connect programs. The OneCare contract with Windstone commenced January 1, 2007 and has been extended four times (January 1, 2010, January 1, 2013, January 1, 2014, and January 1, 2015). On May 7, 2015, the CalOptima Board of Directors authorized a contract with Windstone for the OneCare Connect program for the period July 1, 2015 through June 30, 2016, and extension of the Windstone OneCare contract through December 31, 2016. In addition, the CalOptima Board recommended a RFP process for future coverage, to ensure that the best available behavioral health services are obtained for CalOptima members in a most cost effective manner.

All CalOptima behavioral health contracts have been aligned to have the same expiration date. This change was made in part to minimize the possibility of confusion for members new to OneCare

Back to Agenda

Connect. On February 4, 2016, the CalOptima Board approved the extension of the OneCare Connect contract through December 31, 2016, thereby aligning all behavioral health contracts termination dates. The Board also authorized the use of a consultant to assist with required activities related to the issuance, scoring and awarding of the RFP for MBHO services.

Discussion

On April 1, 2016, CalOptima contracted with Health Management Associates (HMA) to help conduct a thorough search of potential Behavioral Health vendors and assist in the evaluation process to select the a vendor to provide best practice treatment to members. HMA's scope of work for MBHO RFP included providing assistance in the development of the proposal, creation of the proposal scoring tool, assessment of proposals, and selection of vendor.

On June 1, 2016, CalOptima released the Behavioral Health Request for Proposal (RFP) via BidSync. The CalOptima Procurement Department also contacted identified MBHOs nationwide notifying them about the RFP. Vendors had six weeks to submit their proposals. They also had two opportunities to submit questions to CalOptima about the RFP.

The responses to the RFP were reviewed by an evaluation team consisting of the Executive Director of Clinical Operations, Director of Behavioral Health Services, Behavioral Health Medical Director, and members of the Provider Advisory and Member Advisory Committees. Staff representatives from Claims, Information Services, and Finance scored sections related to their respective technical areas. The evaluation team also met with Subject Matter Experts (SMEs), including Customer Service, Quality Improvement, Grievances and Appeals, Compliance, Case Management, Utilization Management, and Behavioral Health, to discuss the strengths and weaknesses of each proposal.

Selection criteria used for scoring the proposals included:

- Experience in managed care
- Accreditation with the National Committee for Quality Assurance (NCQA)
- Corporate capabilities
- Information processing system
- Financial management
- Proposed staffing and project organization
- Ownership
- Outsourced services
- Provider network management
- Operations
- Utilization management
- Claim processing
- Grievances and Appeals
- Care management
- Cultural competency
- Quality improvement
- Information technology, data management
- Business intelligence

Back to Agenda

- Compliance program
- Implementation plan
- Innovation program and services

Based on the evaluation team's scoring, the results for the RFP were as follows:

Vendor	Score
Magellan	4.41
Envolve	4.00
CHIPA	3.54
Optum	3.28
Windstone	2.80

As the table indicates, Magellan finished with the highest score at 4.41 out of 5.

As part of the final review, the evaluation team invited the top two finalists, Magellan and Envolve, to an on-site presentation/interview. In the on-site portion of the evaluation, Magellan finished first with a score of 4.36. Envolve received a score of 2.67 for the on-site portion.

Based on the review of each vendor's capabilities, references, contract requirements and financial costs, the evaluation team is recommending that the Board authorize the CEO to contract with Magellan as the new MBHO. However, in the event that final contract terms cannot be reached within 30 days, staff plans to return to the Board with further recommendations.

Assuming contract terms are reached, the implementation phase will begin as soon as agreement with Magellan has been reached; implementation is calendared to be completed by December 31, 2016. However, if it is identified that additional time is needed for thorough implementation, the team is requesting authorization to extend the existing CHIPA and Windstone proposed to ensure no gap in coverage of behavioral health services. This process includes the winding down of current contracts with CHIPA and Windstone and the transition to the Magellan. Staff also recommends that the Board also authorize a contract with a consultant(s) in an amount not to exceed $50,000 to facilitate this implementation process.

Both CHIPA and Windstone have indicated that they are willing to extend their current contracts in the event that the implementation of the new MBHO contract is not fully completed within the aggressive timeline that is outlined.

Fiscal Impact

Management has included expenses for behavioral health benefits in the CalOptima Fiscal Year (FY) 2016-17 Operating Budget, which is sufficient to fund the projected costs of the new MBHO contract for the period of January 1, 2017, through June 30, 2017. Based on projected enrollment and the proposed rates, Staff estimates the total annual cost of the new MBHO contract will be approximately $41 million.

Back to Agenda

In the event CalOptima will need to extend the CHIPA and Windstone contracts, Management will execute an amendment to extend the termination date of the existing contract. No additional expenses will be incurred due to the contract extensions, since there will not be an overlap in dates for when the CHIPA and Windstone contracts expire and the effective date of the new MBHO contract.

The recommended action to authorize the CEO to contract with a consultant to assist with the implementation of the Behavioral Health MBHO contract is unbudgeted and will not exceed $50,000 through June 30, 2017. An allocation of $50,000 from existing reserves will fund this action.

Rationale for Recommendation

CalOptima staff believes contracting with the selected MBHO will allow CalOptima to continue to provide a comprehensive provider network and Behavioral Health and Autism Spectrum Disorder services for CalOptima's Medi-Cal and Duals programs. The evaluation team reviewed qualified MBHO responses and identified the candidate believed to best meet CalOptima's needs for integration of care, regulatory compliance, operational efficiency, administrative simplification, best practices, as well as overall reasonableness of price. The recommended MBHO is expected to be able to provide all delegated functions related to Behavioral Health Benefits including, but not limited to, customer service, care management, utilization management, credentialing, quality improvement, claims processing and payment, and provider dispute resolution. Moreover, the recommended MBHO will help CalOptima organize care around the needs of our members to achieve efficient and effective assessment, diagnosis, care planning, strength based and person centered treatment implementation, support services and outcomes evaluation.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Actions referenced:
    a. Board Action dated December 5, 2013, Contract with College Health Independent Practice Association for the Provision of Medi-Cal Outpatient Mental Health Services Beginning on January 1, 2014
    b. Board Actions dated October 2, 2014:
        i. Amendments to the Primary Agreement between DHCS and CalOptima to Implement Behavioral Health Therapy Benefit
        ii. Amend CalOptima's Contract with College Health Independent Association to Include Behavioral Health Therapy Services to meet DHCS Requirements
    c. Board Action dated May 7, 2015 Authorizing Contract for Behavioral Health Services with Windstone Behavioral Health
    d. Board Action dated February 4, 2016 Authorizing the Extension of the Contract with Windstone Behavioral Health for Behavioral Health Services
2. Behavioral Health Services PowerPoint Presentation

/s/ Michael Schrader — *8/25/2016*

Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

V. F. Authorize the Chief Executive Officer (CEO) to Contract with College Health Independent Practice Association (CHIPA) for the Provision of Medi-Cal Outpatient Mental Health Services Beginning on January 1, 2014

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Action

Authorize the CEO, with the assistance of legal counsel, to enter into a contract with CHIPA for the provision of Medi-Cal outpatient mental health services, as defined by the Department of Health Care Services (DHCS), effective January 1, 2014 for a one year term with two one year extension options, exercisable at CalOptima's discretion.

Background

At its September 5, 2013 meeting, the CalOptima Board of Directors authorized the CEO to contract with Beacon Health Strategies, LLC (Beacon) to provide outpatient mental health services effective January 1, 2014 based legislative changes requiring Medi-Cal managed care plans to provide these services. Excluded from this arrangement are benefits provided by county mental health plans under the Specialty Mental Health Services Waiver, which CalOptima administers under a separate contract with the Orange County Health Care Agency (OCHCA), and also contracts with Beacon for the provision of administrative services organization (ASO) services under the CalOptima contract with the OCHCA. Separately, CHIPA has a Master Service Agreement with Beacon.

Discussion

As CalOptima prepares to provide all Medi-Cal members with mental health benefits beginning on January 1, 2014, it has been determined that Beacon is neither Knox-Keene licensed in CalOptima's service area nor a professional corporation. Consequently, Beacon cannot be fully delegated for the medical management of the program. Instead, under CalOptima's National Committee Quality Improvement (NCQA) accreditation for the Medi-Cal program, the contract for the medical management of the mental health program must be directly with the delegated entity performing the utilization management for the program. Although Beacon can function as the Management Services Organization (MSO), it cannot perform the full delegation required by CalOptima. As a result, staff recommends that CalOptima instead contract directly with CHIPA, which in turn, has an existing management services agreement with Beacon.

Operational

By contracting with CHIPA, CalOptima will be positioned to continue to leverage Beacon's expertise, experience with the Medi-Cal program, and substantial provider network, as well as meet the NCQA delegation requirements. Additionally, based on CalOptima's experience with Beacon staff co-located at CalOptima's facility for the last three years, CHIPA and Beacon are integrated into CalOptima's operational processes. This is particularly important given the aggressive timeline for implementation of the new benefit.

Back to Agenda

Member Experience
With the implementation of the new benefit, CalOptima's goal is to ensure that members' continue to have a seamless experience of care. CalOptima's relationship with Beacon through CHIPA will allow staff to leverage the existing services and processes that Beacon has in place.

In summary, staff proposes contracting with CHIPA for the provision of the new Medi-Cal managed care mental health benefit. Having a contract in place with CHIPA prior to the implementation date of the new benefit will allow CalOptima staff to respond quickly to the requirements associated with implementing this mandatory new benefit. Staff believes that this recommendation will result in optimal member care and allow CalOptima to leverage existing resources and operational processes to the fullest extent.

Fiscal Impact
The recommended action to provide Medi-Cal mental health services will result in revenue neutrality for CalOptima. Management believes that DHCS will apply an adjustment to Medi-Cal capitation rates through a forthcoming contract amendment in an amount equivalent to the benefit expense plus an administrative load. Management will operate the program within the confines of this revenue allocation.

Rationale for Recommendation
A contract with CHIPA for the delivery of this new Medi-Cal mental health benefit will allow CalOptima to maintain the NCQA standards for delegation and leverage existing Beacon resources and operational processes to the fullest extent. Additionally, CalOptima must be prepared to provide this benefit to all Medi-Cal members beginning January 1, 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachment
None

/s/ Michael Schrader — *11/27/2013*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. A. Authorize and Direct the Chairman of the Board of Directors to Execute Amendments to the Primary Agreement between the California Department of Health Care Services (DHCS) and CalOptima to Implement the Behavioral Health Therapy (BHT) Benefit

Contact
Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Action
Authorize and direct the Chairman of the Board of Directors to execute Amendments to the Primary Agreement between the California DHCS and CalOptima (Primary Agreement) to implement the Behavioral Health Therapy (BHT) Benefit.

Background
As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new agreement with DHCS. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion
On August 29, 2014, DHCS notified Medi-Cal Managed Care Plans (Plans) that effective September 15, 2014, Plans' responsibility for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services will extend to coverage of Behavioral Health Therapy (BHT). Through the same notification, DHCS provided draft interim policy guidance regarding BHT services to include Applied Behavioral Analysis (ABA).

On September 15, 2014, DHCS released the final interim policy guidance pertaining to BHT services in Medi-Cal managed care for children and adolescents 0 to 21 years of age diagnosed with Autism Spectrum Disorder (ASD). The final interim guidance includes information regarding recipient criteria, covered services and limitations.

DHCS is beginning the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT in Medi-Cal, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with health plans and stakeholders. DHCS committed to Plans to develop rates, which will be retroactive to September 15, 2014. DHCS will also engage stakeholders to further define eligibility criteria, provider participation criteria, utilization controls, and the delivery system for ABA services.

At this time, CalOptima staff requests your approval of amendments necessary with DHCS to implement the BHT benefit, subject to the terms being consistent with the requirements of the benefit and the rates being satisfactory to provide the services. While the State has not yet provided any amendments to CalOptima for execution, management understands that the State will present them in

Back to Agenda

the near future and require prompt execution. There is a separate staff report and recommended action for your Board's consideration related to the administration of the BHT benefit by College Health Independent Practice Association (CHIPA)

Fiscal Impact
At this time, the fiscal impact of the BHT benefit is unknown.

Rationale for Recommendation
The approval of amendments will make language changes consistent with EPSDT requirements and ensure CalOptima will receive funding for the benefit.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix summary of amendments to Primary Agreement with DHCS

/s/ Michael Schrader — *9/26/2014*
Authorized Signature — **Date**

APPENDIX TO AGENDA ITEM VII. A.

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012
A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013

Back to Agenda

Amendments to Primary Agreement	Board Approval
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2014 and included language that incorporates provisions related to Medicare Improvements for Patients and Providers Act (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. B. Ratify Amendment of CalOptima's Contract with College Health Independent Practice Association (CHIPA) to Include Behavioral Health Therapy (BHT) Services, Including Applied Behavioral Analysis (ABA) Services, to Meet Department of Health Care Services (DHCS) Requirements; Authorize the Development of Policies and Procedures as Necessary to Implement the BHT Benefit

Contact

Donald Sharps, M.D., Medical Director, (714) 246-8400

Recommended Actions

1. Ratify amendment of CalOptima's contract with College Health Independent Practice Association (CHIPA) to implement the Behavioral Health Therapy (BHT), including ABA services, effective September 15, 2014 for Medi-Cal beneficiaries aged 0 to 21 years diagnosed with Autism Spectrum Disorder (ASD); and
2. Authorize the Chief Executive Officer (CEO) to develop and implement required policies and procedures as required to implement the BHT benefit as required by the Department of Health Care Services (DHCS).

Background

Behavioral Health Treatment Benefit for Autism
On August 29, 2014, the Department of Health Care Services (DHCS) released a draft All Plan Letter (APL) to provide interim policy guidance for Medi-Cal Managed Care Plans' (Plans) coverage of Behavioral Health Treatment (BHT) for children diagnosed with Autism Spectrum Disorder (ASD).

CalOptima was informed at that time of DHCS's intent to provide BHT services as a covered Medi-Cal benefit for individuals 0 to 21 years of age with ASD to the extent required by the federal government under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. DHCS is currently seeking federal approval to provide BHT as it is defined by Section 1374.73 of the California Health and Safety Code. DHCS has begun the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT in Medi-Cal, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with health plans and stakeholders. DHCS released a subsequent APL on this topic dated September 15, 2014. Based on this guidance:

- Effective September 15, 2014, Plans' responsibility for the provision of EPSDT services for beneficiaries 0 to 21 years of age were further defined to include medically necessary BHT services such as ABA and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD. Plans (including CalOptima) are obligated to ensure that appropriate EPSDT services are initiated in accordance with timely access standards; and

Back to Agenda

- Continuity of Care under the following circumstances:
  - Plan members 0 to 21 years diagnosed with ASD who, as of September 14, 2014 were receiving BHT services including ABA services through a Regional Center will continue to receive these services through the Regional Center until such time that the department and the Department of Developmental Services develop a plan for transition.
  - For a Plan's Medi-Cal members receiving BHT services outside of the Plan's network for Medi-Cal services, the Plan is obligated to ensure continuity of care for up to 12 months in accordance with existing contract requirements.
    - DHCS also detailed the requirements for out-of-network providers
  - Plans shall not discontinue BHT services during a continuity of care evaluation.

- Rates:
  - Per the APL, DHCS has committed to working with Plans to develop capitation rates for the costs associated with the provision of ABA services. Any rate adjustments will be retroactively applied to September 15, 2014.
  - On and after September 15, 2014, beneficiaries must receive ABA services from the Plan unless they are receiving their ABA services from a Regional Center.

- DHCS has also provided:
  - Recipient Criteria For ABA-Based Therapy Services
  - Defined Covered Services under Welfare & Institutions Code section 14059.5.
  - Limitations for services to include discontinuation when treatment goals and objectives are achieved or are no longer appropriate

CalOptima's Behavoral Health Intergration unit has been working with our contracted Medi-Cal Behavioral Health Vendor CHIPA/Beacon to gain a better understanding of the population of CalOptima members who may ultimately access ABA services. CalOptima has approximately 314,000 members age 18 and under, with an estimated incidence of autism at approximately 1.0 percent, or roughly 3,140 children. From that group, it is estimated, based on experience with similar populations they service, that approximately 20 percent may use ABA services, or 628 members. Beacon projects approximately half of those children will continue to receive ABA services through the Regional Center of Orange County, which is allowed until the state develops its transition plan. It is anticipated that CalOptima will serve approximately 314 members under this new benefit. However these figures may vary depending on a number of factors, including whether members' parent or guardian wish to continue receiving these services through the Regional Center.

Discussion

CalOptima is currently contracted with CHIPA for the medical management of the Medi-Cal mental health program, which in turn, has an existing management services agreement with Beacon.

Operational
By amending the current contract with CHIPA, CalOptima will be positioned to continue to leverage Beacon's experience with the mental health benefit included in the Medi-Cal program and also meet both DHCS regulatory and National Committee for Quality Assurance (NCQA) accreditation requirements.

Member Experience
With the implementation of the new benefit, CalOptima's goal is to ensure that members continue to have a seamless experience of care. CalOptima's relationship with Beacon through CHIPA allows staff to leverage the existing services and processes that Beacon currently has in place.

Clinical Expertise
Autism Service Group (ASG) has been fully integrated with CHIPA/Beacon for the last four years. Beacon ASG administers autism benefits on behalf of a number of health plans. Services that Beacon ASG provides include Network Management, ASD diagnosis validation, a comprehensive assessment and intake process, Care Management, Claims, and Reporting.
CalOptima and other Plans can expect that DHCS:

- Will require them to undergo a readiness review with DHCS. In the coming weeks, both the DHCS and the Department of Managed Health Care (DMHC) will issue a readiness review checklist. This checklist is expected to include submission timelines which will mirror each other when both Departments are collecting the same information. Both Departments are also working to draft template Evidence of Coverage (EOC) language. This language is expected to be shared with Plans in the near future.

- Will update APL 13-023, *Continuity of Care for Medi-Cal Beneficiaries who Transition from Fee-For-Service Medi-Cal into Medi-Cal Managed Care*, to include the new benefit. These new requirements are expected to include:
    - New noticing requirements when continuity of care: 1) are approved, and 2) approvals are 30 days from ending;
    - Retroactive coverage in certain situations;
    - Utilization management requirements for qualified providers; and
    - Timelines for approving requests when more immediate attention is needed and when there is a risk of harm.

In summary, management requests ratification of an amendment to the current CalOptima-CHIPA contract to include the provision of BHT services related to ASD as required by DHCS.

Fiscal Impact
As proposed, Beacon will be paid via capitation, at a rate of $0.14 per member per month (PMPM) for the period prior to the Regional Center of Orange County transition (September 15, 2014), and $0.25 PMPM for the period after the transition. Based on the projected total costs of ABA services, these rates result in administrative loads of 7.1% and 6.4% respectively for Beacon. As indicated, based on

APL 14-011, management anticipates that the DHCS will work with Plans including CalOptima to ensure that the new capitation rates are sufficient to cover the cost of providing this enhanced benefit.

Rationale for recommendation
The proposed changes are intended to ensure that, within the parameters delineated by the DHCS, CalOptima Medi-Cal beneficiaries have access to this newly added Medi-Cal mental health benefit.

Concurrence
Gary Crockett, Chief Counsel

Attachment
DHCS All Plan Letter 14-011

/s/ Michael Schrader — *9/26/2014*
Authorized Signature — **Date**

Back to Agenda

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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: September 15, 2014

All Plan Letter 14-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: INTERIM POLICY FOR THE PROVISION OF BEHAVIORAL HEALTH TREATMENT COVERAGE FOR CHILDREN DIAGNOSED WITH AUTISM SPECTRUM DISORDER

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with interim policy guidance for providing Behavioral Health Therapy (BHT) services to Medi-Cal children and adolescent beneficiaries 0 to 21 years of age diagnosed with Autism Spectrum Disorder (ASD).

BACKGROUND:
ASD is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called ASD[1]. Currently, the Centers for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD.

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance regarding the coverage of BHT services pursuant to section 1905(a)(4)(B) of the Social Security Act (the Act) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to provide coverage to individuals eligible for the EPSDT benefit for any Medicaid covered service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to ensure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and

[1] See Diagnostic and Statistical Manual (DSM) V.

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1501 Capitol Avenue, P.O. Box 997413, MS 4400
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Back to Agenda

treated as early as possible. When medically necessary, States may not impose limits on EPSDT services and must cover services listed in section 1905(a) of the Act regardless of whether or not they have been approved under a State Plan Amendment.

All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. When a screening examination indicates the need for further evaluation of a child's health, the child must be appropriately referred for medically necessary diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to ensure children receive the health care they need, when they need it.

The Department of Health Care Services (DHCS) intends to include BHT services, including Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD, as a covered Medi-Cal benefit for individuals 0 to 21 years of age with ASD to the extent required by the federal government. DHCS will seek federal approval to provide BHT as it is defined by Section 1374.73 of the Health and Safety (H&S) Code.

Pursuant to Section 14132.56 of the Welfare & Institutions Code (WIC), DHCS is beginning the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT as defined by H&S code section 1374.73, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with stakeholders. In consultation with stakeholders, DHCS will further develop and define eligibility criteria, provider participation criteria, utilization controls, and the delivery system for BHT services, subject to the limitations allowed under federal law, and provide final policy guidance to MCPs upon federal approval.

PROGRAM DESCRIPTION AND PURPOSE:
BHT means professional services and treatment programs, including but not limited to ABA and other evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with ASD. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services are services based on reliable evidence and are not experimental.

INTERIM POLICY:
In accordance with existing contracts, MCPs are responsible for the provision of EPSDT services for members 0 to 21 years of age, including those who have special health care needs. MCPs shall: (1) inform members that EPSDT services are available for beneficiaries 0 to 21 years of age, (2) provide comprehensive screening and prevention

services, (including, but not limited to, a health and developmental history, a comprehensive physical examination, appropriate immunizations, lab tests, lead toxicity screening, etc.), and (3) provide diagnosis and treatment for all medically necessary services, including but not limited to, BHT.

Effective September 15, 2014, the MCP responsibility for the provision of EPSDT services for beneficiaries 0 to 21 years of age includes medically necessary BHT services such as ABA and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD. MCPs shall ensure that appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the MCP's contracts.

CONTINUITY OF CARE:
MCP beneficiaries 0 to 21 years diagnosed with ASD who are receiving BHT services through a Regional Center on September 14, 2014, will automatically continue to receive all BHT services through the Regional Center until such time that DHCS and the Department of Developmental Services (DDS) develop a plan for transition. Until DHCS and DDS develop a plan for transition and communicate this transition plan to Regional Centers and to MCPs (through a forthcoming APL), Regional Centers will continue to provide BHT services for Medi-Cal beneficiaries and reimburse providers for BHT services provided in accordance with existing federal approvals, unless the parent or guardian requests that the MCP provide BHT services to the beneficiary prior to the development and/or implementation of the transition plan. Beneficiaries presenting for BHT services at a Regional Center on or after September 15, 2014, should be referred to the MCP for services.

For Medi-Cal beneficiaries receiving BHT services outside of a Regional Center or the MCPs' network, upon parental or guardian request, the MCPs shall ensure continuity of care for up to 12 months in accordance with existing contract requirements and All Plan Letter (APL) 13-023, unless the parent or guardian requests that the MCP change the service provider to an MCP BHT in-network provider prior to the end of the 12 month period.

BHT services will not be discontinued during a continuity of care evaluation. Pursuant to Health & Safety Code section 1373.96, BHT services must continue until MCPs have established a treatment plan.

An MCP shall offer continuity of care with an out-of-network provider to beneficiaries if all of the following circumstances exist:

- The beneficiary has an existing relationship with a qualified autism service provider. An existing relationship means a beneficiary has seen an out-of-network provider at least twice during the 12 months prior to September 15, 2014;

Back to Agenda

- The provider is willing to accept payment from the MCP based on the current Medi-Cal fee schedule; and

- The MCP does not have any documented quality of care concerns that would cause it to exclude the provider from its network.

HEALTH PLAN READINESS:
DHCS and the Department of Managed Health Care (DMHC) will coordinate efforts to conduct readiness reviews of MCPs for purposes of ensuring that MCPs are providing timely medically necessary BHT services. DHCS and DMHC will engage in joint decision making processes when considering the content of any licensing filing submitted to either department. The departments will work together to issue template language to MCPs, as needed.

Guidance pertaining to MCPs' readiness review requirements will be provided to MCPs separate from this APL.

DELEGATION OVERSIGHT:
MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements, as well as DHCS guidance, including APLs.

REIMBURSEMENT:
DHCS will engage in discussions with the MCPs in order to develop capitation rates for the costs associated with the provision of BHT services as soon as possible. Any rate adjustments for BHT services will be retroactively applied to September 15, 2014, subject to federal approval.

To the extent Medi-Cal beneficiaries received BHT services from licensed providers between July 7, 2014, and up to and including September 14, 2014, and incurred out-of-pocket expenditures for such services, these expenditures shall be submitted to the Fiscal Intermediary for reimbursement of expenditures through the existing *Medi-Cal Out-of-Pocket Expense Reimbursement (Conlan)* process (http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_Conlan.aspx). On and after September 15, 2014, Medi-Cal beneficiaries that are not receiving BHT services from a Regional Center or an out-of-network provider must receive all BHT services from a MCP.

CRITERIA FOR BHT SERVICES:
In order to be eligible for BHT services, a Medi-Cal beneficiary must meet all of the following coverage criteria. The recipient must:

1. Be 0 to 21 years of age and have a diagnosis of ASD;
2. Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to, aggression, self-injury, elopement, and/or social interaction, independent living, play and/or communication skills, etc.);

Back to Agenda

3. Be medically stable and without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID);
4. Have a comprehensive diagnostic evaluation[2] that indicates evidence-based BHT services are medically necessary and recognized as therapeutically appropriate; and
5. Have a prescription for BHT services ordered by a licensed physician or surgeon or developed by a licensed psychologist.

COVERED SERVICES AND LIMITATIONS:

Medi-Cal covered BHT services must be:

1. Medically necessary as defined by Welfare & Institutions Code Section 14132(v).
2. Prior authorized by the MCP or its designee; and
3. Delivered in accordance with the beneficiary's MCP approved treatment plan.

Services must be provided and supervised under an MCP approved treatment plan developed by a contracted and MCP-credentialed "qualified autism service provider" as defined by Health & Safety Code Section 1374.73(c)(3). Treatment services may be administered by one of the following:

1. A qualified autism service provider as defined by H&S Code section 1374.73(c)(3).
2. A qualified autism service professional as defined by H&S Code section 1374.73(c)(4) who is supervised and employed by the qualified autism services provider.
3. A qualified autism service paraprofessional as defined by H&S Code section 1374.73(c)(5) who is supervised and employed by a qualified autism service provider.

BHT services must be based upon a treatment plan that is reviewed no less than every six months by a qualified autism service provider and prior authorized by the MCP for a time period not to exceed 180 days. Services provided without prior authorization shall not be considered for payment or reimbursement except in the case of retroactive Medi-Cal eligibility.

BHT services shall be rendered in accordance with the beneficiary's treatment plan. The treatment plan shall:

1. Be person-centered and based upon individualized goals over a specific timeline;
2. Be developed by a qualified autism service provider for the specific beneficiary being treated;
3. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors;

[2] MCPs shall obtain a diagnostic evaluation of no more than four hours in duration that includes:

- A clinical history with informed parent/guardian, inclusive of developmental and psychosocial history;
- Direct observation;
- Review of available records; and
- Standardized measures including ASD core features, general psychopathology, cognitive abilities, and adaptive functioning using published instruments administered by qualified members of a diagnostic team.

Back to Agenda

4. Identify long, intermediate, and short-term goals and objectives that are specific, behaviorally defined, measurable, and based upon clinical observation;
5. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives;
6. Utilize evidence-based practices with demonstrated clinical efficacy in treating ASD, and are tailored to the beneficiary;
7. Ensure that interventions are consistent with evidenced-based BHT techniques.
8. Clearly identify the service type, number of hours of direct service and supervision, and parent or guardian participation needed to achieve the plan's goals and objectives, the frequency at which the beneficiary's progress is reported, and identifies the individual providers responsible for delivering the services;
9. Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and
10. Include parent/caregiver training, support, and participation.

BHT Service Limitations:

1. Services must give consideration to the child's age, school attendance requirements, and other daily activities as documented in the treatment plan.
2. Services must be delivered in a home or community-based settings, including clinics.
3. BHT services shall be discontinued when the treatment goals and objectives are achieved or are no longer medically necessary.
4. MCPs will comply with current contract requirements relating to coordination of care with Local Education Agencies to ensure the delivery of medically necessary BHT services.

The following services do not meet medical necessity criteria, nor qualify as Medi-Cal covered BHT services for reimbursement:

1. Therapy services rendered when continued clinical benefit is not expected;
2. Services that are primarily respite, daycare or educational in nature and are used to reimburse a parent for participating in the treatment program;
3. Treatment whose purpose is vocationally or recreationally-based;
4. Custodial care
   a. for purposes of BHT services, custodial care:
      i. shall be defined as care that is provided primarily to assist in the activities of daily living (ADLs), such as bathing, dressing, eating, and maintaining personal hygiene and safety;
      ii. is provided primarily for maintaining the recipient's or anyone else's safety; and
      iii. could be provided by persons without professional skills or training.
5. Services, supplies, or procedures performed in a non-conventional setting including, but not limited to:
   a. resorts;
   b. spas; and
   c. camps.

Back to Agenda

6. Services rendered by a parent, legal guardian, or legally responsible person.

For questions about this APL, contact your Medi-Cal Managed Care Division Contract Manager.

Sincerely,

Original Signed by Sarah C. Brooks

Sarah C. Brooks
Program Monitoring and Medical Policy Branch Chief
Medi-Cal Managed Care Division
Department of Health Care Services

Attachments

Back to Agenda

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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

What to Expect if You Suspect or You Have Been Told Your Child has Autism Spectrum Disorder

If you have a concern about how your child is communicating, interacting or behaving, or your child has been diagnosed with autism spectrum disorder (ASD) but you have been unable to access services to treat your child, you are likely wondering what to expect now that Behavioral Health Treatment services to treat children with ASD are available in Medi-Cal.

The following guidance is provided to share information about obtaining an evaluation of your child's development and treatment options, if needed, and the approximate amount of time it will take to obtain evaluations and medically necessary treatment.

1. If you have concerns about your child's development or your child has been diagnosed with ASD, call your Health Plan's Call Center and/or make an appointment to see your child's doctor. Your child's doctor should offer you an appointment within 10 business days. The evaluation and approval processes for your child to receive Behavioral Health Treatment services could take approximately 60 to 90 days to complete.

2. At the appointment with your child's doctor, share your concerns about your child, noting how your child is different from other children the same age, or provide any documents you may have from a health care provider that state your child has been diagnosed with autism spectrum disorder.

3. Your child's doctor will listen to your concerns, review documents that you share, examine your child, and may conduct a developmental screening. The doctor may ask you questions or talk or play with your child during the examination to see how your child learns, speaks, behaves, and moves. This screening provides useful information to identify if your child is developing differently from other children.

4. As a result of this visit with the doctor, your child may be referred to a specialist who will meet with you and your child, conduct further tests/exams of your child, and then prepare a report. The specialist should offer you an appointment within 15 business days after your appointment with your child's doctor.

5. The specialist will submit his/her report to your child's Health Plan for review and approval of medically necessary services, if deemed necessary.

Back to Agenda

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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

6. Your child's Health Plan will notify you of its determination whether or not to provide Behavioral Health Treatment services to your child in accordance with the recommendations of the specialist.

7. If the Health Plan determines that Behavioral Health Treatment services are medically necessary, your child will be referred to a qualified autism service provider who will meet with you and your child and develop a treatment plan. The qualified autism service provider should offer to meet with you within 15 business days after your Health Plan makes its determination.

8. The proposed treatment plan will be submitted by the qualified autism service provider to the Health Plan and reviewed by your Health Plan to determine whether or not the Behavioral Health Treatment services recommended by the qualified autism service provider are medically necessary.

9. Your child's Health Plan will notify you of its determination whether or not to provide Behavioral Health Treatment services to your child in accordance with the treatment plan developed by the qualified autism service provider.

10. If the Health Plan determines that Behavioral Health Treatment services recommended by the qualified autism service provider are medically necessary, your child will be referred back to the qualified autism service provider who will meet with you and your child in your home or another community setting, such as a community clinic, to describe the treatment plan and specific services your child will receive. The qualified autism provider should offer you an appointment within 15 days after your Health Plan makes its determination.

11. You have the right to make complaints about your child's covered services or care. This includes the right to:

    a) File a complaint or grievance or appeal certain decisions made by the Health Plan or health plan provider. For more information on filing a complaint, grievance, or appeal, contact your Health Plan.

    b) Ask for an Independent Medical Review (IMR) of the medical necessity of Medi-Cal Services or terms that are medical in nature from the California Department of Managed Health Care (DMHC). For more information on asking for an IMR, contact DMHC's Help Center at 1-888-466-2219 or (TDD) 1-877-688-9891 or online at http://www.dmhc.ca.gov/FileaComplaint/ConsumerIndependentMedicalReviewComplaint.aspx

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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
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c) Ask for a State Fair Hearing (SFH) from the California Department of Social Services (DSS). You can request a SFH over the phone by contacting DSS at 1-800-952-5253 or (TDD) 1-800-952-8349, by faxing DSS at 916-651-5210 or 916-651-2789, or by sending a letter to DSS. Additional information on the SFH process can be accessed at: http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx

12. The qualified autism service provider will meet with you and your child and describe the behavioral health treatment service type, the number of hours of direct service and the supervision of the service provider, parent or guardian participation needed, the frequency of reporting progress, and identify the individual providers responsible for delivering services to your child. Services will be scheduled at the location and in the frequency approved by the Health Plan.

13. The qualified autism service provider will provide a description of care coordination involving parents, guardians or caregivers, school, state disability programs, and others. The provider will also describe parent, guardian or caregiver training, support and participation that will be required.

14. The effectiveness of Behavioral Health Treatment is dramatically improved when parents or guardians receive training and are actively participating in their child's treatment. Your participation will ensure the best long term outcomes from the treatments your child is receiving.

15. If you have any questions or concerns about obtaining services for your child at any point in the process, call your Health Plan's Call Center or your child's doctor for assistance.

16. If you are concerned about what you can do when your child is not receiving services, the federal government and the Association for Children and Families has put together a guide to help parents facilitate development every day. This guide can be found at www.acf.hhs.gov/ecd/ASD. Themes include:

    a. Engaging your child in play through joint attention
    b. Using your child's interests in activities
    c. Using a shared agenda in daily routines
    d. Using visual cues
    e. Sharing objects and books
    f. Teaching your children to play with each other
    g. Using predictable routines and predictable spaces for your child.

DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: July 7, 2014

FROM: Cindy Mann, Director
Center for Medicaid and CHIP Services

SUBJECT: **Clarification of Medicaid Coverage of Services to Children with Autism**

In response to increased interest and activity with respect to services available to children with autism spectrum disorder (ASD), CMS is providing information on approaches available under the federal Medicaid program for providing services to eligible individuals with ASD.

Background

Autism spectrum disorder is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that used to be diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called autism spectrum disorder. Currently, the Center for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD. [1]

Treatments for children with ASD can improve physical and mental development. Generally these treatments can be categorized in four categories: 1) behavioral and communication approaches; 2) dietary approaches; 3) medications; and 4) complementary and alternative medicine. [2] While much of the current national discussion focuses on one particular treatment modality called Applied Behavioral Analysis (ABA), there are other recognized and emerging treatment modalities for children with ASD, including those described in the ASD Services, Final Report on Environmental Scan (see link below)[3]. This bulletin provides information related to services available to individuals with ASD through the federal Medicaid program.

The federal Medicaid program may reimburse for services to address ASD through a variety of authorities. Services can be reimbursed through section 1905(a) of the Social Security Act (the Act), section 1915(i) state plan Home and Community-Based Services, section 1915(c) Home

[1] http://www.cdc.gov/ncbddd/autism/facts.html
[2] http://www.cdc.gov/ncbddd/autism/treatment.html
[3] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/Autism-Spectrum-Disorders.pdf

Back to Agenda

and Community-Based Services (HCBS) waiver programs and section 1115 research and demonstration programs.

State Plan Authorities

Under the Medicaid state plan, services to address ASD may be covered under several different section 1905(a) benefit categories. Those categories include: section 1905(a)(6) - services of other licensed practitioners; section 1905(a)(13)(c) - preventive services; and section 1905(a)(10) - therapy services. States electing these services may need to update the Medicaid state plan in order to ensure federal financial participation (FFP) is available for expenditures for these services. In addition, for children, as discussed below, states must cover services that could otherwise be covered at state option under these categories consistent with the provisions at 1905(a)(4)(B) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Below is information on these coverage categories for services to address ASD. Under these section 1905(a) benefit categories all other state Medicaid plan requirements such state-wideness and comparability must also be met.

Other Licensed Practitioner Services

Other Licensed Practitioner services (OLP) services, defined at 42 CFR 440.60, are "medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law." If a state licenses practitioners who furnish services to address ASD, the state may elect to cover those providers under this section of their state plan even if the providers are not covered under other sections of the plan (e.g., physical therapist, occupational therapist, etc.). A state would need to submit a state plan amendment (SPA) to add the new licensed provider to their Medicaid plan. The SPA must describe the provider's qualifications and include a reimbursement methodology for paying the provider.

In addition, services that are furnished by non-licensed practitioners under the supervision of a licensed practitioner could be covered under the OLP benefit if the criteria below are met:

- Services are furnished directly by non-licensed practitioners who work under the supervision of the licensed practitioners;
- The licensed provider is able to furnish the service being provided;
- The state's Scope of Practice Act for the licensed practitioners specifically allows the licensed practitioners to supervise the non-licensed practitioners who furnish the service;
- The state's Scope of Practice Act also requires the licensed practitioners to assume professional responsibility for the patient and the service furnished by the unlicensed practitioner under their supervision; and
- The licensed practitioners bill for the service;

Preventive Services

Preventive Services, defined at 42 CFR 440.130(c) are "services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to—

(1) Prevent disease, disability, and other health conditions or their progression;
(2) Prolong life; and
(3) Promote physical and mental health and efficiency"

Back to Agenda

A regulatory change that took effect January 1, 2014, permits coverage of preventive services furnished by non-licensed practitioners who meet the qualifications set by the state, to furnish services under this state plan benefit as long at the services are recommended by a physician or other licensed practitioner. Under the preventive services benefit, in the state plan, the state must 1) list the services to be provided to ensure that services meet the definition of preventive services as stated in section 4385 of the State Medicaid Manual (including the requirement for the service to involve direct patient care); 2) identify the type(s) of non-licensed practitioners who may furnish the services; and 3) include a summary of the state's provider qualifications that make these practitioners qualified to furnish the services, including any required education, training, experience, credentialing, supervision, oversight and/ or registration.

Therapy Services

Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders, may be covered under the Medicaid therapies benefit at 42 CFR 440.110. Physical and occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law and provided to a beneficiary by or under the direction of a qualified therapist. Services for individuals with speech, hearing and language disorders mean diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

States would need to include an assurance in the state plan that the state furnishes the therapy in accordance with 42 CFR 440.110. States would also need to describe the supervisory arrangements if a practitioner is furnishing the therapy under the direction of a qualified therapist. Finally, for audiology services, the state plan must reflect the supervision requirements as set forth at 42 CFR 440.110(c)(3).

Section 1915(i) of the Social Security Act

States can offer a variety of services under a section 1915(i) state plan Home and Community-Based Services (HCBS) benefit. The benefit may be targeted to one or more specific populations including individuals with ASD and can provide services and supports above and beyond those included in section 1905(a). Participants must meet state-defined criteria based on need and typically receive a combination of acute-care medical services (like dental services, skilled nursing services) and other long-term services such as respite care, supported employment, habilitative supports, and environmental modifications.

Other Medicaid Authorities

There are several other Medicaid authorities that may be used to provide services to address ASD. Below is a discussion of each of those authorities:

Section 1915 (c) of the Social Security Act

The section 1915(c) Home and Community-Based Services waiver program allows states to provide a combination of medical services and long-term services and supports. Services include

but are not limited to adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. Participants must meet an institutional level of care but are served in the community. Section 1915(c) waiver programs also require that services be furnished in home and community-based settings. For individuals under the age of 21 who are eligible for EPSDT services, an HCBS waiver could provide services and supports for ASD that are above and beyond services listed in section 1905(a), such as respite care. Additionally, for individuals who are receiving state plan benefits as part of EPSDT that are not available to adults under the state plan, waiver services may be used to help these individuals transition into adulthood and not lose valuable necessary services and supports.

Section 1115 Research and Demonstration Waiver

Section 1115 of the Act provides the Secretary of the Department of Health and Human Services broad authority to authorize experimental, pilot, or demonstration programs that promote the objectives of the Medicaid program. Flexibility under section 1115 is sufficiently broad to allow States to test substantially new ideas, including benefit design or delivery system reform, of policy merit. The Secretary can approve an 1115 demonstration for up to five years, and states may submit extension requests to continue the program for additional periods of time. Demonstrations must be "budget neutral" over the life of the program, meaning they cannot be expected to cost the Federal government more than it would cost without the demonstration.

EPSDT Benefit Requirements

Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to arrange for and cover for individuals eligible for the EPSDT benefit any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. Good clinical practice requires ruling out any additional medical issues and not assuming that a behavioral manifestation is always attributable to the ASD. EPSDT also requires medically necessary diagnostic and treatment services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to assure that children get the health care they need, when they need it – the right care to the right child at the right time in the right setting.

The role of states is to make sure all covered services are available as well as to assure that families of enrolled children, including children with ASD, are aware of and have access to a broad range of services to meet the individual child's needs; that is, all services that can be covered under section 1905(a), including licensed practitioners' services; speech, occupational,

and physical therapies; physician services; private duty nursing; personal care services; home health, medical equipment and supplies; rehabilitative services; and vision, hearing, and dental services.

If a service, supply or equipment that has been determined to be medically necessary for a child is not listed as covered (for adults) in a state's Medicaid State Plan, the state will nonetheless need to arrange for and cover it for the child as long as the service or supply is included within the categories of mandatory and optional services listed in section 1905(a) of the Social Security Act. This longstanding coverage design is intended to ensure a comprehensive, high-quality health care benefit for eligible individuals under age 21, including for those with ASD, based on individual determinations of medical necessity.

Implications for Existing Section 1915(c), Section 1915 (i) and Section 1115 Programs

In states with existing 1915(c) waivers that provide services to address ASD, this 1905(a) policy clarification may impact on an individual's eligibility for the waiver. Waiver services are separated into two categories: waiver services and extended state plan services. Extended state plan services related to section 1905(a) services are not available to individuals under the age of 21 (individuals eligible for EPSDT) because of the expectation that EPSDT will meet the individual's needs. There are therefore a limited number of services that can be provided to this age group under 1915 (c) waivers, primarily respite, and/or environmental/vehicle modifications.

For states that currently provide waiver services to individuals under age 21 to address ASD, the ability to provide services under the 1905(a) state plan may have the effect of making these individuals ineligible for the waiver unless another waiver service is provided. This implication is especially important for individuals with ASD who may not otherwise be eligible for Medicaid absent the (c) waiver. States need to ensure that these individuals are receiving a waiver service, not coverable under section 1905(a), to ensure that they do not lose access to all Medicaid services by losing waiver eligibility. Individuals age 21 and older may continue to receive services to address ASD through the waiver if a state does not elect to provide these services to adults under its Medicaid state plan.

The same issues arise for children under the 1915(i) authority, which allows for services above and beyond section 1905(a) to be provided under the state plan. CMS is available to provide technical assistance to states that currently have approved waivers or state plans that may be impacted by this clarification. Similarly, states with existing 1115 demonstrations authorizing reimbursement for services provided to children with autism should contact CMS to ensure that EPSDT requirements are met.

We hope this information is helpful. If you have questions please send them to AutismServicesQuestions@cms.hhs.gov.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. C. Authorize Contract for Behavioral Health Services with Windstone Behavioral Health for Cal MediConnect/OneCare Connect, and Extend the Current OneCare Contract

Contact
Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel to:

1. Enter into a contract with Windstone Behavioral Health (Windstone) for the Cal MediConnect/OneCare Connect program for the period July 1, 2015 through ~~December 31~~, June 30, 2016. ~~with the option to renew for one additional year at CalOptima's sole discretion.~~ Revised 5/7/15
2. Amend the OneCare contract to extend it for one additional year (through calendar 2016), with the option to renew for one additional year at CalOptima's sole discretion. The current OneCare contract expires December 31, 2015.

Background and Discussion
Behavioral Health is a Medicare covered benefit for OneCare and OneCare Connect members. CalOptima currently contracts with Windstone to provide Medicare covered behavioral health services for the OneCare program. Windstone has been contracted with OneCare for behavioral health since January 1, 2007. The current contract is set to expire December 31, 2015, based on the previous contract extensions.

CalOptima's medical management and behavioral health staff have reviewed the utilization performance of this provider and also evaluated the access needs of CalOptima members, and determined that Windstone adequately meets CalOptima's requirements for the current OneCare program and future OneCare Connect program. At its January 2013 meeting, the CalOptima Board authorized the CEO to leverage the OneCare provider network as the basis for the Duals Delivery system. Therefore, staff recommends initiating a new contract for the OneCare Connect program, and renewing the current OneCare contract as indicated above.

Renewal of the OneCare contract will support the stability of CalOptima's contracted provider network should CalOptima decide to renew the OneCare program for 2016. The new contract for OneCare Connect will initiate a stable network with an already established provider. Contract language does not guarantee any particular volume and allows for CalOptima and the provider to terminate the contracts with or without cause.

Fiscal Impact
Based on forecasted OneCare and OneCare Connect enrollment for the extended contract periods, the fiscal impact of the recommended action is approximately $650,000 for OneCare and $2 million for OneCare Connect. Funding for the recommended actions will be included in the upcoming Fiscal Year 2015-16 CalOptima Consolidated Operating Budget.

Back to Agenda

Rationale for Recommendation

CalOptima staff recommends authorizing an extension to OneCare's contract with Windstone to ensure that OneCare members continue to have access to covered services, and extending a new contract for the OneCare Connect program so that these members will also receive the same quality level of service.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *5/1/2015*

Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Authorize Extension of the Cal MediConnect/OneCare Connect Contract with Windstone Behavioral Health for Behavioral Health Services; Authorize Contract for Consulting Services Related to Request for Proposal (RFP) Development and Delivery Model Optimization for the Behavioral Health Benefit

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Action

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:
    a. Extend the CalOptima-Windstone Behavioral Health Cal MediConnect/OneCare Connect contract for a six month period, through December 31, 2016, with the option to renew for one additional year (or two consecutive six month periods) exercisable at CalOptima's sole discretion; and
    b. Contract for up to $150,000 to hire a consultant through a Request for Proposal (RFP) process to determine the delivery model optimization for the behavioral health benefit and for the development of an RFP for contracted services, as appropriate.
2. Authorize budget allocation of $150,000 from the Medical Management department to the Behavioral Health Integration department.

Background/Discussion

Behavioral Health is a Medicare covered benefit for both OneCare and OneCare Connect members. In actions taken on May 7, 2015, the CalOptima Board of Directors authorized CalOptima staff to:

1. Enter into a contract with Windstone Behavioral Health (Windstone) for the Cal MediConnect/OneCare Connect program for the period July 1, 2015, through June 30, 2016, with direction that CalOptima staff would conduct a Request for Proposal (RFP) process by March 2016, to ensure that the best services are obtained for our members in a cost efficient manner; and
2. Extend the contract with CalOptima-OneCare Windstone for remaining OneCare members through December 31, 2016, with the option to renew for one additional year at CalOptima's sole discretion.

During the process of developing the RFP's Scope of Work for a Managed Care Behavioral Health Organization (MBHO), staff noted that the separate timing for implementation and transition of two MBHO contracts would potentially increase disruption of services for CalOptima OneCare and OneCare Connect members. Additionally, since the CalOptima Medi-Cal contract with CHIPA / Beacon Health Strategies expires on December 31, 2016, there is an opportunity to issue a single MBHO RFP that would potentially allow a single vendor to respond for OneCare, OneCare Connect, and Medi-Cal.

Back to Agenda

In order to minimize disrupting services with multiple MBHO implementations and transitions for OneCare and OneCare Connect members, Staff recommends that the Board authorize extending the current OneCare Connect contract with Windstone through December 31, 2016 (a six month extension) to align with the OneCare and Medi-Cal contracts. Aligning these contract expiration dates would allow time to include the Medi-Cal MBHO in the RFP. In addition, Staff believes that it would be prudent to have the option of renewing the Windstone OneCare Connect contract for one additional year (or two consecutive six month periods) at CalOptima's sole discretion, should additional time be required to complete the selection process.

Extending the current contract will support the stability of CalOptima's contracted provider network and ensure continued services without disruption to OneCare Connect members until the RFP process has been completed. Contract language does not guarantee any particular volume and allows for CalOptima and the provider to terminate the contract with or without cause.

To assist in developing an RFP and determining how best to administer the behavioral health benefit, management proposes to engage a consultant. The consultant, to be selected consistent with CalOptima's Board-approved procurement policy, will help with the development of the RFP and to assist staff in evaluating the advisability and feasibility of building internal capacity to perform some or all of the behavioral health benefit functions. Activities in which the consultant would assist staff include, but are not limited to:

- Development/ refinement of an RFP
- Identifying organizations with the capacity to respond to the RFP
- Developing proposed scoring tool(s)
- Assessing proposals, panel review management
- Assisting in the selection process for a vendor
- Make recommendations on activities that should (or should not) be delegated to the proposed vendor(s)
- Provide support in the contract negotiation process

As future plans for the OneCare and OneCare Connect programs are finalized, staff will return to the Board to request authority to enter into future contracts/contract extensions for behavioral health and or consulting services as appropriate.

Fiscal Impact

Staff assumes the capitation rate included in the OneCare Connect Contract with Windstone Behavioral Health will remain unchanged under the contract extension, and will therefore be budget neutral to CalOptima. Funding for the recommended action will be included in the forthcoming Fiscal Year 2016-17 CalOptima Consolidated Operating Budget.

The recommended action to hire a consultant through an RFP process to determine the delivery model optimization for the behavioral health benefit and for the development an RFP for contracted services, as appropriate, is an unbudgeted item, and will be funded in an amount not to exceed

$150,000 of budgeted funds from the Medical Management department to the Behavioral Health Integration department.

Rationale for Recommendation

CalOptima staff recommends authorizing an extension to the OneCare Connect contract with Windstone to ensure that OneCare Connect members continue to have access to covered services, and to authorize contracting with a consultant to assist in optimizing the administration of the behavioral health benefit.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Previous Board action dated May 7, 2015

/s/ Michael Schrader *01/29/2016*
Authorized Signature **Date**

Attachment to:
February 4, 2016
Agenda Item 7

Back to Agenda

Attachment to:
2/4/16, Agenda Item 7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. C. Authorize Contract for Behavioral Health Services with Windstone Behavioral Health for Cal MediConnect/OneCare Connect, and Extend the Current OneCare Contract

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel to:

1. Enter into a contract with Windstone Behavioral Health (Windstone) for the Cal MediConnect/OneCare Connect program for the period July 1, 2015 through ~~December 31~~, June 30, 2016. ~~with the option to renew for one additional year at CalOptima's sole discretion.~~ Revised 5/7/15
2. Amend the OneCare contract to extend it for one additional year (through calendar 2016), with the option to renew for one additional year at CalOptima's sole discretion. The current OneCare contract expires December 31, 2015.

Background and Discussion

Behavioral Health is a Medicare covered benefit for OneCare and OneCare Connect members. CalOptima currently contracts with Windstone to provide Medicare covered behavioral health services for the OneCare program. Windstone has been contracted with OneCare for behavioral health since January 1, 2007. The current contract is set to expire December 31, 2015, based on the previous contract extensions.

CalOptima's medical management and behavioral health staff have reviewed the utilization performance of this provider and also evaluated the access needs of CalOptima members, and determined that Windstone adequately meets CalOptima's requirements for the current OneCare program and future OneCare Connect program. At its January 2013 meeting, the CalOptima Board authorized the CEO to leverage the OneCare provider network as the basis for the Duals Delivery system. Therefore, staff recommends initiating a new contract for the OneCare Connect program, and renewing the current OneCare contract as indicated above.

Renewal of the OneCare contract will support the stability of CalOptima's contracted provider network should CalOptima decide to renew the OneCare program for 2016. The new contract for OneCare Connect will initiate a stable network with an already established provider. Contract language does not guarantee any particular volume and allows for CalOptima and the provider to terminate the contracts with or without cause.

Fiscal Impact

Based on forecasted OneCare and OneCare Connect enrollment for the extended contract periods, the fiscal impact of the recommended action is approximately $650,000 for OneCare and $2 million for OneCare Connect. Funding for the recommended actions will be included in the upcoming Fiscal Year 2015-16 CalOptima Consolidated Operating Budget.

Back to Agenda

Rationale for Recommendation
CalOptima staff recommends authorizing an extension to OneCare's contract with Windstone to ensure that OneCare members continue to have access to covered services, and extending a new contract for the OneCare Connect program so that these members will also receive the same quality level of service.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

Back to Agenda

A Public Agency

CalOptima

Better. Together.

Behavioral Health Integration - Managed Behavioral Healthcare Organization (MBHO) Vendor Selection

Board of Directors Meeting

September 1, 2016

Richard Helmer, M.D., Chief Medical Officer

Donald Sharps, M.D., Medical Director

Back to Agenda

Today's Agenda

- Behavioral Health Services at CalOptima
- MBHO Functions
- BH Request for Proposal
- Evaluation Team
- Selection Criteria
- Evaluation Process
- Evaluation Result
- Next Step

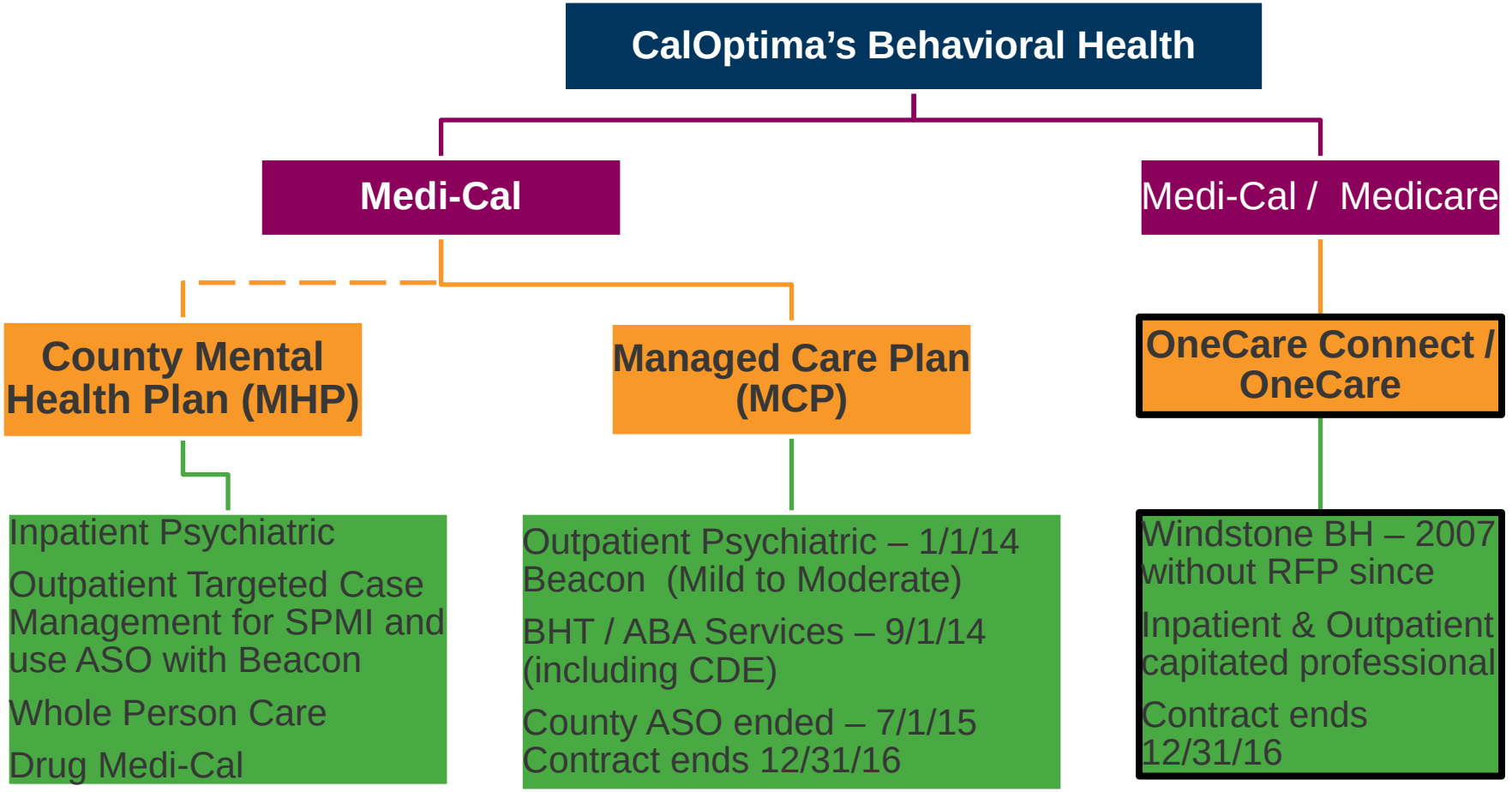
Back to Agenda

Behavioral Health Services at CalOptima

- OneCare (Medicare Duals Special Needs)
  - ➢Benefits began on January 1, 2007
- Medi-Cal Managed Care Plan
  - ➢Behavioral health benefits began on January 1, 2014
  - ➢Autism Spectrum Disorder Behavioral Health Treatment benefit began on September 15, 2014
- OneCare Connect (Duals Demonstration Project)
  - ➢Benefit began on July 1, 2015

Back to Agenda

Behavioral Health Services at CalOptima



Back to Agenda

Behavioral Health Services at CalOptima

- Behavioral Health (BH) services include services to address both mental health and substance use disorder conditions

- CalOptima is responsible for behavioral health services for all of its lines of business

- CalOptima has an opportunity to enhance the overall health of its members through the effective management of its behavioral health benefits

Back to Agenda

Behavioral Health Services at CalOptima

- Like many managed care plans, CalOptima has used Managed Behavioral Health Organizations (MBHOs) to provide expertise and specialization in the management of BH benefits

Line of Business	Current Vendor
OneCare	Windstone Behavioral Health
OneCare Connect	Windstone Behavioral Health
Medi-Cal	CHIPA

Back to Agenda

MBHO Functions

- MBHOs can support managed care plans by providing efficiency and subject matter expertise with:
  - BH Provider Network and Provider Relations
  - BH specific Credentialing
  - Call Center management
  - Eligibility verification
  - Level of care determinations
  - Claims payment and processing
  - Utilization management
  - Care management
  - Quality Improvement
  - Value based payment management

Back to Agenda

BH Request for Proposal Timeline

Date	Key Steps
06/01/16	RFP released
06/29/16	Questions submitted from bidders*
07/15/16	Five bidders submitted proposal by deadline
07/20/16	RFP evaluation team met with CalOptima SME's
08/04/16	Completed scoring of written proposals
08/10/16	Bidder presentations to RFP evaluation team

* "CalOptima is requesting an at-risk (i.e. capitated) pricing model for each line of business"

Back to Agenda

MBHO RFP Status - Evaluation Team

Proposals were evaluated by a collaborative team including CalOptima staff and HMA:

- Executive Director of Clinical Operations
- Behavioral Health Medical Director
- Director of Behavioral Health Services
- MAC member
- MAC OCC member
- PAC member

Additionally, only CalOptima staff scored specific sections of technical nature

Back to Agenda

MBHO Selection Criteria – 21 Elements

- Experience in managed care
- Accreditation
- Corporate capabilities
- Information processing system*
- Financial management*
- Proposed staffing and project organization
- Ownership
- Outsourced services
- Provider network management and credentialing
- Operations
- Utilization management
- Claim processing*
- Grievances and appeals
- Care management
- Cultural competency
- Quality improvement
- Information technology, data management*
- Business intelligence*
- Compliance program
- Implementation plan
- Innovative program and services

* Technical Sections scored only by CalOptima staff

Back to Agenda

MBHO Selection Process – Written Proposal

- The scoring tool contained 171 questions in 21 sections
  - Each question is scored on a scale of 1 to 5
- CalOptima Subject Matter Experts (SMEs) provided the evaluation team qualitative feedback
- CalOptima Staff also provided the evaluation team quantitative scores for the technical sections
- Weighted average score was calculated for each proposal

Back to Agenda

MBHO Written Proposal Scores

Bidder Final Score Summary	Magellan	Envolve	CHIPA	Optum	Windstone
TOTAL Weighted	4.41	4.00	3.54	3.28	2.80
1.0 Experience and References	4.5	4.2	3.7	4.1	3.8
2.0 Accreditation	4.3	3.8	4.1	3.7	2.0
3.0 Corporate Capabilities	4.2	3.8	3.6	3.1	3.5
4.0 Information Processing System*	5.0	4.0	3.0	2.0	1.0
5.0 Financial Management*	4.0	4.0	3.0	4.0	2.0
6.0 Proposed Staffing and Project Organization	4.4	4.0	3.7	3.9	2.5
7.0 Ownership	3.7	3.1	2.9	3.7	3.0
8.0 Outsourced Services	N/A	N/A	3.5	2.3	N/A
9.0 Provider Network Management / Credentialing	4.6	4.7	3.8	3.5	3.6
10.0 Operations	4.2	4.0	3.0	2.7	2.7
11.0 Utilization Management	5.1	4.6	3.5	3.5	3.6
12.0 Claims Processing*	3.4	3.5	3.0	3.3	3.0
13.0 Grievances and Appeals	4.0	3.3	2.9	2.5	2.8
14.0 Care Management / Coordination	4.5	4.4	3.4	3.2	3.4
15.0 Cultural Competency	4.2	4.6	3.7	3.2	3.3
16.0 Quality Improvement	5.1	4.6	3.7	3.3	3.3
17.0 IT, Data Management, Electronic Data Exchange, and Health Information Exchange*	5.1	4.5	3.7	2.8	1.2
18.0 Business Intelligence*	4.6	4.4	4.4	4.4	1.3
19.0 Compliance Program	3.6	2.0	3.9	3.1	2.8
20.0 Implementation Plan	4.7	4.0	4.0	3.2	2.8
21.0 Innovative Programs & Services	4.7	4.5	4.2	3.4	4.4

Back to Agenda

* Technical Sections scored only by CalOptima staff

MBHO Selection Process – Presentation

- The two bidders with highest written proposal scores, also
  1) Submitted bids for both Medi-Cal and Duals
  2) Had reasonableness of price
  3) Submitted bids with an at-risk (i.e. capitated) pricing model for each line of business
- Additional questions were submitted to these two bidders by the evaluation team and asked to present in person on 8/10/16

Back to Agenda

MBHO Presentation Scores

Additional areas with follow-up questions from Evaluation Team	Magellan	ENVOLVE
1. Accreditation	3.71	1.00
2. Provider Network	4.14	3.33
3. Operations	4.71	3.50
4. Utilization Management	4.29	3.33
5. Grievances and Appeals	4.29	2.17
6. Care Management / Coordination	4.43	3.17
7. Quality Improvement	4.14	2.50
8. Reporting	5.00	2.20
9. Claims	4.57	2.83
Overall Average Score	4.36	2.67

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
4. Consider Adoption of Resolution Approving Updated Human Resources Policies.

Contact
Ladan Khamseh, Chief Operations Officer, (714) 246-8400

Recommended Actions
1. Adopt Resolution Approving CalOptima's Updated Human Resources Policies; and
2. Authorize expenditures of up to $263,333 from existing reserves for the additional costs related to a new position.

Background
On November 1, 1994, the Board of Directors delegated authority to the Chief Executive Officer to promulgate employee policies and procedures, and to amend these policies from time to time, subject to annual presentation of the policies and procedures, with specific emphasis on any changes thereto, to the Board of Directors or a committee appointed by the Board of Directors for that purpose. On December 6, 1994, the Board adopted CalOptima's Bylaws, which requires, pursuant to section 13.1, that the Board of Directors adopt by resolution, and from time to time amend, procedures, practices and policies for, among other things, hiring employees and managing personnel.

Pursuant to the California Code of Regulations, Title 2, Section 570.5, CalOptima is required to adopt a publicly available pay schedule that meets the requirements set forth by the California Public Employees' Retirement System (CalPERS) to reflect recent changes, including the addition or deletion of positions and revisions to wage grades for certain positions.

The following table lists existing Human Resources policies that have been updated and are being presented for review and approval.

	Policy No./Name	Summary of Changes	Reason for Change
1.	GA.8035 Translation Rates	• Request to retire Policy • Policy language has been inserted into CalOptima Policy GA.8042: Supplemental Compensation	- Request for Policy GA.8035 Translation Rates to be retired and rolled into Policy GA. 8042: Supplemental Compensation
2.	GA.8042 Supplemental Compensation	• Minor language and formatting changes • Added a new category for Sales Incentives to the list of	-Annual review with minor updates and formatting changes - Addition of sales incentives included in

Back to Agenda

	Policy No./Name	Summary of Changes	Reason for Change
		Supplemental Compensation • Added specificity to Bilingual Pay proficiency for CalOptima threshold languages • Modified the language and eligibility for On Call supplemental pay for clarity and eligibility • Added language from Translation Pay policy • Updated Night Shift Pay rates to maximum of $2.00 per hour, depending on which shift an employee works. • Added definitions to Glossary	policy to formalize incentive and reflect current pay practices. - Revise On Call Pay category to ensure clarity on eligibility. - Request to retire GA.8035: Translation Rates and include requirements in this policy - Business needs - New terms
3.	GA.8058 Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment 1 – Salary Schedule has been revised in order to reflect recent changes, including the addition of a position. A summary of the changes to the Salary Schedule is included for reference.	- Pursuant to CalPERS requirement, 2 CCR §570.5, CalOptima periodically updates the salary schedule to reflect current job titles and pay rates for each job position. New Position: Creation of a new Job Title typically due to a change in the scope of a current position or the addition of a new level in a job family. (1 position)

Fiscal Impact

Staff estimates the fiscal impact for the new position, Sr. Director, Regulatory Affairs and Compliance, is $316,000 annually or $263,333 for the period of September 1, 2017, through June 30, 2018, and is unbudgeted. An allocation of up to $263,333 from existing reserves will fund this action. Management will include updated salaries and benefits expenses in future operating budgets. Management estimates that the expenses associated with the proposed changes to the supplemental compensation policy are budget neutral.

Back to Agenda

Rationale for Recommendation

To address the increased reporting obligations, audit readiness, and related responsibilities associated with new regulatory requirements (e.g., Mega Reg.), the addition of a Sr. Director, Regulatory Affairs & Compliance is necessary to ensure appropriate levels of department leadership.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 17-0907, Approve Updated Human Resources Policies
2. Revised CalOptima Policies:
   a. GA.8035 Translation Rates (To Be Retired)
   b. GA.8042 Supplemental Compensation (redlined and clean versions)
   c. GA.8058 Salary Schedule (redlined and clean copies) with revised Attachment A
3. Summary of Changes to Salary Schedule

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

Back to Agenda

RESOLUTION NO. 17-0907

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

APPROVE UPDATED HUMAN RESOURCES POLICIES

WHEREAS, section 13.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provide that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices and policies for, inter alia, hiring employees, and managing personnel; and

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima employees at will, to set compensation within the boundaries of the budget limits set by the Board, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board for that purpose; and

WHEREAS, California Code of Regulations, Title 2, Section 570.5, requires CalOptima to adopt a publicly available pay schedule that identifies the position title and pay rate for every employee position, and CalOptima regularly reviews CalOptima's salary schedule accordingly.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policies: GA.8035 Translation Rates; GA.8042 Supplemental Compensation; GA.8058 Salary Schedule

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 7th day of September, 2017.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Back to Agenda

Policy #:	GA.8035
Title:	**Translation Rates**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Richard Chambers
Effective Date:	1/5/12

I. PURPOSE

To outline how the Cultural and Linguistic Services Program will compensate CalOptima employees outside of their department for translation work.

II. POLICY

The Cultural and Linguistic Services (C&L) Program may periodically receive a high volume of translation work and may require assistance from other CalOptima staff. During these times, the C&L Program staff may request Bilingual Certified CalOptima employees who work outside of the C&L Program to provide these services. An employee performing translation work for the C&L Program must do it voluntarily and must perform the work outside of their regular work hours. C&L Program staff will assign the work to designated employees on an as needed basis.

There are two (2) key components in providing translation services:

1. Translation of materials from English into the desired language, or from another language into English; and

2. Review and edit the translation to ensure quality and consistency in usage of terms.

Translating is more difficult and time-consuming than reviewing and editing of already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima will reimburse for services at the following rates:

1. Translation – $35 per page

2. Review and edit of translated materials – $25.00 per page

III. PROCEDURE

Responsible Party	Action
C&L Department	1. Inform Bilingual Certified employees outside of the department that there is translation work available. 2. Select employees to perform translation work.
Employee	1. Complete the assigned translation work. 2. Submit the Employee Request for Extra Duty Compensation Form to C&L Department for verification and approval by the C&L Manager.

Human Resources	1. Process employee compensation through the bi-weekly payroll system.

IV. ATTACHMENTS

Employee Request for Extra Duty Compensation Form

V. DEFINITIONS

Auditing Process: To ensure the quality of the translation, C&L Services utilizes a multi-step process. All translation work is assigned a translator and a reviewer. A reviewer, different from the translator, is assigned to conduct the quality review of the translation. The reviewer checks for accuracy, grammar, flow, punctuation and spelling errors, and accents/diacritical marks. After the review is complete, the translator reviews the changes made by the reviewer to determine if the changes are appropriate and correct. If there is a disagreement, a second reviewer is called upon to help complete and finalize the translation.

Bilingual Certified Employee: An employee who has passed CalOptima's Bilingual Screening Process either upon hire or any time during their employment.

Bilingual Screening Process: Prospective staff translators are identified by Cultural and Linguistic (C&L) Services based on qualifications obtained through CalOptima's bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by C&L Services. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.

Budgeting process: Payment for staff translation services is budgeted as extra compensation. This budget is included in the salary line item.

VI. REFERENCES

CalOptima Employee Handbook

VII. APPROVALS OR BOARD ACTION

1/5/12: Regular CalOptima Board Meeting

VIII. REVISION HISTORY

Not Applicable

IX. KEYWORDS

Bilingual Certified Employee
Translation Reimbursement

Policy #: GA.-8042
Title: **Supplemental Compensation**
Department: Human Resources
Section: Not Applicable
CEO Approval: Michael Schrader _____

Effective Date: 01/01/11
Last Review Date: ~~12/03/15~~ 09/07/17
Last Revised Date: ~~12/03/15~~ 09/07/17

~~*Board Approved Policy*~~

I. PURPOSE

~~To establish~~This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Bonus Pay~~	~~Compensation to employees for superior performance such as "annual performance bonus" and "merit pay." If provided only during a member's final compensation period, it shall be excluded from final compensation as "final settlement" pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.~~
~~CalPERS~~	~~California Public Employees Retirement System~~
~~CalPERS Classic Member~~	~~A member enrolled in CalPERS prior to January 1, 2013.~~
~~Classic Director~~	~~A Management Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.~~
~~Classic Executive~~	~~An Executive Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.~~
~~Compensation Earnable~~	~~The pay rate and special compensation as defined in Government Code sections 20636 and 20636.1.~~
~~Executive Staff~~	~~Staff holding Executive level positions as specifically designated by the Board of Directors.~~
~~Management Staff~~	~~Staff holding positions at or above Director level.~~
~~Moderate Usage~~	~~Bilingual language usage is a frequent portion of working time.~~
~~Preferred Usage (Bilingual)~~	~~Bilingual language usage is preferred in the job description and used regularly in the performance of~~

	~~an employee's job duties. The employee is completely fluent in an identified threshold language.~~
~~Required Usage (Bilingual)~~	~~Bilingual language usage is required in an employee's the job description and used regularly in the performance of his or her job duties. The employee is completely fluent in an identified threshold language.~~
~~Special Compensation~~	~~Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).~~

~~III.~~II. POLICY

A. CalOptima considers the following as Special Compensation pursuant to ~~2 CCR section~~Title 2, Section 571~~:~~ of the California Code of Regulations (CCR):

1. Bilingual pay/Bilingual Premium;
2. Night Shift premium/Shift Differential;
3. Active Certified Case Manager (CCM) Pay/Educational Incentive; and
4. Executive Incentive Program/Bonus Pay.

~~.~~

B. Overtime Pay: ~~-~~As a public agency, CalOptima follows Federal wage and hour laws.~~-~~ Overtime pay for non-exempt employees will be provided for all hours worked in excess of forty (40) in any one (1) workweek at the rate of 1.5 times the employee's base hourly rate of pay. ~~-~~Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

C. Bilingual Pay: ~~-~~CalOptima provides supplemental bilingual pay for qualified exempt and non-exempt employees~~.~~ who are fluent in at least one (1) of CalOptima's Threshold Languages. This is considered Bilingual Premium pursuant to 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Bilingual Pay is based on the following schedule:

Proficiency	**Rate Per Pay Period**
~~Required~~Bilingual language usage is required in the job description~~.~~ and used ~~regularly~~more than fifty percent (50%) of the time in the performance of ~~an~~the employee's job duties. ~~The employee is fluent in an identified threshold language. (Required Usage)~~	$60.00
Bilingual language usage is preferred in the job description and used ~~regularly~~less than fifty percent (50%) ~~-~~of ~~their~~ the time in the performance of ~~an~~the employee's job duties. ~~The employee is fluent in an identified threshold language. (Preferred Usage)~~	$40.00

D. Translation Pay.: In certain circumstances when, for business reasons and for the benefit of CalOptima Members, there is a need to translate documents and other written material into languages other than English, the employeeExempt Employee providing such service will be paid a supplemental pay. Non-Exempt Employees are not eligible for translation pay.

1. A CalOptima Exempt Employee, who does not work in the Cultural & Linguistic Services Department (C&L) and who is not required as part of $35 per pagehis or her regular job responsibilities to translate, but is qualified to translate based on successfully passing the CalOptima Bilingual Screening Process, may be eligible for writtenTranslation Pay for performing translation and work. Eligible employees, who are interested in performing translation work during non-work hours, may elect to provide translation services during his or her own personal time based on the rates indicated below.—. The C&L Department shall assign the work to qualified Exempt Employees on an occasional, as-needed basis.

2. There are two (2) key activities in providing translation services:

   a. Translation of materials from English into the desired language, or from another language into English; and

   b. Review and revision of the translation to ensure quality and consistency in usage of terms.

3. Translating is more difficult and time-consuming than reviewing and editing of the already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima will reimburse for services at the following rates:

   a. Translation – Thirty-five dollars ($35.00) per page; and

   b. Review and revision of translated materials – Twenty-five dollars ($25.00) per page for review and edit. .

D. 4. The use of this supplemental pay is limited to situations where the use of professional translation services is either not available or feasibleunfeasible due to business constraints in accordance with CalOptima Policy GA.8035: Translation Rates.

E. Night Shift: CalOptima provides supplemental pay for work performed as part of a Night Shift. Assignments for Night Shift are subject to business needs and are at the discretion of CalOptima management. This is considered a Shift Differential pursuant to 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Night Shift is based on the following schedule:

Definition	Eligibility	Rates (per hour)
Night Shift – Seven (7) consecutive hours or more, including at least four (4) hours of work between 4:00 p.m. and 8:00 a.m.	Non-exempt employees	5% of base hourly rate with a minimum of $0.60 per hour and a maximum ofSecond shift employees (start time 3 p.m.) will receive $1.50 per hour. Third shift employees (start time 11

		p.m.) will receive $2.00 per hour.

F. Call Back and On Call:~~-~~ CalOptima provides supplemental pay for work performed as part of a Call Back and On Call requirement. Assignments for Call Back and On Call are subject to business needs and are at the discretion of CalOptima management. The rates for Call Back and On Call Pay are based on the following schedule:

Definition	**Eligibility**	**Rates (per hour)**
Call Back – Must physically return to work within one (1) hour when requested by a Supervisor. A Supervisor may assign the employee other work until the guaranteed four (4) hour time elapses.	Non-exempt employees	1.5 times of base hourly rate with a minimum of four (4) hours of pay.
On Call – Must remain accessible after normally scheduled work hours and be available to fix problems or report to work, if necessary. Employee will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate.	Non-exempt employees ~~Or~~ ~~Exempt employees excluding those in supervisory positions~~	$3.00/hour for being on-call. If a call is taken, employee is paid 1.5 times the regularly hourly rate with a thirty (30) minute minimum call~~.~~.
On Call Medical Case Managers (RN or LVN) and Clinical Pharmacists - Must remain accessible ~~after normally scheduled work hours to accept calls~~ to accept or respond to calls within a reasonable time designated by Employee's supervisor. In no event shall Employee's supervisor require a response time less than thirty (30) minutes. Employee will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate.	Exempt employees excluding those in supervisory positions	25% of base hourly rate multiplied by the number of hours on call.

G. Active Certified Case Manager (CCM) Pay: ~~-~~CalOptima may recognize supplemental pay of one hundred dollars ($100) per pay period to ~~a Registered Nurse (~~an RN~~)~~ who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties. This is considered as an Educational Incentive pursuant to 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.

H. Executive Incentive Program: The Chief Executive Officer (CEO) may recognize Executive Staff, including interim appointments, using incentive compensation as described in this policy. For Executive Staff who achieve superior performance, the incentive compensation is considered Bonus Pay pursuant to 2 CCR ~~section~~Section 571(a) and is to be reported to CalPERS as Special Compensation for Classic Members.

I. Sales Incentive Program: The OneCare Community Partner and Senior (Sr.) Community Partner staff in the OneCare Sales & Marketing Department shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect programs.

1. The licensed Community Partner and Sr. Community Partner staff will receive a monthly Sales Incentive based on the number of eligible members enrolled into the OneCare and OneCare Connect program on the following monthly incentive range:

Enrollments	**Incentive per eligible member enrolled**
1 – 25	$0.00
26 – 30	$50.00
31 – 45	$100.00
46 – 50	$125.00
51+	$150.00

2. The Sales Incentive for the Manager Member Outreach & Education shall be based on the number of eligible members enrolled into the OneCare and OneCare Connect programs by the Community Partner and Sr. Community Partner in the OneCare Sales & Marketing Department. The Manager, Member Outreach & Education will receive twenty dollars ($20.00) per member enrolled~~-~~, if and only if, the Community Partner or Sr. Community Partner reporting to the Manager, Member Outreach & Education, enrolls thirty-one (31) or more members per month. If a Community Partner or Sr. Community Partner fails to enroll at least thirty-one (31) members per month, the Manager, Member Outreach & Education, would not be eligible for the Sales Incentive for that Community Partner or Sr. Community Partner.

~~I.~~J. Employee Incentive Program:~~-~~ At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima's business needs and mission, vision, and values.

~~J.~~K. Retention Incentive:~~-~~ In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance and/or strategic imperatives, CalOptima may, at the discretion of the CEO, and on an exception basis, award a retention incentive.

~~K.~~L. Recruitment Incentive: ~~-~~At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the median base pay for the applicable ~~job~~ position may be offered to entice an individual to join CalOptima. Recruitment incentives offered for Executive Director and Chief positions require Board of Directors approval.

~~L.~~M. Incentive programs may be modified or withdrawn, at any time. ~~-~~Award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. It is not intended to be a binding contract between Executive Staff or employees and CalOptima.

~~M.~~N. Employer-Paid Member Contribution (EPMC): CalOptima contributes seven percent (7%) of Compensation Earnable, on behalf of eligible employees who hold Management Staff positions as identified in the CalOptima salary schedule, and who qualify based on all of the following:

1. Hired, promoted, or transferred into a Management Staff position, including interim appointments; and

2. Included in one (1) of the following categories:

   a. A CalPERS Classic Member; or

   b. A member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS~~-~~.

~~N.~~O. Annual Performance Lump Sum Bonus:~~-~~ Employees paid at the pay range maximum are not eligible for future base pay increases. As a result, in lieu of future base pay increases, these employees may be eligible for a merit bonus pay delivered as a lump sum bonus in accordance with Section III.J of this policy, provided that their performance meets the goals and objectives set forth by their managers.
~~S~~

~~O.~~P. Automobile Allowance:~~-~~ CalOptima may, at the discretion of the CEO, provide employees in Executive Staff positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars ($500) for the use of their personal vehicle for CalOptima business.

~~P.~~Q. Supplemental Retirement Benefit:~~-~~ Consistent with applicable Board actions, the CEO is authorized to determine CalOptima's contribution rate for employees to the supplemental retirement benefit (SRB) plan administered by the Public Agency Retirement System (PARS) within the limits of the budget and subject to contribution limits established by applicable laws. With the exception employees in Executive Staff positions, the contribution rate shall be uniform for all employees. For employees in Executive Staff positions who earn more than the ~~pensionable~~ applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to PARS, subject to the limitations of applicable laws. These SRB contribution rates to the PARS retirement plan shall continue from year to year, unless otherwise adjusted or discontinued.

~~IV.~~III. PROCEDURE

A. Overtime Pay:~~-~~ Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. ~~-~~This may result in one (1) pay period's delay in the employee receiving the additional compensation.

~~B.~~ Bilingual ~~Pay:~~ Pa~~ɪ~~y: An employee or potential employee shall undergo a written and verbal bilingual evaluation when bilingual proficiency is a part of the employee's~~/~~ or potential employee's

job description and used in the performance of the employee's job duties. ~~-~~If the employee or potential employee passes the evaluations, the bilingual pay shall be established.

~~C.~~

~~Translation Pay: An employee shall be paid Translation Pay in accordance with CalOptima Policy GA.8035: Translation Rates.~~

~~Night Shift:~~

B.

C. Translation Pay: If an eligible Exempt Employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay, identified above, will be provided depending on the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.

D. Night Shift:

1. Night shift differential is automatically calculated for those employees regularly working a night shift, defined as seven (7) consecutive hours or more, including at least four (4) hours of work between 4 p.m. and 8 a.m.

2. Employees who, at their own request and for their own convenience, adjust their work schedule, such as requesting make up time or alternative hours, and as a result, would be eligible for night shift pay, shall be deemed as having waived their right to same. When appropriate, a new Action Form should be submitted, removing the employee from the night shift.

~~D.~~E. Call Back and On Call Pay~~: :~~

~~1.~~ If an employee is on call or gets called back to work, the employee is responsible for adding this time to their schedule through CalOptima's time keeping system, which is then approved by their

1. Supervisor.

~~E.~~F. Active Certified Case Manager (CCM) Pay~~: :~~

1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the employee's case management certification issued by the Case Management Society of America to the Human Resources Department.

~~F.~~G. Incentive Compensation

1. The Board of Directors approves CalOptima's strategic plan for each fiscal year, and the CEO is expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the Executive Staff.

2. The CEO may establish an incentive compensation program for Executive Staff based on the Executive Incentive Program attached within budgeted parameters in accomplishing specific results according to the department and individual goals set forth by the CEO and the level of achievement. Executive Staff will receive a performance evaluation based on the Performance Review of Executives Template attached, which measures their performance against the established goals. Based on the level of performance, the Executive Staff member may be eligible for a lump sum bonus payment. The Executive Staff member must still be employed by CalOptima and in good standing at the time the bonus is distributed in order to be eligible to receive the bonus payment. For eligible Executive Staff members who achieve superior performance, CalOptima will report the bonus payment to CalPERS as Special Compensation. The CEO is authorized to make minor revisions to the Executive Incentive Program and Performance Review of Executives Template from time to time, as appropriate.

3. As circumstances warrant and at the discretion of the CEO, employees not at the Executive Staff level, whose accomplishments have provided extraordinary results, may be considered for incentive compensation.

H. Sales Incentive Program

1. The One Care Community Partner and Sr. Community Partner staff, in the OneCare Sales & Marketing Department, shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect Programs.

2. The Community Partner and Sr. Community Partner staff shall be eligible to receive Sales Incentive pay as described in Section II.I.1 of this policy for successfully enrolling new members into the OneCare and OneCare Connect Programs. Sales Incentive pay for the Manager, Member Outreach & Education, shall be based on the number of members enrolled into the OneCare and OneCare Connect Programs by the Community Partner and Sr. Community Partner as described in Section II.I.2 of this policy.

~~a.~~ CalOptima shall follow the Medicare Marketing Guidelines (MMGs) charge-back guidelines of ninety (90) calendar day rapid disenrollment and recouping the Sales Incentive with the exceptions as specified under the guidelines and applicable CalOptima policies.

a.

3. CalOptima shall pay the Sales Incentive to the eligible employee on a monthly basis approximately one and a half (1 ½) months after the month in which the eligible employee earned the Sales Incentive.

a. In the event a OneCare or OneCare Connect member disenrolls from their respective program within ninety (90) calendar days for reasons other than the exceptions specified under the guidelines and applicable CalOptima policies, the Sales Incentive previously earned will be deducted from a future Sales Incentive.

4. The Chief Operating Officer, Executive Director of Network Operations and Director Network Management who oversee the One-Care Sales & Marketing Department shall approve the Sales Incentive payout~~-~~.

5. Enrollment goals for the Community Partner and Community Partner Sr. staff will be pro-rated for the month if the employee misses one (1) or more full weeks due to vacations, sick days, or a Leave of Absence.

6. The Director, Network Management, Executive Director of Network Operations and the Chief Operations Officer will review the Sales Incentive structure on an annual basis.

~~H.~~I. Retention Incentive:~~-~~ As circumstances warrant, the CEO may award an employee a retention incentive to prevent or delay departures that may adversely impact business operations. The employee offered a retention incentive must be in good standing and accept and sign a retention agreement which contains the condition(s) to be met in order to receive payment. Payment of the incentive will be made when the terms of the agreement have been fully met and at the conclusion of the retention period. ~~-~~The CEO has the authority to offer retention incentives for up to twelve (12) employees per calendar year in an amount not to exceed ten ~~(10)~~ percent (10%) of the employee's current base ~~pay.~~annual salary. Retention incentives that exceed ten ~~(10)~~ percent (10%) of the employee's current base ~~pay~~annual salary require Board of Directors approval.

~~I.~~J. Recruitment Incentive:~~-~~ As circumstances warrant, the CEO may offer a recruitment incentive based on the Compensation Administration Guidelines managed by the Human Resources Department to entice an individual to join CalOptima. Board of Directors approval is required for recruitment incentives offered for Executive Director and Chief positions. ~~-~~In order to receive the recruitment incentive, the individual offered the incentive is required to accept and sign an offer letter which contains a "claw-back" provision obligating the recipient of a recruitment incentive to return the full amount of the recruitment incentive if the recipient voluntarily terminates employment with CalOptima within twenty-four (24) months of the date of hire.

~~J.~~K. Annual Performance Lump Sum Bonus:~~-~~ Once an employee has reached the pay range maximum, the employee may be eligible for merit bonus pay delivered as a lump sum bonus, provided that his or her annual performance evaluation meets the established goals and objectives set forth by their managers. Merit bonus pay will not exceed the maximum percentage of the merit increase matrix and reflects the employee's superior performance measured against established objectives. Annual performance lump sum bonuses are paid out in two (2) incremental amounts – the first half when merit salary increases are normally distributed and the second half six (6) months later. The employee must still be employed by CalOptima ~~and in good standing at both of these dates~~ in order to be eligible to receive the lump sum bonus payments.

~~K.~~L. Automobile Allowance:~~-~~ As circumstances warrant, the CEO may offer to employees in Executive Staff positions an automobile allowance in lieu of the IRS standard mileage reimbursement rate that would otherwise apply in the use of their personal vehicle in the performance of their duties. Such automobile allowance will be identified on the Executive Staff's W-2 forms as taxable income. In addition, as a condition of receiving such allowance, the Executive Staff member must comply with the following requirements:

1. He or she must maintain adequate levels of personal vehicle insurance coverage;
2. He or she shall purchase his or her own fuel for the vehicle; and
3. He or she shall ensure that the vehicle is properly maintained.

~~V.~~IV. ATTACHMENTS

A. Executive Incentive Program
B. Performance Review of Executives Template

~~VI.~~V. REFERENCES

~~A. CalOptima Policy GA.8000: Glossary of Terms~~
~~B.~~A. CalOptima Employee Handbook
~~C. Policy GA.8035: Translation Rates~~
~~D.~~B. Compensation Administration Guidelines
C. Government Code, §20636 and 20636.1
~~E.~~D. Title 2, California Code of Regulations (CCR), ~~section~~ §571
~~F. Government Code sections 20636 and 20636.1~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

~~Not Applicable~~
None to Date

~~VIII.~~VII. BOARD ~~ACTION~~ACTIONS

A. 09/07/17: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/03/15: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 05/01/14: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 01/05/12: Regular Meeting of the CalOptima Board of Directors

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	~~Version~~ Date	Policy Number	Policy Title	Line(s) of Business
~~Original Date~~Effective	01/01/2011	GA.8042	Pay Differentials	Administrative
~~Revision Date 1~~Revised	01/05/2012	GA.8042	Pay Differentials	Administrative
~~Revision Date 2~~Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
~~Revision~~	12/03/2015	GA.8042	Supplemental	Administrative

~~Poli~~ ~~c~~ ~~y~~Policy #: GA.~~-~~8042

Title: Supplemental Compensation Revised Date: ~~12/3/15~~09/07/17

~~Date~~ ~~3~~Revised			Compensation	
Revised	09/07/2017	GA.8042	Supplemental Compensation	Administrative

IX. GLOSSARY

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima's Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process:	Prospective staff translators are identified by Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima's bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by C&L Services Department. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.
Bonus Pay	Compensation to employees for superior performance such as "annual performance bonus" and "merit pay." If provided only during a member's final compensation period, it shall be excluded from final compensation as "final settlement" pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS	California Public Employees Retirement System
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Classic Director	A Management Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
Classic Executive	An Executive Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
Compensation Earnable	The pay rate and special compensation as defined in Government Code sections 20636 and 20636.1.
Executive Staff	Staff holding Executive level positions as specifically designated by the Board of Directors.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare or/ OneCare Connect Program.

Term	**Definition**
Special Compensation	Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).
Threshold Language	For purposes of this policy, a~~A~~ threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

1

Policy #: GA.8042
Title: **Supplemental Compensation**
Department: Human Resources
Section: Not Applicable
CEO Approval: Michael Schrader

Effective Date: 01/01/11
Last Review Date: 09/07/17
Last Revised Date: 09/07/17

I. PURPOSE

This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

II. POLICY

A. CalOptima considers the following as Special Compensation pursuant to Title 2, Section 571 of the California Code of Regulations (CCR):

1. Bilingual pay/Bilingual Premium;

2. Night Shift premium/Shift Differential;

3. Active Certified Case Manager (CCM) Pay/Educational Incentive; and

4. Executive Incentive Program/Bonus Pay.

B. Overtime Pay: As a public agency, CalOptima follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all hours worked in excess of forty (40) in any one (1) workweek at the rate of 1.5 times the employee's base hourly rate of pay. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

C. Bilingual Pay: CalOptima provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima's Threshold Languages. This is considered Bilingual Premium pursuant to 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Bilingual Pay is based on the following schedule:

Proficiency	**Rate Per Pay Period**
Bilingual language usage is required in the job description and used more than fifty percent (50%) of the time in the performance of the employee's job duties.	$60.00
Bilingual language usage is preferred in the job description and used less than fifty percent (50%) of the time in the performance of the employee's job duties.	$40.00

D. Translation Pay: In certain circumstances when, for business reasons and for the benefit of CalOptima Members, there is a need to translate documents and other written material into

languages other than English, the Exempt Employee providing such service will be paid supplemental pay. Non-Exempt Employees are not eligible for translation pay.

1. A CalOptima Exempt Employee, who does not work in the Cultural & Linguistic Services Department (C&L) and who is not required as part of his or her regular job responsibilities to translate, but is qualified to translate based on successfully passing the CalOptima Bilingual Screening Process, may be eligible for Translation Pay for performing translation work. Eligible employees, who are interested in performing translation work during non-work hours, may elect to provide translation services during his or her own personal time based on the rates indicated below. The C&L Department shall assign the work to qualified Exempt Employees on an occasional, as-needed basis.

2. There are two (2) key activities in providing translation services:

   a. Translation of materials from English into the desired language, or from another language into English; and

   b. Review and revision of the translation to ensure quality and consistency in usage of terms.

3. Translating is more difficult and time-consuming than reviewing and editing of the already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima will reimburse for services at the following rates:

   a. Translation – Thirty-five dollars ($35.00) per page; and

   b. Review and revision of translated materials – Twenty-five dollars ($25.00) per page.

4. The use of this supplemental pay is limited to situations where the use of professional translation services is either not available or unfeasible due to business constraints.

E. Night Shift: CalOptima provides supplemental pay for work performed as part of a Night Shift. Assignments for Night Shift are subject to business needs and are at the discretion of CalOptima management. This is considered a Shift Differential pursuant to 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Night Shift is based on the following schedule:

Definition	Eligibility	Rates (per hour)
Night Shift – Seven (7) consecutive hours or more, including at least four (4) hours of work between 4 p.m. and 8 a.m.	Non-exempt employees	Second shift employees (start time 3 p.m.) will receive $1.50 per hour. Third shift employees (start time 11 p.m.) will receive $2.00 per hour.

F. Call Back and On Call: CalOptima provides supplemental pay for work performed as part of a Call Back and On Call requirement. Assignments for Call Back and On Call are subject to business needs and are at the discretion of CalOptima management. The rates for Call Back and On Call Pay are based on the following schedule:

Definition	Eligibility	Rates (per hour)

Definition	Eligibility	Rates (per hour)
Call Back – Must physically return to work within one (1) hour when requested by a Supervisor. A Supervisor may assign the employee other work until the guaranteed four (4) hour time elapses.	Non-exempt employees	1.5 times of base hourly rate with a minimum of four (4) hours of pay.
On Call – Must remain accessible after normally scheduled work hours and be available to fix problems or report to work, if necessary. Employee will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate.	Non-exempt employees	$3.00/hour for being on-call. If a call is taken, employee is paid 1.5 times the regularly hourly rate with a thirty (30) minute minimum call.
On Call Medical Case Managers (RN or LVN) and Clinical Pharmacists - Must remain accessible to accept or respond to calls within a reasonable time designated by Employee's supervisor. In no event shall Employee's supervisor require a response time less than thirty (30) minutes. Employee will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate.	Exempt employees excluding those in supervisory positions	25% of base hourly rate multiplied by the number of hours on call.

G. Active Certified Case Manager (CCM) Pay: CalOptima may recognize supplemental pay of one hundred dollars ($100) per pay period to an RN who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties. This is considered as an Educational Incentive pursuant to 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.

H. Executive Incentive Program: The Chief Executive Officer (CEO) may recognize Executive Staff, including interim appointments, using incentive compensation as described in this policy. For Executive Staff who achieve superior performance, the incentive compensation is considered Bonus Pay pursuant to 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation for Classic Members.

I. Sales Incentive Program: The OneCare Community Partner and Senior (Sr.) Community Partner staff in the OneCare Sales & Marketing Department shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect programs.

1. The licensed Community Partner and Sr. Community Partner staff will receive a monthly Sales Incentive based on the number of eligible members enrolled into the OneCare and OneCare Connect program on the following monthly incentive range:

Enrollments	Incentive per eligible member enrolled
1 – 25	$0.00
26 – 30	$50.00
31 – 45	$100.00
46 – 50	$125.00
51+	$150.00

2. The Sales Incentive for the Manager Member Outreach & Education shall be based on the number of eligible members enrolled into the OneCare and OneCare Connect programs by the Community Partner and Sr. Community Partner in the OneCare Sales & Marketing Department. The Manager, Member Outreach & Education will receive twenty dollars ($20.00) per member enrolled, if and only if, the Community Partner or Sr. Community Partner reporting to the Manager, Member Outreach & Education, enrolls thirty-one (31) or more members per month. If a Community Partner or Sr. Community Partner fails to enroll at least thirty-one (31) members per month, the Manager, Member Outreach & Education, would not be eligible for the Sales Incentive for that Community Partner or Sr. Community Partner.

J. Employee Incentive Program: At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima's business needs and mission, vision, and values.

K. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance and/or strategic imperatives, CalOptima may, at the discretion of the CEO, and on an exception basis, award a retention incentive.

L. Recruitment Incentive: At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the median base pay for the applicable position may be offered to entice an individual to join CalOptima. Recruitment incentives offered for Executive Director and Chief positions require Board of Directors approval.

M. Incentive programs may be modified or withdrawn, at any time. Award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. It is not intended to be a binding contract between Executive Staff or employees and CalOptima.

N. Employer-Paid Member Contribution (EPMC): CalOptima contributes seven percent (7%) of Compensation Earnable, on behalf of eligible employees who hold Management Staff positions as identified in the CalOptima salary schedule, and who qualify based on all of the following:

1. Hired, promoted, or transferred into a Management Staff position, including interim appointments; and

2. Included in one (1) of the following categories:

   a. A CalPERS Classic Member; or

   b. A member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.

O. Annual Performance Lump Sum Bonus: Employees paid at the pay range maximum are not eligible for future base pay increases. As a result, in lieu of future base pay increases, these employees may be eligible for a merit bonus pay delivered as a lump sum bonus in accordance with Section III.J of this policy, provided that their performance meets the goals and objectives set forth by their managers.

P. Automobile Allowance: CalOptima may, at the discretion of the CEO, provide employees in Executive Staff positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars ($500) for the use of their personal vehicle for CalOptima business.

Q. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima's contribution rate for employees to the supplemental retirement benefit (SRB) plan administered by the Public Agency Retirement System (PARS) within the limits of the budget and subject to contribution limits established by applicable laws. With the exception employees in Executive Staff positions, the contribution rate shall be uniform for all employees. For employees in Executive Staff positions who earn more than the applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to PARS, subject to the limitations of applicable laws. These SRB contribution rates to the PARS retirement plan shall continue from year to year, unless otherwise adjusted or discontinued.

III. PROCEDURE

A. Overtime Pay: Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.

B. Bilingual Pay: An employee or potential employee shall undergo a written and verbal bilingual evaluation when bilingual proficiency is a part of the employee's or potential employee's job description and used in the performance of the employee's job duties. If the employee or potential employee passes the evaluations, the bilingual pay shall be established.

C. Translation Pay: If an eligible Exempt Employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay, identified above, will be provided depending on the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.

D. Night Shift:

1. Night shift differential is automatically calculated for those employees regularly working a night shift, defined as seven (7) consecutive hours or more, including at least four (4) hours of work between 4 p.m. and 8 a.m.

2. Employees who, at their own request and for their own convenience, adjust their work schedule, such as requesting make up time or alternative hours, and as a result, would be eligible for night shift pay, shall be deemed as having waived their right to same. When appropriate, a new Action Form should be submitted, removing the employee from the night shift.

E. Call Back and On Call Pay:

1. If an employee is on call or gets called back to work, the employee is responsible for adding this time to their schedule through CalOptima's time keeping system, which is then approved by their Supervisor.

F. Active Certified Case Manager (CCM) Pay:

1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the employee's case management certification issued by the Case Management Society of America to the Human Resources Department.

G. Incentive Compensation

1. The Board of Directors approves CalOptima's strategic plan for each fiscal year, and the CEO is expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the Executive Staff.

2. The CEO may establish an incentive compensation program for Executive Staff based on the Executive Incentive Program attached within budgeted parameters in accomplishing specific results according to the department and individual goals set forth by the CEO and the level of achievement. Executive Staff will receive a performance evaluation based on the Performance Review of Executives Template attached, which measures their performance against the established goals. Based on the level of performance, the Executive Staff member may be eligible for a lump sum bonus payment. The Executive Staff member must still be employed by CalOptima and in good standing at the time the bonus is distributed in order to be eligible to receive the bonus payment. For eligible Executive Staff members who achieve superior performance, CalOptima will report the bonus payment to CalPERS as Special Compensation. The CEO is authorized to make minor revisions to the Executive Incentive Program and Performance Review of Executives Template from time to time, as appropriate.

3. As circumstances warrant and at the discretion of the CEO, employees not at the Executive Staff level, whose accomplishments have provided extraordinary results, may be considered for incentive compensation.

H. Sales Incentive Program

1. The One Care Community Partner and Sr. Community Partner staff, in the OneCare Sales & Marketing Department, shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect Programs.

2. The Community Partner and Sr. Community Partner staff shall be eligible to receive Sales Incentive pay as described in Section II.I.1 of this policy for successfully enrolling new members into the OneCare and OneCare Connect Programs. Sales Incentive pay for the Manager, Member Outreach & Education, shall be based on the number of members enrolled into the OneCare and OneCare Connect Programs by the Community Partner and Sr. Community Partner as described in Section II.I.2 of this policy.

   a. CalOptima shall follow the Medicare Marketing Guidelines (MMGs) charge-back guidelines of ninety (90) calendar day rapid disenrollment and recouping the Sales Incentive with the exceptions as specified under the guidelines and applicable CalOptima policies.

3. CalOptima shall pay the Sales Incentive to the eligible employee on a monthly basis approximately one and a half (1 ½) months after the month in which the eligible employee earned the Sales Incentive.

    a. In the event a OneCare or OneCare Connect member disenrolls from their respective program within ninety (90) calendar days for reasons other than the exceptions specified under the guidelines and applicable CalOptima policies, the Sales Incentive previously earned will be deducted from a future Sales Incentive.

4. The Chief Operating Officer, Executive Director of Network Operations and Director Network Management who oversee the OneCare Sales & Marketing Department shall approve the Sales Incentive payout.

5. Enrollment goals for the Community Partner and Community Partner Sr. staff will be pro-rated for the month if the employee misses one (1) or more full weeks due to vacations, sick days, or a Leave of Absence.

6. The Director, Network Management, Executive Director of Network Operations and the Chief Operations Officer will review the Sales Incentive structure on an annual basis.

I. Retention Incentive: As circumstances warrant, the CEO may award an employee a retention incentive to prevent or delay departures that may adversely impact business operations. The employee offered a retention incentive must be in good standing and accept and sign a retention agreement which contains the condition(s) to be met in order to receive payment. Payment of the incentive will be made when the terms of the agreement have been fully met and at the conclusion of the retention period. The CEO has the authority to offer retention incentives for up to twelve (12) employees per calendar year in an amount not to exceed ten percent (10%) of the employee's current base annual salary. Retention incentives that exceed ten percent (10%) of the employee's current base annual salary require Board of Directors approval.

J. Recruitment Incentive: As circumstances warrant, the CEO may offer a recruitment incentive based on the Compensation Administration Guidelines managed by the Human Resources Department to entice an individual to join CalOptima. Board of Directors approval is required for recruitment incentives offered for Executive Director and Chief positions. In order to receive the recruitment incentive, the individual offered the incentive is required to accept and sign an offer letter which contains a "claw-back" provision obligating the recipient of a recruitment incentive to return the full amount of the recruitment incentive if the recipient voluntarily terminates employment with CalOptima within twenty-four (24) months of the date of hire.

K. Annual Performance Lump Sum Bonus: Once an employee has reached the pay range maximum, the employee may be eligible for merit bonus pay delivered as a lump sum bonus, provided that his or her annual performance evaluation meets the established goals and objectives set forth by their managers. Merit bonus pay will not exceed the maximum percentage of the merit increase matrix and reflects the employee's superior performance measured against established objectives. Annual performance lump sum bonuses are paid out in two (2) incremental amounts – the first half when merit salary increases are normally distributed and the second half six (6) months later. The employee must still be employed by CalOptima in order to be eligible to receive the lump sum bonus payments.

L. Automobile Allowance: As circumstances warrant, the CEO may offer to employees in Executive Staff positions an automobile allowance in lieu of the IRS standard mileage reimbursement rate that

would otherwise apply in the use of their personal vehicle in the performance of their duties. Such automobile allowance will be identified on the Executive Staff's W-2 forms as taxable income. In addition, as a condition of receiving such allowance, the Executive Staff member must comply with the following requirements:

1. He or she must maintain adequate levels of personal vehicle insurance coverage;

2. He or she shall purchase his or her own fuel for the vehicle; and

3. He or she shall ensure that the vehicle is properly maintained.

IV. ATTACHMENTS

A. Executive Incentive Program
B. Performance Review of Executives Template

V. REFERENCES

A. CalOptima Employee Handbook
B. Compensation Administration Guidelines
C. Government Code, §20636 and 20636.1
D. Title 2, California Code of Regulations (CCR), §571

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 09/07/17: Regular Meeting of the CalOptima Board of Directors
B. 12/03/15: Regular Meeting of the CalOptima Board of Directors
C. 05/01/14: Regular Meeting of the CalOptima Board of Directors
D. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2011	GA.8042	Pay Differentials	Administrative
Revised	01/05/2012	GA.8042	Pay Differentials	Administrative
Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
Revised	12/03/2015	GA.8042	Supplemental Compensation	Administrative
Revised	09/07/2017	GA.8042	Supplemental Compensation	Administrative

IX. GLOSSARY

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima's Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process:	Prospective staff translators are identified by Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima's bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by C&L Services Department. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.
Bonus Pay	Compensation to employees for superior performance such as "annual performance bonus" and "merit pay." If provided only during a member's final compensation period, it shall be excluded from final compensation as "final settlement" pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS	California Public Employees Retirement System
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Classic Director	A Management Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
Classic Executive	An Executive Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
Compensation Earnable	The pay rate and special compensation as defined in Government Code sections 20636 and 20636.1.
Executive Staff	Staff holding Executive level positions as specifically designated by the Board of Directors.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare or/ OneCare Connect Program.
Special Compensation	Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).

Term	Definition
Threshold Language	For purposes of this policy, a threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

1

CALOPTIMA EXECUTIVE INCENTIVE PROGRAM

The Leadership Incentive Plan is an annual plan for the members of CalOptima's executive team that provides a monetary reward for superior performance based on the achievement of predetermined goals and objectives. The amount of incentive awarded to participants is determined based on goal achievement scores and the availability of budget for incentive payments.

A. Purpose: To align the performance of CalOptima's executive staff towards the accomplishment of the agency's long-term strategic plan and to reward superior accomplishment of annual key business strategies and initiatives.

B. Eligibility: To be eligible to participate in the Leadership Incentive Plan, an employee must be in an executive level position with job titles containing the designation of "Chief" or "Executive".

C. Goals and Objectives: Specific performance goals and objectives are established by the Chief Executive Officer and members of the executive team. Each goal is assigned a weighted percentage, and a description/measure of accomplishment. Goals are established using the following guidelines.

- Linkage to organization strategy
- Stretch objectives with a reasonable probability of attainment
- Consistency in approach across the department
- Encouragement of teamwork among leadership team and the organization, and
- Simple to understand, communicate and administer

D. Performance Period: Accomplishment of goals and objectives will be determined based on performance during the fiscal year (July 1 to June 30).

E. Incentive Opportunity: Goals and objectives are assigned accomplishment points. A minimum score of 50 points is required to be eligible for incentive compensation. The maximum points awarded is 100. The maximum incentive award is 10% of the participant's annual base compensation. The amount can be prorated based on the number of months participation in the plan. In order to receive an incentive award, the participant must be an active employee at the time the award is paid out. The range of the potential incentive for Executive Staff is contingent upon a range of performance based upon the goals and objectives established by the Chief Executive Officer. Based upon the total accomplishment points received, the incentive opportunities may be determined based upon a performance matrix, as an example, as follows:

Points	Category	Description	Incentive as Percentage of Base Pay
Below 50	Below Threshold	The minimum level of performance was not achieved	0%

Points	Category	Description	Incentive as Percentage of Base Pay
50-60	Threshold	The minimum level of performance which must be achieved before an incentive is paid	0-4%
60-70	Target	The level of performance which generally equates to the achievement of some but not all goals and objectives	4-6%
70-85	Commendable	The level of performance where the combination of personal effort and business produce an above average return for the organization	6-8%
85-100	Outstanding	The very superior level of performance which occasionally occurs when all circumstances come together to produce very high returns for the organization.	8-10%

F. Modification of Plan: The CEO may modify the plan for business need at any time. Participation in the plan is subject to the approval of the CEO. Participation in any single year does not predict participation in subsequent years.

Sample Form

Executive Incentive Goals for FY____- ____

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
Quality Programs and Services	*Goal XYZ*	*10*	*Implement by Q1. Program rolled out to all users. 0 – 25, 0 if not met, 25 if fully met.*	*15*	*Chief Operating Officer*	*Partial completion.*
Culture, Learning and Innovation						
Financial Stability						
Strong Internal Processes						
Community Outreach						

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
			Total Score			

CALOPTIMA EXECUTIVE INCENTIVE PROGRAM

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C. Goals and Objectives: Specific performance goals and objectives are established by the Chief Executive Officer and members of the executive team. Each goal is assigned a weighted percentage, and a description/measure of accomplishment. Goals are established using the following guidelines.

- Linkage to organization strategy
- Stretch objectives with a reasonable probability of attainment
- Consistency in approach across the department
- Encouragement of teamwork among leadership team and the organization, and
- Simple to understand, communicate and administer

D. Performance Period: Accomplishment of goals and objectives will be determined based on performance during the fiscal year (July 1 to June 30).

E. Incentive Opportunity: Goals and objectives are assigned accomplishment points. A minimum score of 50 points is required to be eligible for incentive compensation. The maximum points awarded is 100. The maximum incentive award is 10% of the participant's annual base compensation. The amount can be prorated based on the number of months participation in the plan. In order to receive an incentive award, the participant must be an active employee at the time the award is paid out. The range of the potential incentive for Executive Staff is contingent upon a range of performance based upon the goals and objectives established by the Chief Executive Officer. Based upon the total accomplishment points received, the incentive opportunities may be determined based upon a performance matrix, as an example, as follows:

Points	Category	Description	Incentive as Percentage of Base Pay
Below 50	Below Threshold	The minimum level of performance was not achieved	0%

Points	Category	Description	Incentive as Percentage of Base Pay
50-60	Threshold	The minimum level of performance which must be achieved before an incentive is paid	0-4%
60-70	Target	The level of performance which generally equates to the achievement of some but not all goals and objectives	4-6%
70-85	Commendable	The level of performance where the combination of personal effort and business produce an above average return for the organization	6-8%
85-100	Outstanding	The very superior level of performance which occasionally occurs when all circumstances come together to produce very high returns for the organization.	8-10%

F. Modification of Plan: The CEO may modify the plan for business need at any time. Participation in the plan is subject to the approval of the CEO. Participation in any single year does not predict participation in subsequent years.

Sample Form

Executive Incentive Goals for FY____- ___

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
Quality Programs and Services	*Goal XYZ*	*10*	*Implement by Q1. Program rolled out to all users. 0 – 25, 0 if not met, 25 if fully met.*	*15*	*Chief Operating Officer*	*Partial completion.*
Culture, Learning and Innovation						
Financial Stability						
Strong Internal Processes						
Community Outreach						

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
			Total Score			

Back to Agenda

Performance Review – Executive (Directors and Above)

EMPLOYEE INFORMATION

EMPLOYEE	JOB TITLE	DEPARTMENT

SUPERVISOR/EVALUATOR

REVIEW

to

~~REVIEW DATE~~**SELF REVIEW: In the following section, provide your responses to the following questions for the review period April 1, 2016 through March 31, 2017.**

1) **What did you do well that impacted or demonstrated your performance? (Examples: accomplishments, self-development, projects, productivity, customer service)**
2) **What are you continuing to work on that you set as goal(s) from last year?**
3) **What opportunities for growth, future goals or enhancement to your position will sustain and/or improve your performance?**

~~TYPE OF REVIEW~~

~~90 Day 6 Month Yearly Other~~

1)

2)

3)

Back to Agenda

Manager Review: ***Below are the Core Competencies to be completed by your manager***

CORE BEHAVIORAL COMPETENCIES

This section describes the core competencies required for successful employee performance for this CalOptima position. In the space provided, mark the appropriate rating with an "x" and provide comments as needed. Evaluate the employee on each factor relevant to the job duties and responsibilities by indicating to what degree the employee demonstrates the overall skill or behavior on the job.

Competency Rating Scale Definitions:

Outstanding – Performance **regularly exceeds** job expectations due to **exceptionally high quality** of work in all essential areas of responsibility, resulting in outstanding contribution. Reserved for truly outstanding performance.

Exceeds Expectations - Often demonstrates behaviors that go **above and beyond** expectations in order to achieve exceptional performance or intended results.

Fully Meets Expectations - Demonstrates effective and desired behaviors that **consistently** meet **expected** performance standards.

Needs Development - Demonstrates **some** desired behaviors, or uses behaviors **inconsistently**. Requires some development/improvement.

Unacceptable - Rarely demonstrates competency behaviors. **Does not meet** performance standards. Requires **significant** and **immediate** improvement

~~**I. CORE BEHAVIORAL COMPETENCIES**~~

~~**This section describes the core competencies required for successful employee performance for this CalOptima position. In the space provided, mark the appropriate rating with an "x" and provide comments as needed. Evaluate the employee on each factor relevant to the job by indicating to what degree the employee demonstrates the overall skill or behavior on the job.** *Use the drop-downs in the upper left for language that best describes the employee's behavior and approach and "place" your comments in the "Comments" section.*~~

~~**Competency Rating Scale Definitions:**~~

~~**Outstanding** – **Consistently** demonstrates behaviors that lead to **extraordinary** or **superior** performance. Surpasses expectations and serves as a role model that others turn to for direction and feedback.~~

~~**Exceeds Expectations** – **Often** demonstrates behaviors that go **above and beyond** expectations in order to achieve exceptional performance or intended results.~~

~~**Fully Meets Expectations** – Demonstrates effective and desired behaviors that meet **expected** performance standards. Occasionally exceeds expectations in select areas of individual expertise~~

~~**Needs Development** – Demonstrates **some** desired behaviors, or uses behaviors **inconsistently**. Falls **below** minimum performance standards. Improvement is required.~~

~~**Unacceptable** – Rarely demonstrates competency behaviors. **Does not meet** performance standards. Requires **significant** and **immediate** improvement.~~

COMMUNICATION: • Communicates well with others in both verbal and written form. by adapting his/her tone, style and approach based on people's perspectives and situations. Organizes thoughts, expresses them clearly and respectfully. • Listens attentively to ideas of others; cooperativecooperates and builds good working relationships with others. • Provides colleagues with regular and reliable information, including updates on his/her own activities. • Respectful and attentive to people who are speaking, both in group and one-on-one situations. • Has good presentation skills/decisions, and is well-prepared when speaking in front of a group. Presentations; presentations are clear, and informative, and geared toward audience's needs. • Adapts his/her tone, style and approach, depending on people's perspectives and situations..	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
Comments:Describe specific examples or details of past performance and self development during this review cycle that support the rating: _____	
CUSTOMER FOCUS (internal and/or external) • Actively listens and follows up/through on customer inquiries/requests in a timely, professional, courteous, and sensitive manner; ensures clear and frequent communication with customers about progress, changes and status; takes responsibility for correcting customer problems. • Demonstrates a good understanding of company/department procedures for handling customer complaints; knows when to bring in help/use the chain of command for problems beyond his/her ability. • Viewed as a team player.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
Describe specific examples or details of past performance and self development during this review cycle that support the rating: _____	
LEADERSHIP: • Communicates high level priorities and objectives, a compelling and strategic vision, which is innovative and future-oriented, and creates buy-in at various levels of the organization for each fiscal year. • Manages, inspires, motivates, develops, reviews, and supports the growth of the organization and department staff.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
Describe specific examples or details of past performance and self development during this review cycle that support the rating: _____	
STRATEGIC THINKING: • Applies the SWOT analysis to CalOptima's changing environment to identify opportunities for success in order to redirect the company's course, create realistic and well-balanced strategic plans, and to meet new targets. Understands the players in our industry, both competitors and allies, and is on top of industry shifts and changes. • Includes key stakeholders in strategic planning. • Is an innovative strategic partner.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
Describe specific examples or details of past performance and self development during this review cycle that support the rating: _____	
DECISION MAKING/PROBLEM SOLVING: • Uses sound and consistent judgment when analyzing situations and making decisions that would impact both the department and the entire organization; able to identify potential problems and offers multiple solutions; is conscientious of the department resources. • Able to make decisions even when conditions are uncertain or information is not available by using the correct balance of logic and intuition; discusses his/her decision and its impact with those who will be affected; the group benefits from his/her input in problem solving and	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable

brainstorming sessions. • Reliable, persistent worker who keeps a positive outlook and does not let unexpected problems stop him/her from successfully completing own work; calm under pressure.	

Describe specific examples or details of past performance and self development during this review cycle that support the rating:

_____

PREVIOUS MANAGER'S COMMENTS (if applicable):

List goals that will sustain and/or improve performance, and how they will be measured/evaluated during the next review period:

_____

FINAL OVERALL RATING	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable

CUSTOMER FOCUS (internal and/or external) • Follows up on customer inquiries/requests in a timely manner; ensures clear and frequent communication with customers about progress, changes and status; takes responsibility for correcting customer problems. • Actively listens to understand customer complaints or issues. • Demonstrates a good understanding of company/department procedures for handling customer complaints; knows when to bring in help/use the chain of command for problems beyond his/her ability. • Maintains a professional demeanor and appearance with customers. • Courteous, sensitive and responsive when communicating with customers. • Follows through and meets commitments to ensure customer satisfaction. • **Viewed as a team player in the organization.**	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
Manager's/Evaluator's Comments:	
SELF DEVELOPMENT: • Seeks feedback and opportunities that will create professional growth and development. • Aware of self-development needs as well as strengths. Eager to participate in self-development opportunities. • Has a balanced and mature outlook on their performance. Looks for ways to improve performance based on feedback from others. • Regularly seeks out learning opportunities to develop skills and knowledge. Keeps up-to-date on information important to current job. • Follows through on activities and deadlines in self-development plan. • Demonstrates flexibility and willingness to take on new responsibilities to help the team or support management. • Takes initiative to improve processes or overcome obstacles.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
Comments:	
LEADERSHIP: • Communicates a compelling and strategic vision in a way that creates buy-in at the organizational level, department level, and team level and with our customers. • Outlines high level priorities and objectives for each fiscal year. • Is able to think beyond today's needs and is considered to be both innovative and future-oriented. • Can inspire and motivate the entire organization and/or their division/department/team. • Provides challenging and stretching tasks, projects and assignments that inspire direct reports. • Encourages collaborative work and decision-making through consensus. • Holds one-on-one meetings with all direct reports at least once per month. Discusses developmental opportunities during these meetings. • Is actively working to develop, coach and mentor key individuals identified through succession planning efforts.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable

Back to Agenda

~~**Comments:**~~

Manager's/Evaluator's Signature:

STRATEGIC THINKING:

- Understands our company and competition, and can identify opportunities.
- Knows what is important for success and plans accordingly.
- Understands the players in our industry, both competitors and allies, and is on top of industry shifts and changes.
- Knows where we could be better, and where we have an advantage over the competition. Uses this information to create realistic and well-balanced strategic plans.
- Anticipates changes and redirects our course to meet new targets.
- Includes key stakeholders in strategic planning.
- Relates daily activities to the big picture and determines specific steps that are needed to get there.

☐☐☐☐☐ Outstanding

Signature **Comments:** Date

DECISION MAKING/PROBLEM SOLVING: • Uses sound and consistent judgment when analyzing situations and making decisions. • Looks at the consequences of decisions on both the individual and the entire organization. • Able to make decisions even when conditions are uncertain by using the correct balance of logic and intuition. • Keeps momentum moving forward even though precise information may not be available. • Calm under pressure and able to make good decisions even when time is short. • Discusses his/her decision and its impact with those who will be affected. • Is able to identify potential problems, and moves towards offering multiple solutions with focus on resolving the issue. • Reliable, persistent worker who keeps a positive outlook and does not let unexpected problems stop him/her from successfully completing own work. • The group benefits from his/her input in problem solving and brainstorming sessions.	☐☐☐☐☐ Outstanding Exceeds Expectations Fully Meets Expectations Needs Development Unacceptable
Comments:	☐☐☐☐☐
Section I: OVERALL CORE BEHAVIORAL COMPETENCY RATING	☐☐☐☐☐ Outstanding Exceeds Expectations Fully Meets Expectations Needs Development Unacceptable

Second Level Manager's Comments and Signature:

_____

II. KEY RESPONSIBILITIES

Rating Scale

Key Responsibilities should be the top 3 - 5 most important responsibilities for success in this employee's role, as outlined by the job description. They can include the employee's daily, weekly, monthly, quarterly and yearly responsibilities and job expectations for the review period.

- Be specific about quality/quantity standards
- Describe how the employee performed with this Key Responsibility during the Performance Review period including due dates met/not met, quality of work product, and effectiveness

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Back to Agenda

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Back to Agenda

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~~Fully Meets Expectatio~~

Back to Agenda

~~ns~~ ~~– Performance meets expectations and/or standard requirements. Needs Development – Performance does not meet~~

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Back to Agenda

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Signature Date

~~*Key Responsibility*~~	~~*Rating*~~

Employee's

Back to Agenda

Acknowledgement and Comments:

1.

2.

3. Signature		Date
4.		
5.		

☐ Outstanding
☐ Exceeds Expectations
☐ Fully Meets Expectations
☐ Needs Development
☐ Unacceptable

Section II: OVERALL KEY RESPONSIBILITIES RATING

III. PROJECTS & ASSIGNMENTS

Include any projects or assignments outside of regular Key Responsibilities for the Performance Review period. "Copy and Paste" from prior year's performance evaluation (Section V: Projects & Assignments for the Coming Year) or from goals set at hire date. Provide specific and detailed comments on results achieved.

- Be specific about quality/quantity standards
- Describe how the employee performed with this Project and/or Assignment during the Performance Review period including due dates met/not met quality of work product, and effectiveness.

Rating Scale

Outstanding – **Superior** performance **consistently exceeds** expectations and/or standard requirements.

Exceeds Expectations – Performance **exceeds** expectations and/or standard requirements.

Fully Meets Expectations – Performance **meets** expectations and/or standard requirements.

Needs Development – Performance **does not meet** expectations and/or standard requirements. Improvement is required.

Unacceptable – Performance is **below** expectations and/or standards. Requires **significant** and **immediate** improvement.

Projects & Assignments	*Rating*
1.	
2.	
3.	

Section III: OVERALL PROJECTS & ASSIGNMENTS RATING

☐ Outstanding
☐ Exceeds Expectations
☐ Fully Meets Expectations
☐ Needs Development
☐ Unacceptable

Section IV: FINAL OVERALL RATING

Assess all ratings in Sections I, II, and II in order to assign an overall rating that best reflects the employee's total performance during the review period. *Section I results should be weighted to reflect at least 50% of the Overall Rating.*

☐ Outstanding
☐ Exceeds Expectations
☐ Fully Meets Expectations
☐ Needs Development
☐ Unacceptable

V. DEVELOPMENT PLAN

This section is designed to outline a Development Plan to help the employee improve effectiveness and performance in their current job, or to prepare them for future career opportunities at CalOptima. Examples of developmental actions include seminars/training/classes, special project assignments, reading/self-study, working on a committee, temporary assignments in another department, supervision/monitoring of another employee, frequent coaching, assigning a mentor, joining a professional organization or customer/vendor visits.

- Outline the developmental activity, a target completion date, and the desired results

For sample development plans please click on the following link: **Sample Plans**

Development Action or Activity	***Desired Results***	***Target Completion Date***
1.		
2.		
3.		

COMMENTS AND SIGNATURES

Manager/Evaluator's signature:

_____ _____

Signature Date

Second Level Manager's comments and signature:

_____ _____

Signature Date

Employee's acknowledgement and comments:

~~Signature Date~~

Performance Review – Executive (Directors and Above)

EMPLOYEE INFORMATION

EMPLOYEE	JOB TITLE	DEPARTMENT
SUPERVISOR/EVALUATOR	REVIEW PERIOD	
	to	

SELF REVIEW: In the following section, provide your responses to the following questions for the review period April 1, 2016 through March 31, 2017.

1) **What did you do well that impacted or demonstrated your performance? (Examples: accomplishments, self-development, projects, productivity, customer service)**
2) **What are you continuing to work on that you set as goal(s) from last year?**
3) **What opportunities for growth, future goals or enhancement to your position will sustain and/or improve your performance?**

1)

2)

3)

Manager Review: ***Below are the Core Competencies to be completed by your manager***

CORE BEHAVIORAL COMPETENCIES

This section describes the core competencies required for successful employee performance for this CalOptima position. In the space provided, mark the appropriate rating with an "x" and provide comments as needed. Evaluate the employee on each factor relevant to the job duties and responsibilities by indicating to what degree the employee demonstrates the overall skill or behavior on the job.

Competency Rating Scale Definitions:

Outstanding – Performance **regularly exceeds** job expectations due to **exceptionally high quality** of work in all essential areas of responsibility, resulting in outstanding contribution. Reserved for truly outstanding performance.

Exceeds Expectations - **Often** demonstrates behaviors that go **above and beyond** expectations in order to achieve exceptional performance or intended results.

Fully Meets Expectations - Demonstrates effective and desired behaviors that **consistently** meet **expected** performance standards.

Needs Development - Demonstrates **some** desired behaviors, or uses behaviors **inconsistently**. Requires some development/improvement.

Unacceptable - Rarely demonstrates competency behaviors. **Does not meet** performance standards. Requires **significant** and **immediate** improvement

COMMUNICATION: • Communicates well with others in both verbal and written form by adapting his/her tone, style and approach based on people's perspectives and situations. Organizes thoughts, expresses them clearly and respectfully. • Listens attentively to ideas of others; cooperates and builds good working relationships with others. • Provides colleagues with regular and reliable information, including updates on his/her own activities/decisions, and is well-prepared when speaking in front of a group; presentations are clear and informative.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
Describe specific examples or details of past performance and self development during this review cycle that support the rating:	
CUSTOMER FOCUS (internal and/or external) • Actively listens and follows up/through on customer inquiries/requests in a timely, professional, courteous, and sensitive manner; ensures clear and frequent communication with customers about progress, changes and status; takes responsibility for correcting customer problems. • Demonstrates a good understanding of company/department procedures for handling customer complaints; knows when to bring in help/use the chain of command for problems beyond his/her ability. • Viewed as a team player.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
Describe specific examples or details of past performance and self development during this review cycle that support the rating:	
LEADERSHIP: • Communicates high level priorities and objectives, a compelling and strategic vision, which is innovative and future-oriented, and creates buy-in at various levels of the organization for each fiscal year. • Manages, inspires, motivates, develops, reviews, and supports the growth of the organization and department staff.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
Describe specific examples or details of past performance and self development during this review cycle that support the rating:	
STRATEGIC THINKING: • Applies the SWOT analysis to CalOptima's changing environment to identify opportunities for success in order to redirect the company's course, create realistic and well-balanced strategic plans, and to meet new targets. Understands the players in our industry, both competitors and allies, and is on top of industry shifts and changes. • Includes key stakeholders in strategic planning. • Is an innovative strategic partner.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
Describe specific examples or details of past performance and self development during this review cycle that support the rating:	
DECISION MAKING/PROBLEM SOLVING: • Uses sound and consistent judgment when analyzing situations and making decisions that would impact both the department and the entire organization; able to identify potential problems and offers multiple solutions; is conscientious of the department resources. • Able to make decisions even when conditions are uncertain or information is not available by	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable

using the correct balance of logic and intuition; discusses his/her decision and its impact with those who will be affected; the group benefits from his/her input in problem solving and brainstorming sessions. • Reliable, persistent worker who keeps a positive outlook and does not let unexpected problems stop him/her from successfully completing own work; calm under pressure.	
Describe specific examples or details of past performance and self development during this review cycle that support the rating:	
PREVIOUS MANAGER'S COMMENTS (if applicable):	
List goals that will sustain and/or improve performance, and how they will be measured/evaluated during the next review period:	
FINAL OVERALL RATING	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable

Manager's/Evaluator's Comments

Manager's/Evaluator's Signature:

Signature _____ Date _____

Second Level Manager's Comments and Signature:

Signature Date

Employee's Acknowledgement and Comments:

Signature Date

Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	~~08~~09/~~03~~0
Last Revised Date:	7/17 ~~08~~09/~~03~~0 7/17

~~*Board Approved Policy*~~

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule, meeting the requirements above, are available at CalOptima's offices and immediately accessible for public review during normal business hours or posted on CalOptima's internet website.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of ~~08/03~~09/07/17)

V. REFERENCES

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 09/07/17: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 08/03/17: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 06/01/17: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 05/04/17: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 03/02/17: Regular Meeting of the CalOptima Board of Directors
~~E.~~F. 12/01/16: Regular Meeting of the CalOptima Board of Directors
~~F.~~G. 11/03/16: Regular Meeting of the CalOptima Board of Directors
~~G.~~H. 10/06/16: Regular Meeting of the CalOptima Board of Directors
~~H.~~I. 09/01/16: Regular Meeting of the CalOptima Board of Directors
~~I.~~J. 08/04/16: Regular Meeting of the CalOptima Board of Directors
~~J.~~K. 06/02/16: Regular Meeting of the CalOptima Board of Directors
~~K.~~L. 03/03/16: Regular Meeting of the CalOptima Board of Directors
~~L.~~M. 12/03/15: Regular Meeting of the CalOptima Board of Directors
~~M.~~N. 10/01/15: Regular Meeting of the CalOptima Board of Directors

~~N.~~O. 06/04/15: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative

IX. GLOSSARY

Not Applicable

Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/14
Last Review Date:	09/07/17
Last Revised Date:	09/07/17

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule, meeting the requirements above, are available at CalOptima's offices and immediately accessible for public review during normal business hours or posted on CalOptima's internet website.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of 09/07/17)

V. REFERENCES

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 09/07/17: Regular Meeting of the CalOptima Board of Directors
B. 08/03/17: Regular Meeting of the CalOptima Board of Directors
C. 06/01/17: Regular Meeting of the CalOptima Board of Directors
D. 05/04/17: Regular Meeting of the CalOptima Board of Directors
E. 03/02/17: Regular Meeting of the CalOptima Board of Directors
F. 12/01/16: Regular Meeting of the CalOptima Board of Directors
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J. 08/04/16: Regular Meeting of the CalOptima Board of Directors
K. 06/02/16: Regular Meeting of the CalOptima Board of Directors
L. 03/03/16: Regular Meeting of the CalOptima Board of Directors
M. 12/03/15: Regular Meeting of the CalOptima Board of Directors
N. 10/01/15: Regular Meeting of the CalOptima Board of Directors
O. 06/04/15: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
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Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative

IX. GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised September 7, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Accountant	K	39	$47,112	$61,360	$75,504	
	Accountant Int	L	634	$54,288	$70,512	$86,736	
	Accountant Sr	M	68	$62,400	$81,120	$99,840	
	Accounting Clerk	I	334	$37,128	$46,384	$55,640	
	Actuarial Analyst	L	558	$54,288	$70,512	$86,736	
	Actuarial Analyst Sr	M	559	$62,400	$81,120	$99,840	
	Actuary	O	357	$82,576	$107,328	$131,976	
	Administrative Assistant	H	19	$33,696	$42,224	$50,648	
	Analyst	K	562	$47,112	$61,360	$75,504	
	Analyst Int	L	563	$54,288	$70,512	$86,736	
	Analyst Sr	M	564	$62,400	$81,120	$99,840	
	Applications Analyst	K	232	$47,112	$61,360	$75,504	
	Applications Analyst Int	L	233	$54,288	$70,512	$86,736	
	Applications Analyst Sr	M	298	$62,400	$81,120	$99,840	
	Associate Director Customer Service	O	593	$82,576	$107,328	$131,976	
	Associate Director Information Services	Q	557	$114,400	$154,440	$194,480	
	Associate Director Provider Network	O	647	$82,576	$107,328	$131,976	
	Auditor	K	565	$47,112	$61,360	$75,504	
	Auditor Sr	L	566	$54,288	$70,512	$86,736	
	Behavioral Health Manager	N	383	$71,760	$93,184	$114,712	
	Biostatistics Manager	N	418	$71,760	$93,184	$114,712	
	Board Services Specialist	J	435	$40,976	$53,352	$65,624	
	Business Analyst	J	40	$40,976	$53,352	$65,624	
	Business Analyst Sr	M	611	$62,400	$81,120	$99,840	
	Business Systems Analyst Sr	M	69	$62,400	$81,120	$99,840	
	Buyer	J	29	$40,976	$53,352	$65,624	
	Buyer Int	K	49	$47,112	$61,360	$75,504	
	Buyer Sr	L	67	$54,288	$70,512	$86,736	
	Care Manager	M	657	$62,400	$81,120	$99,840	
	Care Transition Intervention Coach (RN)	N	417	$71,760	$93,184	$114,712	
	Certified Coder	K	399	$47,112	$61,360	$75,504	
	Certified Coding Specialist	K	639	$47,112	$61,360	$75,504	
	Certified Coding Specialist Sr	L	640	$54,288	$70,512	$86,736	
	Change Control Administrator	L	499	$54,288	$70,512	$86,736	
	Change Control Administrator Int	M	500	$62,400	$81,120	$99,840	
	Change Management Analyst Sr	N	465	$71,760	$93,184	$114,712	
**	Chief Counsel	T	132	$197,704	$266,968	$336,024	
**	Chief Executive Officer	V	138	$319,740	$431,600	$543,600	
**	Chief Financial Officer	U	134	$237,224	$320,216	$403,312	
**	Chief Information Officer	T	131	$197,704	$266,968	$336,024	
**	Chief Medical Officer	U	137	$237,224	$320,216	$403,312	
**	Chief Operating Officer	U	136	$237,224	$320,216	$403,312	
	Claims - Lead	J	574	$40,976	$53,352	$65,624	
	Claims Examiner	H	9	$33,696	$42,224	$50,648	
	Claims Examiner - Lead	J	236	$40,976	$53,352	$65,624	
	Claims Examiner Sr	I	20	$37,128	$46,384	$55,640	
	Claims QA Analyst	I	28	$37,128	$46,384	$55,640	
	Claims QA Analyst Sr.	J	540	$40,976	$53,352	$65,624	
	Claims Recovery Specialist	I	283	$37,128	$46,384	$55,640	
	Claims Resolution Specialist	I	262	$37,128	$46,384	$55,640	
	Clerk of the Board	O	59	$82,576	$107,328	$131,976	
	Clinical Auditor	M	567	$62,400	$81,120	$99,840	
	Clinical Auditor Sr	N	568	$71,760	$93,184	$114,712	
	Clinical Documentation Specialist (RN)	O	641	$82,576	$107,328	$131,976	
	Clinical Pharmacist	P	297	$95,264	$128,752	$162,032	
	Clinical Systems Administrator	M	607	$62,400	$81,120	$99,840	
	Clinician (Behavioral Health)	M	513	$62,400	$81,120	$99,840	
	Communications Specialist	J	188	$40,976	$53,352	$65,624	
	Community Partner	K	575	$47,112	$61,360	$75,504	

CalOptima - Annual Base Salary Schedule - Revised September 7, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Community Partner Sr	L	612	$54,288	$70,512	$86,736	
	Community Relations Specialist	J	288	$40,976	$53,352	$65,624	
	Community Relations Specialist Sr	K	646	$47,112	$61,360	$75,504	
	Compliance Claims Auditor	K	222	$47,112	$61,360	$75,504	
	Compliance Claims Auditor Sr	L	279	$54,288	$70,512	$86,736	
	Contract Administrator	M	385	$62,400	$81,120	$99,840	
	Contracts Manager	N	207	$71,760	$93,184	$114,712	
	Contracts Specialist	K	257	$47,112	$61,360	$75,504	
	Contracts Specialist Int	L	469	$54,288	$70,512	$86,736	
	Contracts Specialist Sr	M	331	$62,400	$81,120	$99,840	
*	Controller	Q	464	$114,400	$154,440	$194,480	
	Credentialing Coordinator	J	41	$40,976	$53,352	$65,624	
	Credentialing Coordinator - Lead	J	510	$40,976	$53,352	$65,624	
	Customer Service Coordinator	J	182	$40,976	$53,352	$65,624	
	Customer Service Rep	H	5	$33,696	$42,224	$50,648	
	Customer Service Rep - Lead	J	482	$40,976	$53,352	$65,624	
	Customer Service Rep Sr	I	481	$37,128	$46,384	$55,640	
	Data Analyst	K	337	$47,112	$61,360	$75,504	
	Data Analyst Int	L	341	$54,288	$70,512	$86,736	
	Data Analyst Sr	M	342	$62,400	$81,120	$99,840	
	Data and Reporting Analyst - Lead	O	TBD	$82,576	$107,328	$131,976	
	Data Entry Tech	F	3	$27,872	$34,840	$41,808	
	Data Warehouse Architect	O	363	$82,576	$107,328	$131,976	
	Data Warehouse Programmer/Analyst	O	364	$82,576	$107,328	$131,976	
	Data Warehouse Project Manager	O	362	$82,576	$107,328	$131,976	
	Data Warehouse Reporting Analyst	N	412	$71,760	$93,184	$114,712	
	Data Warehouse Reporting Analyst Sr	O	522	$82,576	$107,328	$131,976	
	Database Administrator	M	90	$62,400	$81,120	$99,840	
	Database Administrator Sr	O	179	$82,576	$107,328	$131,976	
**	Deputy Chief Counsel	S	160	$164,736	$222,352	$280,072	
**	Deputy Chief Medical Officer	T	561	$197,704	$266,968	$336,024	
*	Director Accounting	P	122	$95,264	$128,752	$162,032	
*	Director Applications Management	R	170	$137,280	$185,328	$233,376	
*	Director Audit & Oversight	Q	546	$114,400	$154,440	$194,480	
*	Director Behavioral Health Services	P	392	$95,264	$128,752	$162,032	
*	Director Budget and Procurement	Q	527	$114,400	$154,440	$194,480	
*	Director Business Development	P	351	$95,264	$128,752	$162,032	
*	Director Business Integration	Q	543	$114,400	$154,440	$194,480	
*	Director Case Management	Q	318	$114,400	$154,440	$194,480	
*	Director Claims Administration	P	112	$95,264	$128,752	$162,032	
*	Director Clinical Outcomes	Q	602	$114,400	$154,440	$194,480	
*	Director Clinical Pharmacy	R	129	$137,280	$185,328	$233,376	
*	Director Coding Initiatives	P	375	$95,264	$128,752	$162,032	
*	Director Communications	P	361	$95,264	$128,752	$162,032	
*	Director Community Relations	P	292	$95,264	$128,752	$162,032	
*	Director Configuration & Coding	Q	596	$114,400	$154,440	$194,480	
*	Director Contracting	P	184	$95,264	$128,752	$162,032	
*	Director COREC	Q	369	$114,400	$154,440	$194,480	
*	Director Customer Service	P	118	$95,264	$128,752	$162,032	
*	Director Electronic Business	P	358	$95,264	$128,752	$162,032	
*	Director Enterprise Analytics	Q	520	$114,400	$154,440	$194,480	
*	Director Facilities	P	428	$95,264	$128,752	$162,032	
*	Director Finance & Procurement	P	157	$95,264	$128,752	$162,032	
*	Director Financial Analysis	R	374	$137,280	$185,328	$233,376	
*	Director Financial Compliance	P	460	$95,264	$128,752	$162,032	
*	Director Fraud Waste & Abuse and Privacy	Q	581	$114,400	$154,440	$194,480	
*	Director Government Affairs	P	277	$95,264	$128,752	$162,032	
*	Director Grievance & Appeals	P	528	$95,264	$128,752	$162,032	
*	Director Health Education & Disease Management	Q	150	$114,400	$154,440	$194,480	

CalOptima - Annual Base Salary Schedule - Revised September 7, 2017
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
* Director Health Services	Q	328	$114,400	$154,440	$194,480	
* Director Human Resources	Q	322	$114,400	$154,440	$194,480	
* Director Information Services	R	547	$137,280	$185,328	$233,376	
* Director Long Term Support Services	Q	128	$114,400	$154,440	$194,480	
* Director Medi-Cal Plan Operations	P	370	$95,264	$128,752	$162,032	
* Director Network Management	P	125	$95,264	$128,752	$162,032	
* Director OneCare Operations	P	425	$95,264	$128,752	$162,032	
* Director Organizational Training & Education	P	579	$95,264	$128,752	$162,032	
* Director PACE Program	Q	449	$114,400	$154,440	$194,480	
* Director Process Excellence	Q	447	$114,400	$154,440	$194,480	
* Director Program Implementation	Q	489	$114,400	$154,440	$194,480	
* Director Project Management	Q	447	$114,400	$154,440	$194,480	
* Director Provider Data Quality	Q	TBD	$114,400	$154,440	$194,480	
* Director Provider Services	P	597	$95,264	$128,752	$162,032	
* Director Public Policy	P	459	$95,264	$128,752	$162,032	
* Director Quality (LTSS)	Q	613	$114,400	$154,440	$194,480	
* Director Quality Analytics	Q	591	$114,400	$154,440	$194,480	
* Director Quality Improvement	Q	172	$114,400	$154,440	$194,480	
* Director Regulatory Affairs and Compliance	Q	625	$114,400	$154,440	$194,480	
* Director Strategic Development	P	121	$95,264	$128,752	$162,032	
* Director Systems Development	R	169	$137,280	$185,328	$233,376	
* Director Utilization Management	Q	265	$114,400	$154,440	$194,480	
Disease Management Coordinator	M	70	$62,400	$81,120	$99,840	
Disease Management Coordinator - Lead	M	472	$62,400	$81,120	$99,840	
EDI Project Manager	O	403	$82,576	$107,328	$131,976	
Enrollment Coordinator (PACE)	K	441	$47,112	$61,360	$75,504	
Enterprise Analytics Manager	P	582	$95,264	$128,752	$162,032	
Executive Assistant	K	339	$47,112	$61,360	$75,504	
Executive Assistant to CEO	L	261	$54,288	$70,512	$86,736	
** Executive Director Clinical Operations	S	501	$164,736	$222,352	$280,072	
** Executive Director Compliance	S	493	$164,736	$222,352	$280,072	
** Executive Director Human Resources	S	494	$164,736	$222,352	$280,072	
** Executive Director Network Operations	S	632	$164,736	$222,352	$280,072	
** Executive Director Operations	S	276	$164,736	$222,352	$280,072	
** Executive Director Program Implementation	S	490	$164,736	$222,352	$280,072	
** Executive Director Public Affairs	S	290	$164,736	$222,352	$280,072	
** Executive Director Quality Analytics	S	601	$164,736	$222,352	$280,072	
** Executive Director, Behavioral Health Integration	S	614	$164,736	$222,352	$280,072	
Facilities & Support Services Coord - Lead	J	631	$40,976	$53,352	$65,624	
Facilities & Support Services Coordinator	J	10	$40,976	$53,352	$65,624	
Facilities Coordinator	J	438	$40,976	$53,352	$65,624	
Financial Analyst	L	51	$54,288	$70,512	$86,736	
Financial Analyst Sr	M	84	$62,400	$81,120	$99,840	
Financial Reporting Analyst	L	475	$54,288	$70,512	$86,736	
Gerontology Resource Coordinator	M	204	$62,400	$81,120	$99,840	
Graphic Designer	M	387	$62,400	$81,120	$99,840	
Grievance & Appeals Nurse Specialist	N	226	$71,760	$93,184	$114,712	
Grievance Resolution Specialist	J	42	$40,976	$53,352	$65,624	
Grievance Resolution Specialist - Lead	L	590	$54,288	$70,512	$86,736	
Grievance Resolution Specialist Sr	K	589	$47,112	$61,360	$75,504	
Health Coach	M	556	$62,400	$81,120	$99,840	
Health Educator	K	47	$47,112	$61,360	$75,504	
Health Educator Sr	L	355	$54,288	$70,512	$86,736	
Health Network Liaison Specialist (RN)	N	524	$71,760	$93,184	$114,712	
Health Network Oversight Specialist	M	323	$62,400	$81,120	$99,840	
HEDIS Case Manager	N	443	$71,760	$93,184	$114,712	
HEDIS Case Manager (LVN)	M	552	$62,400	$81,120	$99,840	
Help Desk Technician	J	571	$40,976	$53,352	$65,624	
Help Desk Technician Sr	K	573	$47,112	$61,360	$75,504	

CalOptima - Annual Base Salary Schedule - Revised September 7, 2017
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
HR Assistant	I	181	$37,128	$46,384	$55,640	
HR Business Partner	M	584	$62,400	$81,120	$99,840	
HR Coordinator	J	316	$40,976	$53,352	$65,624	
HR Representative	L	278	$54,288	$70,512	$86,736	
HR Representative Sr	M	350	$62,400	$81,120	$99,840	
HR Specialist	K	505	$47,112	$61,360	$75,504	
HR Specialist Sr	L	608	$54,288	$70,512	$86,736	
HRIS Analyst Sr	M	468	$62,400	$81,120	$99,840	
ICD-10 Project Manager	O	411	$82,576	$107,328	$131,976	
Infrastructure Systems Administrator	J	541	$40,976	$53,352	$65,624	
Infrastructure Systems Administrator Int	K	542	$47,112	$61,360	$75,504	
Inpatient Quality Coding Auditor	L	642	$54,288	$70,512	$86,736	
Intern	E	237	$25,272	$31,720	$37,960	
Investigator Sr	L	553	$54,288	$70,512	$86,736	
IS Coordinator	J	365	$40,976	$53,352	$65,624	
IS Project Manager	O	424	$82,576	$107,328	$131,976	
IS Project Manager Sr	P	509	$95,264	$128,752	$162,032	
IS Project Specialist	M	549	$62,400	$81,120	$99,840	
IS Project Specialist Sr	N	550	$71,760	$93,184	$114,712	
Kitchen Assistant	E	585	$25,272	$31,720	$37,960	
Legislative Program Manager	N	330	$71,760	$93,184	$114,712	
Licensed Clinical Social Worker	L	598	$54,288	$70,512	$86,736	
Litigation Support Specialist	M	588	$62,400	$81,120	$99,840	
LVN (PACE)	M	533	$62,400	$81,120	$99,840	
Mailroom Clerk	E	1	$25,272	$31,720	$37,960	
Manager Accounting	N	98	$71,760	$93,184	$114,712	
Manager Actuary	P	453	$95,264	$128,752	$162,032	
Manager Applications Management	P	271	$95,264	$128,752	$162,032	
Manager Audit & Oversight	O	539	$82,576	$107,328	$131,976	
Manager Behavioral Health	O	633	$82,576	$107,328	$131,976	
Manager Business Integration	O	544	$82,576	$107,328	$131,976	
Manager Case Management	O	270	$82,576	$107,328	$131,976	
Manager Claims	N	92	$71,760	$93,184	$114,712	
Manager Clinic Operations	O	551	$82,576	$107,328	$131,976	
Manager Clinical Pharmacist	Q	296	$114,400	$154,440	$194,480	
Manager Coding Quality	N	382	$71,760	$93,184	$114,712	
Manager Communications	N	398	$71,760	$93,184	$114,712	
Manager Community Relations	M	384	$62,400	$81,120	$99,840	
Manager Contracting	O	329	$82,576	$107,328	$131,976	
Manager Creative Branding	N	430	$71,760	$93,184	$114,712	
Manager Cultural & Linguistic	N	349	$71,760	$93,184	$114,712	
Manager Customer Service	N	94	$71,760	$93,184	$114,712	
Manager Decision Support	O	454	$82,576	$107,328	$131,976	
Manager Disease Management	O	372	$82,576	$107,328	$131,976	
Manager Electronic Business	O	422	$82,576	$107,328	$131,976	
Manager Employment Services	N	420	$71,760	$93,184	$114,712	
Manager Encounters	N	516	$71,760	$93,184	$114,712	
Manager Environmental Health & Safety	N	495	$71,760	$93,184	$114,712	
Manager Facilities	N	209	$71,760	$93,184	$114,712	
Manager Finance	N	148	$71,760	$93,184	$114,712	
Manager Financial Analysis	O	356	$82,576	$107,328	$131,976	
Manager Government Affairs	N	437	$71,760	$93,184	$114,712	
Manager Grievance & Appeals	N	426	$71,760	$93,184	$114,712	
Manager Health Education	N	173	$71,760	$93,184	$114,712	
Manager HEDIS	O	427	$82,576	$107,328	$131,976	
Manager Human Resources	O	526	$82,576	$107,328	$131,976	
Manager Information Services	P	560	$95,264	$128,752	$162,032	
Manager Information Technology	P	110	$95,264	$128,752	$162,032	
Manager Integration Government Liaison	N	455	$71,760	$93,184	$114,712	

CalOptima - Annual Base Salary Schedule - Revised September 7, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Manager Long Term Support Services	O	200	$82,576	$107,328	$131,976	
	Manager Marketing & Enrollment (PACE)	O	414	$82,576	$107,328	$131,976	
	Manager Medical Data Management	O	519	$82,576	$107,328	$131,976	
	Manager Medi-Cal Program Operations	N	483	$71,760	$93,184	$114,712	
	Manager Member Liaison Program	N	354	$71,760	$93,184	$114,712	
	Manager Member Outreach & Education	N	616	$71,760	$93,184	$114,712	
	Manager Member Outreach Education & Provider Relations	O	576	$82,576	$107,328	$131,976	
	Manager MSSP	O	393	$82,576	$107,328	$131,976	
	Manager OneCare Clinical	O	359	$82,576	$107,328	$131,976	
	Manager OneCare Customer Service	N	429	$71,760	$93,184	$114,712	
	Manager OneCare Regulatory	N	197	$71,760	$93,184	$114,712	
	Manager OneCare Sales	O	248	$82,576	$107,328	$131,976	
	Manager Outreach & Enrollment	N	477	$71,760	$93,184	$114,712	
	Manager PACE Center	O	432	$82,576	$107,328	$131,976	
	Manager Process Excellence	O	622	$82,576	$107,328	$131,976	
	Manager Program Implementation	O	488	$82,576	$107,328	$131,976	
	Manager Project Management	O	532	$82,576	$107,328	$131,976	
	Manager Provider Data Management Services	N	TBD	$71,760	$93,184	$114,712	
	Manager Provider Network	O	191	$82,576	$107,328	$131,976	
	Manager Provider Relations	N	171	$71,760	$93,184	$114,712	
	Manager Provider Services	O	TBD	$82,576	$107,328	$131,976	
	Manager Purchasing	N	275	$71,760	$93,184	$114,712	
	Manager QI Initiatives	N	433	$71,760	$93,184	$114,712	
	Manager Quality Analytics	O	617	$82,576	$107,328	$131,976	
	Manager Quality Improvement	O	104	$82,576	$107,328	$131,976	
	Manager Regulatory Affairs and Compliance	O	626	$82,576	$107,328	$131,976	
	Manager Reporting & Financial Compliance	O	572	$82,576	$107,328	$131,976	
	Manager Strategic Development	O	603	$82,576	$107,328	$131,976	
	Manager Strategic Operations	N	446	$71,760	$93,184	$114,712	
	Manager Systems Development	P	515	$95,264	$128,752	$162,032	
	Manager Utilization Management	O	250	$82,576	$107,328	$131,976	
	Marketing and Outreach Specialist	J	496	$40,976	$53,352	$65,624	
	Medical Assistant	H	535	$33,696	$42,224	$50,648	
	Medical Authorization Asst	H	11	$33,696	$42,224	$50,648	
	Medical Case Manager	N	72	$71,760	$93,184	$114,712	
	Medical Case Manager (LVN)	L	444	$54,288	$70,512	$86,736	
*	Medical Director	S	306	$164,736	$222,352	$280,072	
	Medical Records & Health Plan Assistant	G	548	$30,576	$38,272	$45,968	
	Medical Records Clerk	E	523	$25,272	$31,720	$37,960	
	Medical Services Case Manager	K	54	$47,112	$61,360	$75,504	
	Member Liaison Specialist	I	353	$37,128	$46,384	$55,640	
	MMS Program Coordinator	K	360	$47,112	$61,360	$75,504	
	Nurse Practitioner (PACE)	P	635	$95,264	$128,752	$162,032	
	Occupational Therapist	N	531	$71,760	$93,184	$114,712	
	Occupational Therapist Assistant	M	623	$62,400	$81,120	$99,840	
	Office Clerk	C	335	$21,008	$26,208	$31,408	
	OneCare Operations Manager	O	461	$82,576	$107,328	$131,976	
	OneCare Partner - Sales	K	230	$47,112	$61,360	$75,504	
	OneCare Partner - Sales (Lead)	K	537	$47,112	$61,360	$75,504	
	OneCare Partner - Service	I	231	$37,128	$46,384	$55,640	
	OneCare Partner (Inside Sales)	J	371	$40,976	$53,352	$65,624	
	Outreach Specialist	I	218	$37,128	$46,384	$55,640	
	Paralegal/Legal Secretary	K	376	$47,112	$61,360	$75,504	
	Payroll Specialist	J	554	$40,976	$53,352	$65,624	
	Performance Analyst	L	538	$54,288	$70,512	$86,736	
	Personal Care Attendant	E	485	$25,272	$31,720	$37,960	
	Personal Care Attendant - Lead	E	498	$25,272	$31,720	$37,960	
	Personal Care Coordinator	I	525	$37,128	$46,384	$55,640	
	Pharmacy Resident	K	379	$47,112	$61,360	$75,504	

CalOptima - Annual Base Salary Schedule - Revised September 7, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Pharmacy Services Specialist	I	23	$37,128	$46,384	$55,640	
	Pharmacy Services Specialist Int	J	35	$40,976	$53,352	$65,624	
	Pharmacy Services Specialist Sr	K	507	$47,112	$61,360	$75,504	
	Physical Therapist	N	530	$71,760	$93,184	$114,712	
	Physical Therapist Assistant	M	624	$62,400	$81,120	$99,840	
	Policy Advisor Sr	O	580	$82,576	$107,328	$131,976	
	Privacy Manager	N	536	$71,760	$93,184	$114,712	
	Privacy Officer	P	648	$95,264	$128,752	$162,032	
	Process Excellence Manager	O	529	$82,576	$107,328	$131,976	
	Program Assistant	I	24	$37,128	$46,384	$55,640	
	Program Coordinator	I	284	$37,128	$46,384	$55,640	
	Program Development Analyst Sr	M	492	$62,400	$81,120	$99,840	
	Program Manager	M	421	$62,400	$81,120	$99,840	
	Program Manager Sr	O	594	$82,576	$107,328	$131,976	
	Program Specialist	J	36	$40,976	$53,352	$65,624	
	Program Specialist Int	K	61	$47,112	$61,360	$75,504	
	Program Specialist Sr	L	508	$54,288	$70,512	$86,736	
	Program/Policy Analyst	K	56	$47,112	$61,360	$75,504	
	Program/Policy Analyst Sr	M	85	$62,400	$81,120	$99,840	
	Programmer	L	43	$54,288	$70,512	$86,736	
	Programmer Int	N	74	$71,760	$93,184	$114,712	
	Programmer Sr	O	80	$82,576	$107,328	$131,976	
	Project Manager	M	81	$62,400	$81,120	$99,840	
	Project Manager - Lead	M	467	$62,400	$81,120	$99,840	
	Project Manager Sr	O	105	$82,576	$107,328	$131,976	
	Project Specialist	K	291	$47,112	$61,360	$75,504	
	Project Specialist Sr	L	503	$54,288	$70,512	$86,736	
	Projects Analyst	K	254	$47,112	$61,360	$75,504	
	Provider Enrollment Data Coordinator	I	12	$37,128	$46,384	$55,640	
	Provider Enrollment Data Coordinator Sr	J	586	$40,976	$53,352	$65,624	
	Provider Enrollment Manager	K	190	$47,112	$61,360	$75,504	
	Provider Network Rep Sr	L	391	$54,288	$70,512	$86,736	
	Provider Network Specialist	K	44	$47,112	$61,360	$75,504	
	Provider Network Specialist Sr	L	595	$54,288	$70,512	$86,736	
	Provider Office Education Manager	L	300	$54,288	$70,512	$86,736	
	Provider Relations Rep	K	205	$47,112	$61,360	$75,504	
	Provider Relations Rep Sr	L	285	$54,288	$70,512	$86,736	
	Publications Coordinator	J	293	$40,976	$53,352	$65,624	
	QA Analyst	L	486	$54,288	$70,512	$86,736	
	QA Analyst Sr	N	380	$71,760	$93,184	$114,712	
	QI Nurse Specialist	N	82	$71,760	$93,184	$114,712	
	QI Nurse Specialist (LVN)	M	445	$62,400	$81,120	$99,840	
	Receptionist	F	140	$27,872	$34,840	$41,808	
	Recreational Therapist	L	487	$54,288	$70,512	$86,736	
	Recruiter	L	406	$54,288	$70,512	$86,736	
	Recruiter Sr	M	497	$62,400	$81,120	$99,840	
	Registered Dietitian	L	57	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Analyst	K	628	$47,112	$61,360	$75,504	
	Regulatory Affairs and Compliance Analyst Sr	L	629	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Lead	M	630	$62,400	$81,120	$99,840	
	RN (PACE)	N	480	$71,760	$93,184	$114,712	
	Security Analyst Int	N	534	$71,760	$93,184	$114,712	
	Security Analyst Sr	O	474	$82,576	$107,328	$131,976	
	Security Officer	F	311	$27,872	$34,840	$41,808	
	SharePoint Developer/Administrator Sr	O	397	$82,576	$107,328	$131,976	
	Social Worker	K	463	$47,112	$61,360	$75,504	
*	Special Counsel	R	317	$137,280	$185,328	$233,376	
*	Sr Director Regulatory Affairs and Compliance	R	TBD	$137,280	$185,328	$233,376	New Position
	Sr Manager Human Resources	P	649	$95,264	$128,752	$162,032	

CalOptima - Annual Base Salary Schedule - Revised September 7, 2017
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Sr Manager Information Services	Q	650	$114,400	$154,440	$194,480	
Sr Manager Government Affairs	O	451	$82,576	$107,328	$131,976	
Sr Manager Provider Network	O	651	$82,576	$107,328	$131,976	
Staff Attorney	P	195	$95,264	$128,752	$162,032	
Supervisor Accounting	M	434	$62,400	$81,120	$99,840	
Supervisor Audit and Oversight	N	618	$71,760	$93,184	$114,712	
Supervisor Budgeting	M	466	$62,400	$81,120	$99,840	
Supervisor Case Management	N	86	$71,760	$93,184	$114,712	
Supervisor Claims	K	219	$47,112	$61,360	$75,504	
Supervisor Coding Initiatives	M	502	$62,400	$81,120	$99,840	
Supervisor Customer Service	K	34	$47,112	$61,360	$75,504	
Supervisor Data Entry	K	192	$47,112	$61,360	$75,504	
Supervisor Day Center (PACE)	K	619	$47,112	$61,360	$75,504	
Supervisor Dietary Services (PACE)	M	643	$62,400	$81,120	$99,840	
Supervisor Disease Management	N	644	$71,760	$93,184	$114,712	
Supervisor Encounters	L	253	$54,288	$70,512	$86,736	
Supervisor Facilities	L	162	$54,288	$70,512	$86,736	
Supervisor Finance	N	419	$71,760	$93,184	$114,712	
Supervisor Grievance and Appeals	M	620	$62,400	$81,120	$99,840	
Supervisor Health Education	M	381	$62,400	$81,120	$99,840	
Supervisor Information Services	N	457	$71,760	$93,184	$114,712	
Supervisor Long Term Support Services	N	587	$71,760	$93,184	$114,712	
Supervisor MSSP	N	348	$71,760	$93,184	$114,712	
Supervisor OneCare Customer Service	K	408	$47,112	$61,360	$75,504	
Supervisor Payroll	M	517	$62,400	$81,120	$99,840	
Supervisor Pharmacist	P	610	$95,264	$128,752	$162,032	
Supervisor Provider Enrollment	K	439	$47,112	$61,360	$75,504	
Supervisor Provider Relations	M	652	$62,400	$81,120	$99,840	
Supervisor Quality Analytics	M	609	$62,400	$81,120	$99,840	
Supervisor Quality Improvement	N	600	$71,760	$93,184	$114,712	
Supervisor Regulatory Affairs and Compliance	N	627	$71,760	$93,184	$114,712	
Supervisor Social Work (PACE)	L	636	$54,288	$70,512	$86,736	
Supervisor Systems Development	O	456	$82,576	$107,328	$131,976	
Supervisor Therapy Services (PACE)	N	645	$71,760	$93,184	$114,712	
Supervisor Utilization Management	N	637	$71,760	$93,184	$114,712	
Systems Manager	N	512	$71,760	$93,184	$114,712	
Systems Network Administrator Int	M	63	$62,400	$81,120	$99,840	
Systems Network Administrator Sr	N	89	$71,760	$93,184	$114,712	
Systems Operations Analyst	J	32	$40,976	$53,352	$65,624	
Systems Operations Analyst Int	K	45	$47,112	$61,360	$75,504	
Technical Analyst Int	L	64	$54,288	$70,512	$86,736	
Technical Analyst Sr	M	75	$62,400	$81,120	$99,840	
Technical Writer	L	247	$54,288	$70,512	$86,736	
Technical Writer Sr	M	470	$62,400	$81,120	$99,840	
Therapy Aide	J	521	$40,976	$53,352	$65,624	
Training Administrator	L	621	$54,288	$70,512	$86,736	
Training Program Coordinator	K	471	$47,112	$61,360	$75,504	
Translation Specialist	G	241	$30,576	$38,272	$45,968	
Web Architect	O	366	$82,576	$107,328	$131,976	

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Text in red indicates new changes to the salary schedule proposed for Board approval.

Summary of Changes to Salary Schedule

For September 2017 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Sr. Director Regulatory Affairs and Compliance	N/A	R	This new position is responsible for ensuring CalOptima complies with all applicable state and federal regulatory, contractual and policy requirements, as well as fraud, waste and abuse standards.	N/A	September 2017

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Authorizing Expenditures for CalOptima Staff Wellness Programs from Funding Received from CIGNA HealthCare for Calendar Year 2017

Contact
Ladan Khamseh, Chief Operations Officer, (714) 246-8400

Recommended Action
Authorize expenditures for CalOptima staff wellness programs from funding received from CIGNA HealthCare (CIGNA) Wellness/Health Improvement Fund for calendar year 2017.

Background
CIGNA, one of CalOptima's health and welfare benefit carriers, provides a Wellness/Health Improvement Fund to assist in improving the health and productivity of CalOptima's employees, focusing on behavior change and health status improvement, and creating a health and wellness program strategy leading toward a culture of well-being. Each year, CIGNA informs CalOptima of the amount of funds offered for the upcoming calendar year. Proposed expenditures and the use of the funds are pre-approved by CIGNA and reimbursed following the event by submitting receipts to CIGNA. Unused funds cannot be rolled over to the next calendar year and will be forfeited.

CalOptima has an Employee Activities Committee (EAC) whose mission is to unite CalOptima employees through regularly organized events. The EAC is comprised of employees who volunteer their time and represent a broad cross-section of the organization. Through their input, potential wellness activities and programs funded by CIGNA are recommended.

Discussion
CIGNA has specific guidelines regarding the types of events the Wellness/Health Improvement Fund can be used towards. The funds may be used to reimburse CalOptima for employee health and wellness program expenses, including but not limited to gym discount sponsorships, educational workshops, and employee wellness activities. CIGNA also has specific guidelines by which proposed activities are approved and submitted for reimbursement.

For calendar year 2017, the proposed wellness activities recommended by the EAC include:

2017 Wellness Program/Event/Activity	Estimated Cost
24 Hour Fitness Corporate Sponsorship Fees (annual cost affording discounted memberships to employees as low as $25.99 per month)	$6,000.00
LA Fitness Corporate Sponsorship Fees (annual cost affording discounted memberships to employees for $29.99 per month)	$2,500.00

Back to Agenda

2017 Wellness Program/Event/Activity	Estimated Cost
Wellness program incentives for employee participation in wellness programs (Walk Across America, Biggest Loser)	$1,000.00
Wellness Fair (includes cholesterol/glucose testing, blood pressure and nutritional promotion items)	$10,000.00
Wellness Week - cooking demonstration	$1,000.00
Wellness Week - paint therapy	$750.00
Wellness Week - Yoga Classes (2)	$400.00
Wellness Week – other activities	$1,750.00
Health Education Programs and speakers	$7,000.00
Softball Tournament	$600.00
Onsite chair massages	$2,500.00
CPR training	$1,500.00
Total	**$35,000.00**

Fiscal Impact
The recommended action has no fiscal impact to CalOptima's operating budget.

Rationale for Recommendation
The CIGNA Wellness/Health Improvement Fund provides for activities related to health and wellness benefits to CalOptima employees. The proposed process allows spending of the funds towards activities consistent with staff recommendations for wellness programs, and authorizes the CEO to use the CIGNA Wellness/Health Improvement Funds for these specific programs or events.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Cigna Wellness Fund Letter 2017

/s/ Michael Schrader — *8/31/2017*
Authorized Signature — **Date**

Back to Agenda

Mae Kahle

CalOptima

505 City Parkway West

Orange, CA 92868

Dear Mae:

Wellness Funds are provided by Cigna Healthcare to assist in improving the health and productivity of your entire employee population, focus on behavior change and health status improvement, and create a health and wellness program strategy leading toward a culture of well-being.

Examples of eligible expenses

- Incentives or rewards for wellness program participation (excluding cash)
- Health promotion communication materials
- Health and Wellness activity or challenge programs
- Health education related onsite classes, workshops or speakers
- Onsite chair massage sessions or fitness classes
- Employee sponsorship in community health events

Examples of ineligible expenses

- Premium reductions, including HSA, HRA and FSA contributions or other medical/Rx plan expenses
- Outdoor parties, (injury and liability factor)
- Employee Travel (liability factor)
- Paid time off, employee holidays or discounts
- Charitable donations
- Gym equipment
- Health assessment vendors
- Food (unless related to nutrition/cooking education or demonstrations)

This letter is confirm that Cigna offered $35,000 to be used for wellness for the 2017 policy period.

Sincerely,

Rakeia Pratt

Senior Client Manager

Cc: Jacob Delong-Cigna Healthcare

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
6. Consider Authorizing Employee and Retiree Group Health Insurance for Calendar Year 2018

Contact
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions
1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into contracts and/or amendments to provide group health insurance policies, including medical, dental, vision, for CalOptima employees and retirees, and basic employee life insurance and accidental death and dismemberment, short-term and long-term disability, employee assistance program, and flexible spending accounts, for CalOptima employees, effective January 1, 2018, for a total amount for calendar year (CY) 2018 not to exceed $17,480,553;
2. Authorize an increase to employer contributions (based on the percent of premium the employer pays for each plan), to absorb a portion of the increase to premium rates, increasing costs to CalOptima for CY 2018 of an amount not to exceed $1,368,980; and
3. Authorize a Spousal Surcharge of $50 per pay period (for 24 pay periods) for those employees/retirees whose spouses or Registered Domestic Partners (1) have access to other medical plans through their own employers or other sources, but choose to be enrolled under the CalOptima plan, or (2) are enrolled in their own medical plan, and elect to also enroll under the CalOptima plan. The employees/retirees will be required to submit an attestation substantiating enrollment of their spouse/Registered Domestic Partner. The anticipated savings for CalOptima is $193,200 for CY 2018.

Background
California Government Code section 53201 provides that local public agencies including CalOptima have the option of providing health and welfare benefits for the benefit of their officers, employees, and retired employees, who elect to accept the benefits and who authorize the local agencies to deduct the premiums, dues or other charges from their compensation. Government Code section 53200 provides that health and welfare benefits may include hospital, medical, surgical, dental, disability, group life, legal expense, and income protection insurance or benefits. While CalOptima previously contracted with the California Public Employees Retirement System (CalPERS) to provide these benefits, on August 5, 2003, the Board of Directors approved the cancellation of CalOptima's contract with CalPERS for employee health insurance coverage effective January 1, 2004, and opted to contract directly with Aetna and Kaiser for plan year 2004, and CalOptima has offered such benefits from commercial insurers since that time. CalOptima has been purchasing group health insurance through Ascension, an insurance broker, since 2014 on a year-to-year basis. CalOptima currently contracts with both Kaiser and Cigna to provide group health insurance coverage for all benefited employees.

In addition, in CY 2014 CalOptima began charging a $50 per pay period (for 24 pay periods) Spousal Surcharge to those employees/retirees whose spouses or Registered Domestic Partners have access to other medical plans through their own employers or other sources, but choose to be enrolled under the CalOptima plan. In CY 2015, CalOptima added a second category to the Spousal Surcharge for those

Back to Agenda

employees/retirees whose spouses are enrolled in their own medical, and elect to also enroll under the CalOptima plan. In CY 2016 and 2017, the surcharge was suspended.

By statute, the Board may authorize payment of all, or such portion as it may elect, of premiums for these health and welfare benefits. CalOptima currently pays a portion of the premiums for health and welfare benefits for officers, employees, and eligible retired employees. In plan year 2015, there was no increase to the employee contributions because CalOptima received a rate decrease, which in effect decreased CalOptima's contributions towards the premiums. In plan year 2016, there was an increase in premium rates, wherein CalOptima shared in the costs of premium rate increases, paying a small portion and passing along the remaining increase to employees, averaging roughly 3% to 4% to employee contributions for Kaiser HMO, Cigna HMO, Cigna HDHP, Cigna PPO and Cigna Dental PPO. In plan year 2017, there was an increase in premium rates, wherein CalOptima absorbed the 2.6% or $375,794 costs of premium rate increases.

Discussion

Ascension marketed the group health benefits on behalf of CalOptima for the renewal of CalOptima's health benefit insurance policies, and the total group health benefit insurance package cost will result in an annual increase of 10.7% for CY 2018, totaling $1,683,172. The proposed increase falls within the regional average increase range of 8% to 15%. Based on the same contribution methodology from CY 2017, staff is recommending that CalOptima absorb a proportional share of the increase, and CalOptima employees would absorb a proportional share of the increase. The overall annual cost impact to CalOptima would be $1,368,980. The recommended changes are summarized below:

Benefit Plan	CY 2017	CY 2018	$ Change
Medical	$13,667,915	$15,359,558	$1,691,643
Dental	1,210,096	1,214,641	4,545
Vision	188,098	174,111	(13,987)
Basic Employee Life & AD&D	61,337	61,337	0
Short Term Disability	399,326	399,326	0
Long Term Disability	211,205	211,205	0
Employee Assistance Program	32,848	33,818	970
Flexible Spending Accounts	26,556	26,556	0
Total	**$15,797,382**	**$17,480,553**	**$1,683,172**
CalOptima's Share	**$14,323,748**	**$15,692,727**	**$1,368,980**
Employees' Share	**$1,473,634**	**$1,787,826**	**$314,192**

Please find below additional details by benefit plan for CY 2018:

Medical

Cigna: Ascension negotiated a proposed 9.9% increase. Cigna's wellness fund will be $20,000 in 2018.

Kaiser: Kaiser proposed increase of 15.0% for active employees/eligible retirees and 12.0% for Medicare Retirees.

Back to Agenda

AmWINS PPO**:** Rates for 2018 will not be available until mid to end of September. AmWINS is for PPO Supplemental Medicare-eligible retirees.

Dental
Cigna Dental: Rate pass (no proposed rate increase) to the PPO and 4.7% increase for the DHMO for Active employees and Retirees.

Vision
VSP**:** VSP proposed a rate decrease of -7.4% with a two year rate guarantee.

Other Ancillary Plans
Cigna Life & Disability: Rate pass

Employee Assistance Program: ACI proposed a 3.0% increase with a two year rate guarantee.

CalOptima's and the employee's share of the premiums differ depending on the employee's elections. As set forth in the attached presentation, employer contributions for full time employees range from 74.5% to 94.3%. The methodology used to calculate the employer and employee contributions is to attract and retain talent. CalOptima's group health benefits insurance are comparable to the County of Orange with an average of 89% employer contribution rate for CalOptima's employee only coverage, in comparison to the County's 90% employer contribution rate. However, CalOptima's employer contribution for employees with dependents is higher at an average of 85% employer contribution rate compared to the County's 75% employer contribution rate.

Recommendations to continue the same methodology in the share of premiums are made based on a thorough review by CalOptima's Human Resources Department to ensure that CalOptima remains competitive with market trends and meets its ongoing obligation to provide a comprehensive benefits package to attract and retain talent.

Spousal Surcharge
Spousal Surcharge of $50 per pay period (for 24 pay periods) will be deducted from employees whose spouses or Registered Domestic Partners (1) have access to other medical plans through their own employers or other sources, but choose to be enrolled under the CalOptima plan, or (2) are enrolled in their own medical, and elect to also enroll under the CalOptima plan. This spousal surcharge will also apply to retirees. The employees/retirees will be required to submit an attestation substantiating the enrollment of their spouse/Registered Domestic Partner. The anticipated savings for CalOptima is $193,200 for CY 2018.

Fiscal Impact
The recommended action to provide group health insurance policies for the period of January 1, 2018, through June 30, 2018 and associated anticipated expenditures within the budgeted amounts included in the CalOptima FY 2017-18 Operating Budget approved by the Board on June 1, 2017. The fiscal impact for group health insurance policies for CalOptima employees in CY 2018 is estimated at a total cost of $17,480,553. The employer cost to absorb a portion of the increased premiums totals $1,368,980 for CY 2018, or $684,490 for the remainder of Fiscal Year (FY) 2017-2018, covering the period of January 1, 2018, through June 30, 2018. Management will include funding for group health

Back to Agenda

insurance policies for the period of July 1, 2018, through December 31, 2018, in the CalOptima FY 2018-19 Operating Budget.

The fiscal impact to implement a spousal surcharge of $50 per pay period (for 24 pay periods) for certain employees/retirees with spouses or Registered Domestic Partners with other health coverage is estimated at $193,200 in savings for CY 2018.

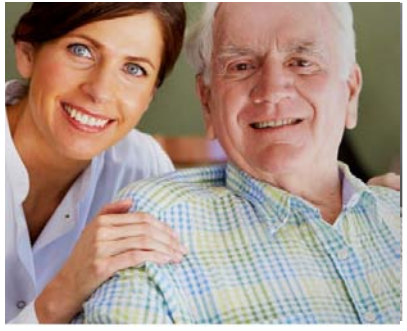
Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Presentation - January 2018 Benefits Renewal

/s/ Michael Schrader — *8/31/2017*
Authorized Signature — **Date**

Back to Agenda




CalOptima
A Public Agency
Better. Together.

January 2018 Benefits Renewal

August 11, 2017

Presented by

Keri Lopez, President, Western Region Benefits
Kasey Flanary, Senior Consultant
Carla Franco, Senior Client Manager
Eva English, Underwriter

Back to Agenda

Ascension™

Renewal Summary

Based on current enrollment, your **2018** group insurance costs would increase by 10.7% or $1,683,172. CalOptima's proposed increase falls within the regional average increase range of 8-15%.

Below is a recap of each plan's renewal action:

- Cigna Medical – Ascension negotiated a proposed 9.9% increase; **currently 36.6% participation and carriers require 50% or more along side Kaiser (last year was 44%);** Cigna's wellness fund will be $20,000 in 2018
- Kaiser HMO - proposed increase of 15.0% for Actives/Early Retirees and 12.0% for Medicare Retirees
- Cigna Dental – Ascension negotiated a proposed rate pass to the PPO and 4.7% for the DHMO for Actives and Retirees
- VSP proposed a rate decrease of -7.4% with a 2 year rate guarantee
- Cigna Life & Disability – Ascension negotiated a proposed rate pass for Life and Disability with a 2 year rate guarantee
- ACI proposed a 3.0% increase with a 2 year rate guarantee
- WageWorks FSA proposed a rate pass
- Amwins PPO rates for 2018 won't be available until September

Back to Agenda

Recommendation

Back to Agenda

Renewal Summary

		2017 Current	2018 Incumbent Renewal	$ Change	% Change
All Medical	**1071**	**$13,667,915**	**$15,359,558**	**$1,691,643**	**12.38%**
Kaiser HMO Actives	588	$6,585,301	$7,573,992	$988,691	15.01%
Kaiser HMO Early Retirees(Pre-65)	6	$110,853	$127,491	$16,638	15.01%
Kaiser HMO Medicare Retirees(Post-65)	15	$93,386	$104,626	$11,240	12.04%
Cigna HMO Actives & Early Retirees (Pre-65)	353	$5,152,440	$5,662,051	$509,611	9.89%
Cigna PPO Actives & Early Retirees (Pre-65)	47	$899,234	$988,177	$88,943	9.89%
Cigna HDHP Actives Only	40	$621,990	$683,510	$61,520	9.89%
Amwins PPO Medicare Retirees (Post-65)	22	$155,051	$155,051	$0	0.00%
HRA Administration	594	$0	$0	$0	n/a
HRA Funding ($900 single / $1,800 with deps)	594	$0	$0	$0	n/a
HSA Administration	40	$2,160	$2,160	$0	0.00%
HSA Funding ($1,250 single / $2,500 with deps)	40	$82,500	$82,500	$0	0.00%
Wellness Funding		($35,000)	($20,000)	$15,000	-42.86%
All Ancillary		**$2,129,467**	**$2,120,995**	**($8,472)**	**-0.40%**
Cigna Dental PPO Actives & Retirees	794	$1,112,867	$1,112,867	$0	0.00%
Cigna Dental HMO Actives & Retirees	295	$97,229	$101,774	$4,546	4.68%
VSP Vision Actives & Retirees	1,091	$188,098	$174,111	($13,987)	-7.44%
Cigna Basic Employee Life & AD&D	1,152	$61,337	$61,337	$0	0.00%
Cigna Short Term Disability	1,155	$399,326	$399,326	$0	0.00%
Cigna Long Term Disability	1,155	$211,205	$211,205	$0	0.00%
ACI Employee Assistance Program	1,155	$32,848	$33,818	$970	2.95%
WageWorks Flexible Spending Accounts	412	$26,556	$26,556	$0	0.00%

Back to Agenda

Renewal Summary

	2017 Current	2018 Incumbent Renewal
Premiums		
Monthly - Estimated	$1,316,448	$1,456,713
Annual - Estimated	$15,797,382	$17,480,553
Differences		
Versus Current - $		$1,683,172
Versus Current - %		10.7%
Annual Employee Contributions (same % as current)	$1,473,634	$1,787,826
NET Annual -Estimated Employer Cost	$14,323,748	$15,692,727
NET Employer Differences		
Versus Current - $		$1,368,980
Versus Current - %		9.6%

NOTES:

Cigna rates shown are the negotiated rates. The initial renewal was anticipated in the high teens.
Amwins rates for 2018 are pending.

Back to Agenda

Renewal Summary

2017 Employer vs. Employee Contributions

FULL TIME ACTIVES & EARLY RETIREES	Enrollment	2017 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Early Retirees		**Cigna HMO**				
Employee	103	$560.83	$31.83	5.7%	$529.00	94.3%
Employee + One	78	$1,177.74	$80.34	6.8%	$1,097.40	93.2%
Employee + Family	172	$1,626.40	$116.31	7.2%	$1,510.09	92.8%
MONTHLY TOTAL	353	$429,370	$29,550		$399,820	
Actives & Early Retirees		**Cigna PPO**				
Employee	22	$899.60	$170.19	18.9%	$729.41	81.1%
Employee + One	14	$1,889.13	$405.22	21.5%	$1,483.91	78.5%
Employee + Family	11	$2,608.83	$607.85	23.3%	$2,000.98	76.7%
MONTHLY TOTAL	47	$74,936	$16,104		$58,833	
Actives		**Cigna HDHP**				
Employee	14	$681.51	$92.94	13.6%	$588.57	86.4%
Employee + One	12	$1,446.60	$250.72	17.3%	$1,195.88	82.7%
Employee + Family	14	$1,780.87	$453.34	25.5%	$1,327.53	74.5%
MONTHLY TOTAL	40	$51,833	$10,657		$41,176	
Actives		**Kaiser HMO**				
Employee	222	$505.41	$31.83	6.3%	$473.58	93.7%
Employee + One	141	$1,010.82	$80.34	7.9%	$930.48	92.1%
Employee + Family	221	$1,314.07	$116.31	8.9%	$1,197.76	91.1%
MONTHLY TOTAL	584	$545,136	$44,099		$501,037	
Early Retirees		**Kaiser HMO**				
Employee	1	$757.19	$31.83	4.2%	$725.36	95.8%
Employee + One	3	$1,514.38	$80.34	5.3%	$1,434.04	94.7%
Employee + Family	2	$1,968.70	$116.31	5.9%	$1,852.39	94.1%
MONTHLY TOTAL	6	$9,238	$505		$8,732	
PART TIME ACTIVES	**Enrollment**	**2017 RATES**	**EE Contributions**	**EE Contribution % of Premium**	**CalOptima Contributions**	**CalOptima % of Premium**
		Cigna HMO				
Employee	0	$560.83	$63.67	11.4%	$497.16	88.6%
Employee + One	0	$1,177.74	$160.68	13.6%	$1,017.06	86.4%
Employee + Family	0	$1,626.40	$232.62	14.3%	$1,393.78	85.7%
MONTHLY TOTAL	0	$0	$0		$0	
		Cigna PPO				
Employee	0	$899.60	$340.37	37.8%	$559.23	62.2%
Employee + One	0	$1,889.13	$810.45	42.9%	$1,078.68	57.1%
Employee + Family	0	$2,608.83	$1,215.70	46.6%	$1,393.13	53.4%
MONTHLY TOTAL	0	$0	$0		$0	
		Cigna HDHP				
Employee	0	$681.51	$185.87	27.3%	$495.64	72.7%
Employee + One	0	$1,446.60	$501.44	34.7%	$945.16	65.3%
Employee + Family	0	$1,780.87	$906.69	50.9%	$874.18	49.1%
MONTHLY TOTAL	0	$0	$0		$0	
		Kaiser HMO				
Employee	2	$505.41	$63.67	12.6%	$441.74	87.4%
Employee + One	0	$1,010.82	$160.68	15.9%	$850.14	84.1%
Employee + Family	2	$1,314.07	$232.62	17.7%	$1,081.45	82.3%
MONTHLY TOTAL	4	$3,639	$593		$3,046	
		$13,369,818	$1,218,087		$12,151,731	

2018 Employer vs. Employee Contributions

FULL TIME ACTIVES & EARLY RETIREES	Enrollment	2018 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Early Retirees		**Cigna HMO**				
Employee	103	$616.30	$34.98	5.7%	$581.32	94.3%
Employee + One	78	$1,294.23	$88.29	6.8%	$1,205.94	93.2%
Employee + Family	172	$1,787.26	$127.81	7.2%	$1,659.45	92.8%
MONTHLY TOTAL	353	$471,838	$32,473		$439,365	
Actives & Early Retirees		**Cigna PPO**				
Employee	22	$988.58	$187.02	18.9%	$801.56	81.1%
Employee + One	14	$2,075.98	$445.30	21.5%	$1,630.68	78.5%
Employee + Family	11	$2,866.87	$667.97	23.3%	$2,198.90	76.7%
MONTHLY TOTAL	47	$82,348	$17,696		$64,652	
Actives		**Cigna HDHP**				
Employee	14	$748.92	$102.13	13.6%	$646.79	86.4%
Employee + One	12	$1,589.68	$275.52	17.3%	$1,314.16	82.7%
Employee + Family	14	$1,957.01	$498.18	25.5%	$1,458.83	74.5%
MONTHLY TOTAL	40	$56,959	$11,711		$45,249	
Actives		**Kaiser HMO**				
Employee	222	$581.29	$34.98	6.0%	$546.31	94.0%
Employee + One	141	$1,162.58	$88.29	7.6%	$1,074.29	92.4%
Employee + Family	221	$1,511.36	$127.81	8.5%	$1,383.55	91.5%
MONTHLY TOTAL	584	$626,981	$48,460		$578,520	
Early Retirees		**Kaiser HMO**				
Employee	1	$870.84	$34.98	4.0%	$835.86	96.0%
Employee + One	3	$1,741.68	$88.29	5.1%	$1,653.39	94.9%
Employee + Family	2	$2,264.19	$127.81	5.6%	$2,136.38	94.4%
MONTHLY TOTAL	6	$10,624	$555		$10,069	
PART TIME ACTIVES	**Enrollment**	**2018 RATES**	**EE Contributions**	**EE Contribution % of Premium**	**CalOptima Contributions**	**CalOptima % of Premium**
		Cigna HMO				
Employee	0	$616.30	$69.97	11.4%	$546.33	88.6%
Employee + One	0	$1,294.23	$176.57	13.6%	$1,117.66	86.4%
Employee + Family	0	$1,787.26	$255.63	14.3%	$1,531.63	85.7%
MONTHLY TOTAL	0	$0	$0		$0	
		Cigna PPO				
Employee	0	$988.58	$374.04	37.8%	$614.54	62.2%
Employee + One	0	$2,075.98	$890.61	42.9%	$1,185.37	57.1%
Employee + Family	0	$2,866.87	$1,335.95	46.6%	$1,530.92	53.4%
MONTHLY TOTAL	0	$0	$0		$0	
		Cigna HDHP				
Employee	0	$748.92	$204.25	27.3%	$544.67	72.7%
Employee + One	0	$1,589.68	$551.04	34.7%	$1,038.64	65.3%
Employee + Family	0	$1,957.01	$996.37	50.9%	$960.64	49.1%
MONTHLY TOTAL	0	$0	$0		$0	
		Kaiser HMO				
Employee	2	$581.29	$69.97	12.0%	$511.32	88.0%
Employee + One	0	$1,162.58	$176.57	15.2%	$986.01	84.8%
Employee + Family	2	$1,511.36	$255.63	16.9%	$1,255.73	83.1%
MONTHLY TOTAL	4	$4,185	$651		$3,534	
		$15,035,221	$1,338,565		$13,696,656	

Back to Agenda

Renewal Summary

2017 Employer vs. Employee Contributions

MEDICARE RETIREES	Enrollment	2017 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
		Amwins PPO				
Retiree (Medicare)	9	$369.17	$90.49	24.5%	$278.68	75.5%
Retiree + 1 (2 Medicare)	13	$738.34	$215.24	29.2%	$523.10	70.8%
MONTHLY TOTAL	22	$12,921	$3,613		$9,308	
		Kaiser HMO				
Retiree (Medicare)	7	$196.77	$12.40	6.3%	$184.37	93.7%
Retiree + 1 (1 Medicare)	4	$953.96	$75.83	7.9%	$878.13	92.1%
Retiree + 1 (2 Medicare)	3	$393.54	$31.09	7.9%	$362.45	92.1%
Retiree + Family (1 Medicare)	1	$1,408.28	$126.18	9.0%	$1,282.10	91.0%
Retiree + Family (2 Medicare)	0	$847.86	$75.77	8.9%	$772.09	91.1%
MONTHLY TOTAL	15	$7,782	$610		$7,173	

DENTAL & VISION	Enrollment	2017 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Retirees		Dental PPO				
Employee	275	$47.48	$5.20	11.0%	$42.28	89.0%
Employee + One	248	$96.74	$15.72	16.2%	$81.02	83.8%
Employee + Family	335	$166.24	$31.54	19.0%	$134.70	81.0%
MONTHLY TOTAL	858	$92,739	$15,894		$76,844	
Actives & Retirees		Dental HMO				
Employee	109	$12.00	$0.00	0.0%	$12.00	100.0%
Employee + One	66	$24.10	$0.00	0.0%	$24.10	100.0%
Employee + Family	126	$41.30	$0.00	0.0%	$41.30	100.0%
MONTHLY TOTAL	301	$8,102	$0		$8,102	
Actives & Retirees		VSP Vision				
Employee	418	$7.96	$0.00	0.0%	$7.96	100.0%
Employee + One	307	$12.37	$1.00	8.1%	$11.37	91.9%
Employee + Family	436	$19.61	$2.00	10.2%	$17.61	89.8%
MONTHLY TOTAL	1,161	$15,675	$1,179		$14,496	

ANNUAL TOTAL	$15,016,449	$1,473,634	$13,542,815
% Share of Premium		9.8%	90.2%

2018 Employer vs. Employee Contributions

MEDICARE RETIREES	Enrollment	2018 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
		Amwins PPO				
Retiree (Medicare)	9	$369.17	$90.49	24.5%	$278.68	75.5%
Retiree + 1 (2 Medicare)	13	$738.34	$215.24	29.2%	$523.10	70.8%
MONTHLY TOTAL	22	$12,921	$3,613		$9,308	
		Kaiser HMO				
Retiree (Medicare)	7	$213.45	$12.84	6.0%	$200.61	94.0%
Retiree + 1 (1 Medicare)	4	$1,084.29	$82.34	7.6%	$1,001.95	92.4%
Retiree + 1 (2 Medicare)	3	$426.90	$32.42	7.6%	$394.48	92.4%
Retiree + Family (1 Medicare)	1	$1,606.80	$135.88	8.5%	$1,470.92	91.5%
Retiree + Family (2 Medicare)	0	$851.40	$72.00	8.5%	$779.40	91.5%
MONTHLY TOTAL	15	$8,719	$652		$8,066	

DENTAL & VISION	Enrollment	2018 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Retirees		Dental PPO				
Employee	275	$47.48	$5.20	11.0%	$42.28	89.0%
Employee + One	248	$96.74	$15.72	16.2%	$81.02	83.8%
Employee + Family	335	$166.24	$31.54	19.0%	$134.70	81.0%
MONTHLY TOTAL	858	$92,739	$15,894		$76,844	
Actives & Retirees		Dental HMO				
Employee	109	$12.56	$0.00	0.0%	$12.56	100.0%
Employee + One	66	$25.23	$0.00	0.0%	$25.23	100.0%
Employee + Family	126	$43.23	$0.00	0.0%	$43.23	100.0%
MONTHLY TOTAL	301	$8,481	$0		$8,481	
Actives & Retirees		VSP Vision				
Employee	418	$7.37	$0.00	0.0%	$7.37	100.0%
Employee + One	307	$11.45	$1.00	8.7%	$10.45	91.3%
Employee + Family	436	$18.15	$2.00	11.0%	$16.15	89.0%
MONTHLY TOTAL	1,161	$14,509	$1,179		$13,330	

+Spousal Surcharge		$193,200	($193,200)
ANNUAL TOTAL	$16,683,650	$1,787,826	$14,895,824
$ Difference From Current	$1,667,201	$314,192	$1,353,010
% Share of Premium		10.7%	89.3%

Back to Agenda

Spousal Surcharge

Spousal Surcharge Analysis (based on prior history)

Spouses assessed surcharge	161
x Annual Surcharge	$1,200
Total Spousal Surcharge Savings	$193,200

Pros:

- Savings to CalOptima
- Spouses only assessed this surcharge when they have other coverage available to them (i.e. – spouse's employer, Medicare, tri-care, Medi-Cal, etc.)
- Smaller percentage of population impacted by this versus a change to contributions for all employees
- Could reduce overall claims costs if spouses do not enroll and therefore would not incur claims under CalOptima's plan; reduced claims costs positively impacts future premiums

Cons:

- Honor system for reporting
- Potential increased cost for employees who are assessed the surcharge and/or who drop spouses from coverage due to this surcharge

Back to Agenda

Open Enrollment Planning

Back to Agenda

Renewal and Open Enrollment Timeline

September/October

- **September 18th** - All decisions must be made in order to provide rates, contributions & benefits to Dayforce for system update for Open Enrollment
- **September 18th – October 30th**
  - Communications developed & distributed
  - Dayforce system updated, tested, ready for Open Enrollment
  - Required notices/documentation prepared & distributed
  - Carriers notified of decisions
- **October 30th – November 13th** – Open Enrollment

November

- Carriers update systems with new elections, produce & distribute new ID cards as needed

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
7. Consider Actions Related to Reimbursement for Newborn Coverage

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Authorize payment of capitation to Health Networks for eligible newborn members who are assigned a Client Index Number (CIN), even though CalOptima does not receive payment from the Department of Health Care Services (DHCS) for all of these members.

Background/Discussion
Beneficiaries eligible for Medi-Cal are assigned a CIN as their unique member identification number. Medi-Cal eligibility and payments for claims and capitation are processed according to the member's CIN. Historically, a newborn without his or her own CIN would be eligible for benefits and is financially covered under the mother's CIN for the birth month plus one month (up to two months total). This continues to be true; DHCS does not pay separate capitation to CalOptima for a newborn while the child is eligible for Medi-Cal coverage under the mother's CIN. Similarly, CalOptima does not make separate payments, whether fee-for-service or capitation, to contracted health networks, providers, and vendors for newborns who do not have their own CIN.

On January 13, 2017, DHCS informed CalOptima of a recent change in the state's eligibility data file feed. Per the email communication, newborns are now assigned an individual CIN, though capitation will not be paid for the birth month and the immediately following month (up to two months total) because the newborns will continue to be covered under the mother's eligibility. DHCS provides a "B1" indicator in the eligibility file to identify these newborns. However, in the eligibility system, a direct link between the individual newborn's CIN and the mother is not always possible as the newborn may be linked in the eligibility file to another eligible family member or not have links to other family members at all.

On January 17, 2017, DHCS sent a follow-up email communication confirming that this change (i.e., assigning newborns with their own CINs with "B1" indicators) was made effective January 1, 2017. DHCS has not released specific technical guidance (referred to as the 834 Companion Guide) regarding changes to the eligibility data file necessary to fully implement this change. Based on subsequent communications with DHCS, CalOptima staff received greater clarity on the minimum technical requirements, and staff has been able to track the newborn CINs with the "B1" indicators as of April 2017. CalOptima has identified that not all newborns receive their own CIN during their birth month and that many of the newborn CINs with a "B1" indicator are reported retrospectively. Any retroactive eligibility is assigned to CalOptima instead of a health network. Consequently, newborn member records now fall into one of three categories during the first two months of life:

Back to Agenda

1. Newborn eligible under own CIN with a B1 indicator; CalOptima does not receive capitation from DHCS for newborn;
2. Newborn eligible under mother's CIN and without own CIN; CalOptima does not receive capitation from DHCS for newborn; or
3. Newborn eligible under own CIN; CalOptima receives capitation from DHCS for newborn.

Identifying which category a newborn falls into is unpredictable. Because there is not always a direct linkage between newborn and mother's CIN, newborn member records cannot consistently be assigned to the mother's health network. CalOptima staff considered suppressing the CIN for a newborn with the "B1" indicator to avoid the capitation payment concerns; however DHCS requires that newborn CINs be recognized as eligible for benefits. Suppressing capitation for these newborns was also an option considered. However, because there is not always a direct link between the newborn and mother's CIN, a newborn member may be assigned to a health network different than the mother's, which could result in a health network not receiving capitation for the mother, which is to be used to cover the newborn's medical cost during up to the newborn's birth and following month.

Based on these factors, CalOptima staff recommends payment of capitation to health networks and other capitated providers for newborns with a CIN and "B1" indicator, even though CalOptima is not paid by DHCS for up to two months for the members. CalOptima is required to recognize newborn CINs as eligible for benefits and because CalOptima is unable to consistently link the newborn with the mother's eligibility, continuing capitation to providers will keep providers financially whole and mitigate potential member delays in care due to eligibility.
This will result in CalOptima paying additional expenses associated with downstream capitation during this two month period. Should DHCS begin providing an indicator to directly link the newborn and the mother's CIN or CalOptima develop a methodology to make the linkage, CalOptima staff will return to the Board with further recommendations.

Fiscal Impact
Assuming current levels of birth rates and payment levels to providers, the recommendation of paying downstream capitation to the Health Networks before CalOptima begins receiving capitation from the DHCS is projected at approximately $20,000 per month, or $240,000 annually. If the number of births is higher, the costs would also be higher. The anticipated additional capitation expense resulting from the issuance of a CIN for newborns with a B1 status was included in the Fiscal Year 2017-18 Consolidated Operating Budget under the Provider Capitation category that was approved by the Board on June 1, 2017.

Rationale for Recommendation
CalOptima staff considered other options to address the "B1" indicator issue; however, options to align the newborn's eligibility with the mother's assigned health network are not currently completely achievable due to lack of a consistent system links between the newborn and the mother. Continuation of existing processes to pay capitation for newborns with a CIN has minimal operational and financial impact.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Policy FF.2004: Financial Responsibility for Newborn Coverage

/s/ Michael Schrader — *8/31/2017*
Authorized Signature — **Date**

Back to Agenda

Policy #: FF.2004
Title: **Financial Responsibility for Newborn Coverage**
Department: Claims Administration
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 10/27/95
Last Review Date: 11/01/16
Last Revised Date: 11/01/16

I. PURPOSE

This policy clarifies the financial responsibility for coverage of a newborn, if the newborn does not have eligibility through his or her own Client Index Number (CIN).

II. POLICY

A. If a mother is a Health Network Member and the newborn does not have eligibility through his or her own CIN, the Health Network shall remain financially responsible for Covered Services for the newborn until the newborn receives a CIN from the Social Services Agency (SSA) or through the month following the month of birth (Month Two), whichever is earlier.

B. Capitation Payments made to a Health Network for Covered Services to the mother represent payment in full for Covered Services for the newborn.

C. If a mother is a CalOptima Direct Member during the month of birth (Month One) and Month Two, and the newborn does not have eligibility through his or her own CIN, CalOptima Direct shall remain financially responsible for Covered Services for the newborn until the newborn receives a CIN from SSA, or through Month Two, on a fee-for-service basis, using the mother's CIN.

D. If a newborn does not have a CIN after Month Two, CalOptima, or a Health Network, shall not be responsible to provide Covered Services for the newborn.

E. CalOptima shall enroll the newborn in a Health Network upon receipt of a CIN from the Social Services Agency, in accordance with CalOptima Policies AA.1207a: CalOptima Auto Assignment Policy and DD.2008: Health Network Selection.

III. PROCEDURE

A. If the newborn does not have a CIN, a Provider, or Practitioner, shall bill for newborn Covered Services under the mother's CIN until the newborn receives a CIN from the SSA, or for a maximum period of Month One and Month Two.

B. After Month Two, a Provider, or Practitioner, shall not bill for newborn Covered Services under the mother's CIN.

IV. ATTACHMENTS

Not Applicable

Back to Agenda

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1207a: CalOptima Auto Assignment Policy
E. CalOptima Policy DD.2008: Health Network Selection

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/27/1995	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	11/01/1997	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	05/01/2007	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	11/01/2016	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal

IX. GLOSSARY

Term	Definition
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Client Index Number (CIN)	For the purposes of this policy, refers to the unique 9-digit number assigned to eligible Members enrolled in the Medi-Cal program.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Newborn Child	Means a child under the age of one (1) who was born to a Member during her membership or the month prior to her membership.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendment of Existing Contract with Verscend Technologies to Include Scope of Services Related to Review of Institutional and Professional Claims for All Lines of Business Covering the Period January 1, 2017 through February 28, 2018

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Len Rosignoli, Chief Information Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend the existing Verscend Technologies contract to include a new scope of work for review of institutional and professional claims for the period January 1, 2017 through February 28, 2018; and
2. Approve unbudgeted expenditures of up to $788,500 from existing reserves for the Verscend Technologies contract amendment.

Background

CalOptima currently processes (adjudicates) approximately 223,000 claims per month related to all lines of business for CalOptima Community Network, Health Network shared risk, and other services that are the financial responsibility of CalOptima. During adjudication, claims are processed through a series of system validation edits prior to payment. The validation edits are currently conducted directly in CalOptima's core business system, Facets, or through the Optum Claims Edit System (CES) – an integrated solution.

Beginning in 2008, CalOptima contracted with Verscend Technologies (formerly Verisk) for a variety of claims review services, including (a) claims editing; (b) catastrophic forensic claims review; (c) identification of potential fraud, waste, or abuse (FWA) cases. CalOptima continues to contract with Verscend for items (b) and (c) above; however, claims editing services under (a) were migrated to the Optum CES product in December of 2016. This was addressed in the attached COBAR, "Authorize Extension of Contract with Healthcare Insight, a Division of Verisk Health, Inc." during the August 4, 2016 Board meeting. The claims editing scope of work under the Verscend Technologies terminated December 31, 2016.

In 2015, CalOptima staff conducted a Request for Proposal (RFP) process for the purposes of developing more comprehensive claims editing capabilities and incorporating pre-payment claims edits into its core business system, Facets. As a result of the RFP process, the Optum CES product was selected and implemented effective December 27, 2016. The initial term of the Optum contract is from February 19, 2016 through February 18, 2019.

Back to Agenda

Discussion

CalOptima has encountered significant challenges with implementation of the Optum CES product over the last eight months, including the sophistication and implementation of Medi-Cal program claims edits. CalOptima staff has reviewed sample claims during this period which suggest that edits have not been properly implemented or are missing, which results in erroneous claims adjudication and/or the need to re-adjudicate previously paid claims. Staff has determined that it needs to engage a third-party vendor with expertise in secondary claims editing in order to identify the potentially problematic or missing edits and, once identified, to allow for timely and efficient remediation and identification of any prior overpayments or underpayments in order to make timely claims adjustments.

In light of the need to expedite this process, staff believes the most cost-effective and expedient option is to re-engage Verscend Technologies to act as the temporary secondary claims editor. This is particularly efficient as Verscend continues to receive CalOptima claims on a daily basis to perform the other current services. The intent would be to re-engage Verscend for a limited time period to review claims from January 1,2017 through February 28, 2018. During that period, Verscend would also recommend implementation of appropriate edits and identify claims that need to be re-processed.

The cost of this engagement is estimated to be a fixed fee of $128,500 for review of previously paid claims through September 11, 2017. As proposed, Verscend would receive 22% of savings realized for claims reviewed between September 11, 2017 and February 28, 2018. During this period, CalOptima staff plans to continue to evaluate the efficiency of the Optum CES product and the most appropriate long-term claims editing solution for CalOptima, and return to the Board with a recommendation in the next several months.

Fiscal Impact

The recommended action to amend the Verscend Technologies Contract to include secondary claims editing services is an unbudgeted item. As proposed, an allocation of up to $788,500 from existing reserves will be used to fund this action. This amount includes $128,500 for services during the period of January 1, 2017 through September 11, 2017, and $660,000 for the period thereafter through February 28, 2018.

Rationale for Recommendation

The above action is recommended to maintain appropriate levels of validation review prior to final claims adjudication and payment, to identify, adjust and recover any incorrect payments previously made and to identify and correct claims edit variances.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments

Board Action dated August 4, 2016, Authorize Extension of Contract with Healthcare Insight, a Division of Verisk Health, Inc.

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
34. Authorize Extension of Contract with Healthcare Insight, a Division of Verisk Health, Inc.

Contact
Ladan Khamseh, Chief Operating Officer, (714)246-8400
Silver Ho, Executive Director, Compliance, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to negotiate an amendment to extend the existing Amended and Restated Contract (Contract) with Verisk Health, Inc. (Verisk) through December 31, 2017.

Background
CalOptima currently contracts with Verisk to provide three separate and distinct functions: 1) pre-payment claims clinical edits; 2) forensic claims review; and 3) identification of potential fraud, waste, and abuse (FWA) cases. CalOptima initially contracted with Verisk on October 1, 2008, following a competitive bidding process, to provide professional claims review and FWA reporting services. CalOptima amended the contract, effective September 1, 2010, to include catastrophic claim pre-payment forensic review services and to clarify several other contractual requirements, which amendments were ratified and approved by the Board on July 7, 2011. At that time, the contract was also extended to December 31, 2014 with two, one year extension options. CalOptima has subsequently exercised both of the extension options such that the contract now expires on December 31, 2016.

A summary of the Verisk contracted services is as follows:

1. Pre-Payment Claims Edits: During the pre-payment claims review, Verisk applies the National Correct Coding Initiative (NCCI) standards for Medicare and Medi-Cal outpatient claims as well as other pre-payment clinical claims edits to identify irregular claims billing practices. These edits are conducted in addition to the edits currently embedded in CalOptima's core operating system, Facets. The largest volume of data is processed during the pre-payment claims review.

2. Catastrophic Forensic Claims Review: Verisk provides clinical forensic review of large dollar claims with total billed charges in excess of $100,000 or $50,000 in reimbursement payments per claim. The reviews generally focus on claims that include services paid based on a charge reimbursement methodology. During the clinical forensic review process, charges will not be allowed if determined to be coded/billed inappropriately. The clean portion of the claim is paid and disallowed charges are pended if additional medical justification is required to support the disallowed charges. Verisk conducts a medical record review to verify accuracy of billed charges. The disallowed charges are denied if additional information is not received within the required time limits. CalOptima has final determination on whether to deny charges based on Verisk recommendation. Verisk is reimbursed for the forensic reviews based on a percent of savings realized by CalOptima.

Back to Agenda

3. Identification of Potential FWA Cases: Medicare Advantage and Medicaid managed care regulations require that the plan sponsor or managed care organization performs effective monitoring in order to prevent and detect FWA. Verisk analyzes historical and current claims data to identify potential FWA cases. Potential FWA cases are referred to CalOptima's Special Investigations Unit (SIU) for further consideration.

CalOptima contracted with a new pre-payment claims edit vendor, Optum, which was selected through a Request for Proposal (RFP) process. When fully implemented in November 2016, the Optum process will include new clinical editing protocols integrated into Facets; this will eliminate the need for outside vendor review, leading to a more robust and timely clinical edit processing of claims in-house.

Due to the complexity, cost consideration and specialized skill set required for the forensic review of high dollar claims as well as FWA reporting, staff plans to conduct separate RFP processes to consider vendors for these two services currently performed by Verisk.

Discussion

During the past year, CalOptima staff has made efforts to improve efficiencies in identifying inappropriate coding/claims billing practices and potential FWA cases. As such, an RFP was issued for the purposes of developing more comprehensive editing capabilities and incorporating pre-payment claims edits into the core business system, Facets, rather than sending data to an external vendor for review. Implementation efforts with its new vendor, Optum, began in early 2016 with an expected go-live in November 2016. Additionally, dedicated staff with technical experience (clinical as well as hospital coding) will be resourced to oversee this function.

While CalOptima has contracted with Optum to begin pre-payment claim editing in-house as the first step, CalOptima will continue to rely on Verisk for two of its claims review functions—forensic claims review and FWA reporting services—until an RFP process is completed and contract(s) are entered into with appropriate vendor(s). Staff is currently in the process of issuing RFPs for these services.

During the past year, savings of over $2.8 million, after payment of contingency fees, have been realized by CalOptima under this contract based on the forensic review of claims. To ensure best practices and effective management of these functions, staff has evaluated how these services can be best provided. To date, CalOptima has implemented strategies intended to reduce the number of disputes related to high dollar claims while meeting applicable requirements to ensure the appropriate payments, as well as identify and report potential fraud, waste and abuse trending.

CalOptima staff seeks authority to extend the current Verisk contract as it relates to forensic claims review and FWA reporting services through December 31, 2017. Extension of the contract through this period will provide sufficient time for CalOptima staff to conduct the RFPs, complete the contracting process and, as applicable, implement these services with qualified vendors.

Fiscal Impact

Funding for this recommended action is included in the CalOptima FY 2016-17 Operating Budget approved by the Board on June 2, 2016. Management will budget expenses related to the proposed contract extension in the CalOptima FY 2017-18 Operating Budget accordingly.

Back to Agenda

Rationale for Recommendation
Staff recommends that the Board authorize an extension and amendment of the Verisk contract through December 2017 to allow sufficient time to complete competitive bidding processes for forensic claims review and FWA reporting services.

Concurrence
Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer

Attachment
July 7, 2011 CalOptima Board Action Agenda Referral, VI. B., Authorize the Chief Executive Officer (CEO) to Execute a Contract with One or More Vendors for Credit Balance Recovery Services; Ratify and Authorize the Chief Executive Officer to Amend an Existing Vendor Claims Contract with HealthCare Insight to Add Catastrophic Claims Post-Payment Review

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken July 7, 2011
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. B. Authorize the Chief Executive Officer (CEO) to Execute a Contract with One or More Vendors for Credit Balance Recovery Services; Ratify and Authorize the Chief Executive Officer to Amend an Existing Vendor Claims Contract with HealthCare Insight to Add Catastrophic Claims Post-Payment Review

Contact

Ruth Watson, Executive Director - Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into a three-year contingency-based contract with two separate one-year extension options, with one or more vendors, for the provision of Credit Balance Recovery (CBR) Services; and,

2. Ratify amendment to HealthCare Insight contract for prepayment recovery services to add catastrophic claims post-payment review, and authorize the Chief Executive Officer, with the assistance of legal counsel, to further amend the contract regarding those services.

Background

CalOptima currently processes approximately 1.5 million claims per year for CalOptima Direct and OneCare members, with payments associated with these claims exceeding $660 million dollars annually. Since 2008, as part of CalOptima's program integrity strategy, staff has sought and received Board approval to contract with several vendors to ensure claim payment accuracy. These include the following:

- In 2008, the Board authorized staff to enter into a contract with a vendor to provide coordination of benefits (COB) identification and overpayment recovery services for claims when it is determined that CalOptima is not the primary payer. Under this authority, staff contracted with Health Management Services, which has identified and recovered more than $5 million on behalf of CalOptima using a data mining process.

- In 2008, the Board also authorized staff to contract with a vendor for claims pre-payment code review, fraud, waste, and abuse prevention services. Based on this authority, staff contracted with HealthCare Insight (HCI). CalOptima has recognized pre-payment savings in excess of $3.5 million since the inception of the HCI contract.

Back to Agenda

- In 2010, staff received approval to enter into a contract with Socrates to pursue third party liability (TPL) subrogation recovery services for the OneCare and Healthy Families lines of business.

Discussion

Program integrity activities are key to ensuring that public funds are appropriately spent. As indicated, CalOptima has successfully implemented a variety of cost containment initiatives in support of that goal. Medi-Cal's size and diversity make it vulnerable to improper payments that can result from fraud, waste, abuse, or clerical errors. CalOptima staff continues to look for additional program integrity activities that can prevent, detect, and recover improper payments, and has identified two additional programs designed to prevent and/or recover claim overpayments as a result of fraud, waste, abuse or clerical errors.

1) Credit Balance Recovery. Credit balances are improper or excess payments made to a provider. Such payments can occur on patient accounts when the reimbursement received by the provider exceeds the appropriate or expected reimbursement for services rendered, for example, as a result of multiple reimbursements from different payers (by both CalOptima and the primary payer), adjustments to previously-paid claims, computer-generated billing errors, or mis-postings to accounts (e.g., where no refund is due to the patient or payer). Some of the amounts may be considered "overpayments" due to the Medicaid program. When such "credit balances" occur, they appear in the provider's records as a credit on the patient account that is carried forward month to month in the provider's books. Under Federal law, providers are obligated to disclose and refund known overpayments. In addition, having such credit balances on their books distorts the liabilities in a provider's patient accounting system. Providers work with CBR vendors to identify and address credit balances that are the result of billing and/or payment errors made by both hospitals and payers. Credit Balance Recovery Services involve a financial review of the provider's patient accounts; it is not a hospital bill audit. The vendor works collaboratively with the provider's staff to reconcile accounts to resolve the outstanding credit balance and refund the overpayment to the appropriate payor. Implementing CBR services can translate into a $1-$5 per member per year in overpayment recovery opportunity.

   Earlier this year, CalOptima staff issued a Request for Proposal (RFP) soliciting vendors that had a well-established presence in the Credit Balance Recovery arena in Orange County. Staff is currently evaluating RFP responses to identify the vendor or vendors whose service offerings best meet CalOptima's needs. Specific criteria to be included in the vendor contract include an agreed upon approval process to ensure that CalOptima will make the final determination regarding all overpayment recovery activities in compliance with CalOptima's policies and procedures, as well as all applicable regulatory requirements.

As proposed, vendors for CBR services are paid a percentage of the recovery on a contingency basis after CalOptima recovers credit balances it is owed. While the provider has an independent obligation to reimburse CalOptima for such amounts involving its members, contracting with a CBR vendor is expected to result in greater recoveries.

2) Catastrophic Claim Post-Payment Review. In unique situations such as when services needed by a CalOptima member are not available at a contracted facility, CalOptima staff negotiates with non-contracted facilities. With non-contracted providers, reimbursement for each admission is typically negotiated separately and a Letter of Agreement (LOA) is signed by the facility and CalOptima. The Assist Group (TAG), a strategic partner of HCI, provides pre-payment and post-payment review of large dollar claims to ensure billed services are supported by corresponding medical records. TAG performs a pre-screen review and makes a recommendation on whether a detailed forensic review is warranted. Non-contested charges would be paid at the agreed upon LOA rate, while any contested charges would be reviewed against medical records to determine whether the charges are substantiated. The provider has the right to appeal this determination by submitting additional information to TAG as part of CalOptima's standard Provider Dispute Resolution (PDR) process for first level appeals. If a provider is not satisfied with the outcome of this first level review, it would have the ability to submit a second level appeal through CalOptima's standard processes to CalOptima's Grievance and Appeals Services (GARS) department. Additional payment would be made to the facility if the forensic review, PDR process or GARS process determines that some portion of the contested charges are supported.

As indicated above, CalOptima entered into a contract with HCI for pre-payment claims review in 2008. This contract was amended twice in 2010, first to reflect a change in vendor ownership status, and second to extend the agreement through September 2013 and to incorporate a number of changes to the scope of work, including the addition of post payment forensic review services. Ratification of these changes is now being sought, along with authority to further amend the HCI agreement consistent with regulatory requirements, and to clarify issues including PDR review responsibilities, settling authority, and criteria for vendor reimbursement.

Fiscal Impact

1. CBR Services - As proposed, the contract with the selected vendor will be structured with a negotiated contingency payment scale related to a percentage of savings. It is anticipated that net recovery over the proposed three-year term of the agreement may be as much as $1million.

Back to Agenda

2. Catastrophic Claim Post-Payment Review - The HCI contract contains a contingency payment scale related to a percentage of savings. The estimated annual savings/ recoupments from post payment review services could potentially reach $1 million.

Rationale for Recommendation

By contracting with a Credit Balance Recovery vendor, CalOptima will have the ability to identify and recover overpayments due to other insurance coverage, misapplied payments and contractual issues that remain un-reimbursed on a provider's accounts receivables.

Ratifying and further amending the HCI contract for Catastrophic Claim Post-Payment Review better ensures that CalOptima will reimburse facilities for only those charges that are substantiated through a detailed review of large dollar hospital bills.

Successful implementation of these services will enable CalOptima to better meet its obligations to insure program integrity and identify potential instances of fraud, waste and abuse.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Richard Chambers — **Authorized Signature**

7/5/11 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to OneCare Connect Enrollment and Deemed Eligibility; Consider Amendments to Related Contracts and Policies

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400

Recommended Actions

1. Ratify a two-month deeming period effective September 1, 2017 for OneCare Connect (OCC) members who no longer meet Cal MediConnect (CMC) eligibility requirements due to loss of Medi-Cal eligibility with CalOptima as determined by the Department of Health Care Services (DHCS);
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend CalOptima's contract with Liberty Dental to allow two-month deemed eligibility for OCC members receiving Denti-Cal services provided by Liberty Dental; and
3. Direct the CEO to amend OneCare Connect Policy CMC.4004, Member Disenrollment to implement said deeming period and operational updates.

Background

On June 15, 2015, DHCS, in conjunction with the Centers for Medicare & Medicaid Services (CMS), issued guidance encouraging Cal MediConnect (CMC) plans to offer an optional one or two-month period of deemed continued eligibility due to loss of Medi-Cal eligibility. For members who lose OCC eligibility due to loss of Medi-Cal eligibility, health plans including CalOptima were given the option of offering a one or two-month period of deemed continued eligibility. Based on this optional guidance, on August 6, 2015, the CalOptima Board of Directors authorized a one-month deeming period for OCC members. The one-month deeming period was implemented on November 1, 2015. Based on the addition of this one-month deeming period, the CalOptima Board authorized an amendment to the Liberty Dental contract on December 3, 2015, to continue to provide dental services during the one-month deeming period.

In April 2016, DHCS announced it was exploring the possibility of extending deeming for CMC as part of a larger discussion related to CMC program sustainability. Staff is not aware of DHCS making any further mention of extending deeming during 2016. During a CEO meeting in January 2017 and an all managed care plan call in February 2017, DHCS announced the requirement to extend deeming to two-months effective January 2017. Plans, including CalOptima, asked for written guidance on several occasions. Further, CalOptima staff communicated to the DHCS/CMS Contract Management Team that deeming for OCC was originally presented by CalOptima as an optional election of none, one, or two-months. Staff additionally advised the DHCS/CMS Contract Management Team that, as a result of the August 2015 CalOptima Board action approving one-month deeming, any change would require CalOptima Board approval. On May 18, 2017, DHCS issued updated written guidance

Back to Agenda

requiring CMC plans to offer two-months of deemed eligibility effective October 2016. This requirement communicated to plans as a directive from DHCS.

Discussion

Members enrolled in OCC must have both Medicare (Parts A and B) and Medi-Cal. Since November 1, 2015, CalOptima provided one-month deeming eligibility to OCC members who lose their Medi-Cal eligibility. The deeming period applies to OCC members who no longer qualify for OCC due to loss of Medi-Cal eligibility or change of circumstance impacting Medi-Cal eligibility. For example, a Member may lose Medi-Cal eligibility as a result of late submission of annual Medi-Cal redetermination documentation, delays in redetermination processing, a report of having an out of county residence, or other health coverage information. In some instances, the situation is quickly remediated either by submission of required redetermination documentation or correcting erroneous records, and Medi-Cal eligibility is reinstated. Without a deeming period, these members who regain eligibility, along with the majority who do not regain eligibility during the deeming period, would be disenrolled from OCC and cannot be automatically enrolled back to the plan. Instead, these members would have to voluntarily re-enroll with OCC to continue coverage.

The DHCS identifies and notifies CalOptima of those members eligible for deemed eligibility. Once OCC members are identified by the DHCS as eligible for deeming, CalOptima sends regulatory notices to affected members informing them of their deemed eligible status. CalOptima Customer Service Representatives also conduct telephonic outreach to members to provide additional information regarding deeming status and make referrals to available community resources. OCC members requiring additional assistance are referred to DHCS or the OCC Ombudsman, Legal Aid Society of Orange County. The Legal Aid Society of Orange County, with the member's permission, will provide assistance to help the member regain Medi-Cal eligibility.

In addition to monitoring deeming status of OCC members who regain eligibility after one month, CalOptima staff also monitors members who would have regained eligibility after two-months and reports this information to the OCC Member Advisory Committee. Approximately 2,900 members were identified by the DHCS as eligible for deeming from November 2015 to May 2017. These members would have had the potential to regain eligibility by July 1, 2017, if two-month deeming was in place. Approximately 900 of these members, or 32%, regained eligibility with OCC during the one-month deeming period. Roughly 2,000, or 68%, of the members did not. Based on historical information, 93 of the remaining 2,000 members would have regained eligibility in the second month. This would have resulted in an overall 35% of members reinstating during the two-month deeming period. CalOptima would have covered the remaining 65% for an additional month without receiving reimbursement from the State. In other words, staff estimates that extending the deeming period for an additional month increases the number of members who regain eligibility by 3%.

On May 18, 2017, DHCS issued updated written guidance requiring CMC plans to offer two-months of deeming effective October 2016. It is anticipated that more members will regain Medi-Cal eligibility if the deeming period is extended to two months. Subsequently, DHCS reiterated that two-month deeming is a regulatory requirement and must be implemented immediately. As a result, CalOptima implemented two-month deeming effective September 1, 2017. During the extended two-

month deeming period, CalOptima will continue providing all OCC benefits to deemed-eligible Members, including dental services through Liberty Dental, as required. CalOptima will continue to receive member premium payments for Medicare; however, Medi-Cal capitation payments will be suspended during this time. Medi-Cal capitation payments from DHCS will be retroactively paid for the deeming months if the Member regains Medi-Cal eligibility during the deeming period. However, if the Member does not regain Medi-Cal eligibility during the deeming period, as is expected to be the case for roughly two-thirds of those deemed eligible, then DHCS is expected to process the OCC disenrollment, and CalOptima is not reimbursed for any Medi-Cal expenses incurred on behalf of the Member during the two-month deeming period.

All regulatory notice requirements to Members will be followed for this process. OCC policy CMC.4004: Member Disenrollment will be modified to include DHCS required revisions related to member deeming and other operational requirements. Consistent with existing policy, CalOptima will, on an ad hoc basis, with member request, retroactively reinstate members in deeming for June through August 2017, who would have remained enrolled in the plan had two-month deeming been in place at the time of their OCC disenrollment. Additionally, CalOptima staff will amend, with the assistance of Legal Counsel, the Liberty Dental contract to extend the Denti-Cal benefit during the second deeming month. Based on follow-up discussions with DHCS during August 2017, staff does not anticipate any adverse regulatory action based on the proposed effective date.

Fiscal Impact

The recommended action to authorize a two-month deeming period for OCC members who no longer meet CMC eligibility requirements due to loss of Medi-Cal eligibility with CalOptima, as determined by DHCS, has been incorporated into the medical expense in the FY 2017-18 Consolidated Operating Budget, approved by the Board on June 1, 2017. The projected total annual cost for two months of deeming (month one and month two) is approximately $2,000,000. The projected cost for the additional second month of deeming from September 1, 2017, through June 30, 2018, including any retroactive reinstatements for June through August 2017, is approximately $800,000 based on historical deeming experience and associated cure rates forecasted forward. Management will include updated medical expenses in future operating budgets.

Rationale for Recommendation

In order to comply with the DHCS requirements for OCC enrollment and to minimize disruption of services to Members while their eligibility status is being updated, CalOptima staff proposes the actions as noted above.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments

1. Board Action dated December 3, 2015, Authorize Contract Amendments with Liberty Dental for a Supplemental Dental Benefit for OneCare; Extend the Supplemental Dental Benefit for OneCare Connect; and Authorize Deemed Eligibility for Members Receiving Denti-Cal
    a. Attachment - Board Action dated August 6, 2015, Authorize Actions Related to OneCare Connect Enrollment
2. Coordinated Care Initiative (CCI) Deeming Process for Cal MediConnect Plan Guidance
3. OneCare Connect Policy CMC.4004, Member Disenrollment (redline and clean copies)

/s/ Michael Schrader — *8/31/2017*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 3, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Authorize Contract Amendments with Liberty Dental for a Supplemental Dental Benefit for OneCare; Extend the Supplemental Dental Benefit for OneCare Connect; and Authorize Deemed Eligibility for Members Receiving Denti-Cal

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into contract amendments with Liberty Dental for supplemental dental benefits for:
    a. OneCare from January 1, 2016 through December 31, 2016, with two additional one year extension options, each exercisable at CalOptima's sole discretion
    b. OneCare Connect from January 1, 2016 through December 31, 2017; and
2. Authorize one month of deemed eligibility for OneCare Connect members receiving Denti-Cal services provided by Liberty Dental.

Background/ Discussion

In actions taken on April 2, 2015, the CalOptima Board of Directors authorized a supplemental dental benefit for the OneCare Connect program as well as funding and contracting with Liberty Dental. Voluntary enrollment into OneCare Connect has increased based on the additional supplemental dental benefits being offered by CalOptima in the program. The supplemental dental benefit provides services not covered by the Denti-Cal benefit. Staff believes the supplemental dental benefit has increased member retention in the program.

In order to keep the benefits similar to OneCare Connect, OneCare added the same supplemental dental benefit to the 2016 Centers for Medicare &Medicaid Services (CMS) approved OneCare bid.

At its August 6, 2015 meeting, the CalOptima Board of Directors authorized a one month deeming period for OneCare Connect Members who no longer met Cal MediConnect eligibility requirements due to loss of Medi-Cal eligibility with CalOptima. This benefit was added to mitigate breaks in coverage and maintain continuity of care for members. Management proposes a similar one month deeming period for Denti-Cal benefits for OneCare Connect members. Should a member fail to regain eligibility for the Medi-Cal program during the one month period of deemed eligibility, CalOptima would be financially responsible for the cost of the month of deemed eligibility. Based on the proposed action, eligibility for the one month of deemed dental benefits through Liberty Dental would be available through December 31, 2017 for OneCare Connect members.

Fiscal Impact

Based on the forecasted OneCare enrollment for Fiscal Year (FY) 2015-16, the fiscal impact of the recommended action to issue a contract amendment for the supplemental dental benefit for the OneCare Program from January 1, 2016, through June 30, 2016, is approximately $55,000. Costs associated with the recommended action were incorporated into Calendar Year 2016 OneCare capitation rate. Funding

Back to Agenda

for the recommended action for the period July 1, 2016 through December 31, 2016, will be included in the FY 2016-17 CalOptima Consolidated Operating Budget.

Based on the forecasted OneCare Connect enrollment for FY 2015-16, the fiscal impact of the recommended action to issue a contract amendment for supplemental dental benefit for the OneCare Connect Program from January 1, 2016 through June 30, 2016, is approximately $445,000. This is a budgeted item under the CalOptima FY 2015-16 Operating Budget approved by the Board on June 4, 2015. Funding for the recommended action for the period July 1, 2016 through December 31, 2017, will be budgeted in subsequent operating budgets.

Projected expenses related to the provision of the deeming benefit are approximately $3,500 per month.

Rationale for Recommendation

CalOptima staff recommends supplemental dental services to OneCare Connect members to strengthen the programs ability to minimize pre-enrollment opt out, maximize post enrollment retention and strong provider participation in the program. OneCare members will continue to have the same CMS approved supplemental benefit as OneCare Connect members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Previous Board actions referenced in this Report Item:

- August 6, 2015, Agenda Item VIII. J., Authorize Actions Related to OneCare Connect Enrollment
- April 2, 2015, Agenda Item VIII. B., Authorize Modifications to Member Assignment Process for the OneCare Connect Program; Authorize Supplemental Dental Benefit for the OneCare Connect Program, as well as Funding and Contracting with a Vendor as Necessary to Implement

/s/ Michael Schrader *11/25/2015*

Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. B. Authorize Modifications to Member Assignment Process for the OneCare Connect Program; Authorize Supplemental Dental Benefit for the OneCare Connect Program, as well as Funding and Contracting with a Vendor as Necessary to Implement

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize modifications to the Board approved OneCare Connect (Cal MediConnect) Program member enrollment process to allow for enrollment by Long Term Care (LTC) Facility, subject to approval by the Department of Health Care Services (DHCS); and
2. Authorize the Chief Executive Officer (CEO) to contract with dental benefits administrator to provide a supplemental benefit to the Medi-Cal dental benefit subject to approval by the DHCS and the Centers for Medicare & Medicaid Services (CMS), and upon the successful negotiation of contract terms with Liberty Dental from July 1, 2015 to December 31, 2015.

Background

In actions taken on January 3, 2013, February 7, 2013 and December 5, 2013, the Board authorized the CEO to develop a provider delivery system for implementation of the Duals Demonstration, a program for beneficiaries eligible for Medi-Cal and Medicare or "Duals", also known as Cal MediConnect Program and branded by CalOptima as OneCare Connect.

On December 5, 2013 the Board approved the Member enrollment process in order to ensure a seamless passive enrollment of OneCare Connect members who will be allowed the opportunity to make a voluntary choice to disenroll (opt-out). The enrollment process, previously approved, is based on the DHCS requirements to passively enroll eligible members on their birthday month. Approximately 3,900 members in Orange County are expected to be eligible for passive enrollment monthly.

The Cal MediConnect program launched state wide on April 1, 2014 and has been implemented in six counties. Passive enrollment start dates have been staggered throughout the state and the opt-out rates have varied by county with an overall statewide average of 49%. Concerned about the high opt-out rate, CalOptima staff has developed strategies to mitigate opt-out. The member strategies include increasing member outreach efforts and outreach to our community stakeholders informed as they are considered our member's "trusted advisors". Provider strategies, as approved by your Board, include increased provider participation through the implementation of the Community Network and increasing primary care and specialist reimbursement from 80% to 100% of Medicare fee-for-service. Based on the experience of the other Cal MediConnect plans, staff proposes two additional strategies related to the member enrollment process and dental services.

Back to Agenda

Discussion

As CalOptima prepares to launch the Cal MediConnect or OneCare Connect program, CalOptima staff has explored strategies intended to reduce the pre-enrollment opt-out and strengthening retention of members who are passively enrolled in the program. The strategies CalOptima staff considered are both from the member and provider perspective so as to ensure that both stakeholder groups are motivated to remain in OneCare Connect.

Long Term Care Facility Based Enrollment. From the member impact perspective, CalOptima is proposing to modify the previously approved passive enrollment strategy for individuals who are residing in Long-Term Care (LTC) Facilities. Among the approximately 80,000 Dual eligible individuals in Orange County, approximately 3,500 reside in 56 LTC facilities. These 3,500 individuals are among the most vulnerable members, have complex health care needs, and would greatly benefit from increased integration and coordination of care, which will be available with OneCare Connect. For this reason, CalOptima staff is proposing that it would be a better approach to passively enroll these Duals by LTC facility rather than by birth month based on DHCS approval and on a mutually agreed upon schedule with DHCS. This would allow CalOptima to communicate one-on-one with members and their families regarding care options available to them through OneCare Connect. CalOptima staff would also be able to personally educate providers and coordinate member care. Providing the opportunity to work closely with the LTC facilities, to educate and answer questions and provide the additional care coordination component will help improve the OneCare Connect retention rate.

Dental Benefit. Another proposal to improve the retention rate is by providing supplemental dental services not covered by Medi-Cal to CalOptima OneCare Connect members. While OneCare Connect members are eligible for Denti-Cal, in certain situations, access remains an issue. Management believes that improving access to dental services facilitates a positive member experience, thereby motivating members to stay in OneCare Connect. The CalOptima OneCare program previously offered a supplemental dental benefit that was very popular in attracting Duals to enroll in OneCare. Based on member input, CalOptima staff views the availability of dental services as a key component of a successful OneCare Connect program. Subject to approval by both DHCS and the Centers for Medicare & Medicaid Services (CMS), CalOptima management proposes to utilize funding from the DHCS for the Medi-Cal component of the Cal MediConnect capitation payment to implement this option.

If approved, staff recommends contracting with Liberty Dental Plan to administer and coordinate the proposed supplemental dental benefits for OneCare Connect members on a per member per month (PMPM) payment basis. Liberty Dental has been the dental benefit administrator that administered the OneCare benefit on behalf of CalOptima. Management believes that Liberty Dental Plan is the only potential subcontractor qualified to provide the appropriate supplement to the Medi-Cal benefit. Liberty Dental Plan will ensure timely access to a comprehensive, contracted network of primary and specialty Denti-Cal providers. Unlike in Denti-Cal where certain members may face delays or difficulty in accessing care, the proposed benefit would allow OneCare Connect members to have an

Back to Agenda

assigned primary care dentist through which to obtain dental services to guarantee a straightforward and seamless path to dental coverage. Through this arrangement, CalOptima intends to:

- Increase CMC members' awareness of the dental benefit through education and outreach;
- Improve utilization of preventive dental services;
- Improve coordination between dental and physical health care providers;
- Provide limited supplemental benefits not covered under Denti-Cal; and
- Improve access to dental providers.

Both the LTC member enrollment and dental strategies require Board and regulator approval. Staff will return to the Board for additional authority, as necessary, to implement these and potentially other retention strategies.

Fiscal Impact

The recommended action to execute a contract with Liberty Dental Plan to provide supplemental dental benefits will have a total fiscal impact between $1.7 million and $2.0 million at capitation rates from $7.00 per member per month (PMPM) to $8.00 PMPM for Fiscal Year 2015-16. Under this capitated arrangement, Liberty Dental Plan will assume full risk for dental services, and will coordinate dental benefits with Denti-Cal. As such, the capitation payment will cover supplemental dental benefits only, including enhanced access to their dental network, with no additional payments made to Liberty Dental Plan. Denti-Cal will remain the primary payor and provider of dental services to OneCare Connect members.

Rationale for Recommendation

CalOptima staff recommends these actions to strengthen the OneCare Connect program's ability to minimize pre enrollment opt-out, maximize post enrollment retention and strong provider participation in the OneCare Connect program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *3/27/2015*

Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. J. Authorize Actions Related to OneCare Connect Enrollment

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions
1. Authorize implementation of transition plan of OneCare members to OneCare Connect effective January 1, 2016;
2. Authorize a one-month deeming period effective no sooner than September 1, 2015 for OneCare Connect members who no longer meet Cal MediConnect eligibility requirements due to loss of Medi-Cal eligibility with CalOptima;
3. Authorize enhancement of the delivery model for OneCare Connect members who reside in a long-term care facility that is exclusive to CalOptima Direct, subject to approval by the Department of Health Care Services and the Centers for Medicare & Medicaid Services; and
4. Authorize updates to policies as necessary for implementation.

Background
On December 5, 2013, the CalOptima Board of Directors authorized execution of the Three-Way Agreement between the California Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS) and CalOptima for implementation of Cal MediConnect (CMC), branded CalOptima OneCare Connect Plan (Medicare-Medicaid Plan) (OCC) in Orange County. OCC is a managed care plan that combines Medicare and Medi-Cal, including long-term services and supports (such as In-Home Supportive Services, Multipurpose Senior Services Program, Community-Based Adult Services, and long-term care). Both the DHCS and CMS have continued to issue guidance regarding the implementation of CMC. Two topics of recent regulatory discussion include the enrollment of Medicare Dual-Eligible Special Needs Plans (D-SNPs) and a period of deemed continued eligibility for CMC. Additionally, CalOptima is involved in ongoing communications with CMS and DHCS regarding initiatives specific to members residing in long-term care facilities.

Enrollment into D-SNPs
DHCS issued guidance through an All Plan Letter *(APL) 14-014: Enrollment Requirements for Dual-Eligible Special Needs Plan in Alameda and Orange Counties,* which delineates D-SNP enrollment criteria once CMC is implemented in a county. Specific to CalOptima, the APL states that if a D-SNP is also a CMC plan, the following will apply: "No earlier than January 1, 2016, DHCS will crosswalk all Duals who are eligible for CMC into the corresponding CMC plan once CMC is implemented in Orange County. These Duals will not be permitted to re-enroll in the CMC D-SNP; and the CMC D-SNP may serve any existing or new beneficiaries who are not eligible for CMC (Excluded Beneficiaries) only."

Back to Agenda

Based on this guidance, CalOptima is required to transition its OCC-eligible OneCare Members into OCC effective January 1, 2016. OneCare can no longer enroll Members eligible for CMC. However, OneCare can continue to enroll dual eligible Members not eligible for CMC into the OneCare plan. These include, for example, Members under 21 years of age, Members receiving services through Regional Center or Members participating in Section 1115(c) waiver programs, such as Assisted Living, In Home Operations, and Nursing Facility/Acute Hospital Waivers. During this transition to OCC, Members are subject to the same noticing requirements as apply to Members being passively enrolled into OCC, and CalOptima staff is in the process of obtain approval of modifications to the existing notice templates so that they can be used in conjunction with this transition.

Deeming Process for CMC

Current OCC policy provides that Members, who lose Medi-Cal eligibility, as determined by the State, are disenrolled from the plan. DHCS, in compliance with CMS policy, issued guidance on June 15, 2015 encouraging plans such as CalOptima to offer an optional one or two-month period of deemed continued eligibility in the Medicare-Medi-Cal Plan (MMP) due to loss of Medi-Cal eligibility. For OCC members who lose eligibility with the plan due to 1) loss of Medi-Cal eligibility or 2) change of circumstance impacting eligibility (such as a change in Medi-Cal eligibility aid code or a move out of the service area), DHCS will allow plans to choose to provide a one or two month period of deemed continued eligibility. Deeming guidance became effective July 1, 2015.

Long-Term Care

CalOptima has been responsible for the Medi-Cal long-term care benefit since January 1996. The Medi-Cal long-term care benefit includes room and board for Members who are no longer able to live safely at home or in the community, require round-the-clock custodial care prescribed by a physician, and meet DHCS level of care requirements. These members receive medical, social, and personal care services in a nursing facility. Only care in sub-acute, skilled nursing facilities and intermediate care facilities apply; assisted living and board and care facilities are not eligible.

Traditionally, for Dual eligible members, physician and hospital services are provided through the Medicare fee-for-service program, a Medicare Advantage Plan, or a Special-Needs Plan. CalOptima has managed and paid for long-term care services for these members directly and has not delegated this responsibility. Through OCC, Dual eligible members can now receive all of their services through one coordinated plan.

Since 2009, CalOptima Medi-Cal members in long-term care have received physician, hospital, and long-term care services through the CalOptima Direct network, which includes the CalOptima Community Network. OCC now affords CalOptima the opportunity to provide the full scope of services covered under both Medicare and Medi-Cal through the CalOptima Community Network.

Discussion

Enrollment into D-SNPs

As indicated, effective January 1, 2016, CalOptima is required to transition eligible OneCare Members into OCC. CalOptima intends to make the transition as seamless as possible for Members

and ensure that disruption is kept to a minimum. For this reason, staff intends to assign the Member to the same OneCare primary care provider (PCP) and health network, unless otherwise requested by Member. If the PCP participates in a different OCC health network at the time of transition, the Member will be assigned to the same PCP and the PCP's new health network. This is in alignment with the DHCS March 27, 2015 Dual Plan Letter (DPL) 15-003 requirements for continuity of care which states "if the MMP contracts with delegated entities, the MMP must assign the beneficiary to a delegated entity that has the beneficiary's preferred PCP in its network."

If the member's OneCare PCP does not participate in the same OCC health network but does participate in two or more OCC health networks or none, the Member will be assigned according to the OCC auto-assignment policy initially approved during the December 2013 Board meeting and amended in May 2015, unless otherwise requested by Member.

CalOptima will modify its OCC policies related to primary care selection, network assignment, and member notification to the extent necessary to reflect the above.

Deeming Process for CMC

DHCS issued guidance allowing CMC plans to offer up to two months of deeming eligibility due to loss of Medi-Cal eligibility. The deeming period would apply to OCC members who no longer qualify for OCC due to loss of Medi-Cal eligibility or change of circumstance impacting Medi-Cal eligibility. Plans already participating in CMC have reported that many members who have been involuntarily disenrolled from CMC due to loss of Medi-Cal eligibility regain their Medi-Cal eligibility within one to two months after disenrollment.

For example, a Member may lose Medi-Cal eligibility as a result of late submission of annual Medi-Cal redetermination documentation, delays in redetermination processing, a report of having an out of county residence, or other health coverage information. In many instances, the situation is quickly remediated either by submission of required redetermination documentation or correcting erroneous records, and Medi-Cal eligibility is reinstated. Without a deeming period, these members will be disenrolled from OCC and cannot be automatically enrolled back to the plan. Instead, these members would have to voluntarily re-enroll with OCC to continue coverage.

In order to mitigate breaks in coverage and maintain continuity of care for members, staff proposes to allow a one-month deeming period for OCC Members. A one month deeming period is recommended at this time to limit CalOptima's financial exposure. Based on the proposed action, during the deeming period, CalOptima would continue providing OCC benefits to the Member. CalOptima will continue to receive member premium payments from Medicare; however, Medi-Cal capitation payments will be suspended during this time. Medi-Cal capitation payments from DHCS will be retroactively paid for the deeming month if the member regains Medi-Cal eligibility. However, if the Member does not regain Medi-Cal eligibility during the deeming period, the member would be disenrolled from OCC at the end of the deeming period month, and CalOptima would not be reimbursed for Medi-Cal expenses incurred on behalf of this member during the one-month period.

All regulatory notice requirements to Members will be followed for this process. While DHCS permits plans to implement deeming effective July 1, 2015, due to the time required for regulatory

approval of member materials, CalOptima staff proposes to implement the one month deeming process no earlier than September 1, 2015. As proposed, deeming will continue through the duration of the CMC, currently authorized by the DHCS and CMS through December 31, 2017.

CalOptima will modify its OCC policies related to member enrollment and disenrollment, to the extent necessary to implement the above.

Long-Term Care

On April 2, 2015, the CalOptima Board of Directors authorized staff to modify the OCC enrollment process to allow for enrollment by long-term care facility. Regulatory approval was received in July 2015 and the enrollment of members by facility will begin in November 2015. In order to enhance the care for OCC members residing in a long-term care facility, staff proposes to implement a delivery model specific for these members. By enhancing the delivery model, staff expects to:

- Improve coordination of Medicare and Medi-Cal services, consistent with the goals of Cal MediConnect
- Improve member, family and facility satisfaction
- Promote member enrollment in OCC
- Utilize emergency department (ED) and inpatient resources appropriately with subsequent reduction in ED visits, hospital admissions, days and readmissions rates
- Adhere to regulatory requirements for OCC
- Improve communication and discuss expectations with member, facility, providers, and family
- Measure and report benefits of integrated care

A key component of this delivery model is to contract with providers who provide services in skilled nursing and long-term care facilities. These providers are referred to as skilled nursing facility (SNF) physicians. Because these members permanently reside in the facility, it is important for the members' care to be rendered by physicians who go directly to the facility to provide services on a regular and frequent basis in order to identify and treat acute or deteriorating conditions. These physicians will also be available around-the-clock to provide urgent care services at the facility in order to avoid unnecessary emergency department admissions. As such, new contracts requiring the SNF physician to provide around-the-clock care and minimum thresholds of visits in addition to traditional primary care services will be developed. These contracts will be offered exclusively through CalOptima Direct to individual providers and physician groups and may be based on fee-for-service or capitated with a risk sharing agreement.

The other key component of enhancing the deliver model is to designate the managed CalOptima Community Network, a part of CalOptima Direct, as the assigned network for OCC members residing in a long-term care facility, similar to CalOptima's current policy for Medi-Cal members. The CalOptima Community Network is designed to provide physician, hospital, and long-term care services to all Medi-Cal members residing in a long-term care facility. For Dual eligible members, while physician and hospital services are provided through the Medicare fee-for-service program, a Medicare Advantage Plan, or a Special-Needs Plan, CalOptima has always managed and paid for long-term care services for these members directly. Assigning OCC members to CalOptima

Community Network, therefore, promotes continuity with their CalOptima Medi-Cal network. Additionally, this allows a single entity to be responsible for the members entire covered services.

Subject to approval by both the DHCS and CMS, CalOptima will modify and/or develop OCC policies related to health network selection, primary care selection, auto-assignment, and services provided to a member residing in a long-term care facility to the extent necessary to reflect the above.

Fiscal Impact
The recommended actions are budget neutral. Transition of OneCare members into OneCare Connect, expenses due to deeming, and direct costs related to the reimbursement to long-term care facilities are accounted for in the FY16 budget.

Rationale for Recommendation
In order to comply with the DHCS guidelines for OCC enrollment and to maintain maximum membership and minimize disruption of member's health care services, CalOptima staff proposes to implement the above recommended actions.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/31/2015*
Authorized Signature — **Date**

Back to Agenda

Title	**Cal MediConnect (CMC) Deeming Process for California**
Purpose	The purpose of this document is to describe the approach to implementing the deeming process in California.
Date	**04/14/15.** First release to Plans. **05/12/15.** Updated based on plan comments/questions submitted on 4/20. **06/09/15**. Updated based on plan questions from version sent on 5/12/15. **08/17/15:** Updated to align with new deeming Health Care Plan (HCP) status codes effective 9/1/15. **5/12/2017:** Updated to align with deeming period of two months for all HCP's
Exhibits*	**Exhibit 22** – Deemed Continued Eligibility due to Loss of Medicaid Eligibility (for use with HCP Status = 41 **– no change to exhibit**). **Exhibit 30a** – Deemed Continued Eligibility Due to Member no Longer Eligible for Cal MediConnect (for use with HCP Status = 61 **– no change to exhibit**). **Appendix 5** – CA-Specific Enrollment/Disenrollment Guidance *CMS released Exhibits 22 and 30a via HPMS on 6/10/15. Updates to Appendix 5 will be published separately by CMS and posted to the CMS website.

Deeming Policy Effective 10/1/2016: For individuals that lose CMC eligibility due to: 1) loss of Medi-Cal eligibility, or 2) a change in circumstance impacting CMC eligibility (such as a change in Medi-Cal eligibility aid code or move out of the service area), the CMC plan will provide a two- month period of deemed continued eligibility. CMC plans must comply with requirements specified in Section 40.2.3.2 of the Medi-Care Medi-Caid Plan (MMP) Enrollment and Disenrollment Guidance and Appendix 5 – California specific requirements as updated by the Department of Health Care Services (DHCS). Updates to AEVS messaging effective 9/1/15:

- ➔ **HCP Status '41'** – New AEVS message: "Subscriber limited to services covered by health plan:_____"
- ➔ **HCP status '61' –** Current AEVS message used for active HCP Status code. Includes plan name and Medi-Cal eligibility information.

I Operational Requirements

A. Start Deeming Period for Beneficiary

1. For plans in the two-month deeming period, plans will be informed of the start of the deeming period through a new HCP Status Code specific on the month-end 834 enrollment file.

   DHCS maintains an internal system table that identifies the deeming period for each plan. The elected deeming period will remain in effect throughout the Demonstration. Any changes to the deeming period should be requested through the Contract Management Team Operational (CMTO).

The deeming period starts on the first day of the month following the month the CMC plan is notified of a change identified by the HCP Status code from an active enrollment to a Hold status (HCP Status = 41 or 61) through the month-end 834 enrollment file. The HCP Status Code is located in Loop 2300 REF HD04 in the 834 enrollment file.

Hold HCP Status Code Descriptions:

HCP Status = '41' – HCP Hold Due to Loss of Medi-Cal Eligibility.
HCP Status = '61' – HCP Hold due to Loss of State-Specific Eligibility for Cal MediConnect.

Plans must send the appropriate notice (Exhibit 22 or 30a) to beneficiary within 10 calendar days of learning of the change in the HCP Status code in the month-end 834 enrollment file:

- Exhibit 22 – use for HCP status = '41'
- Exhibit 30a – use for HCP status = '61'

Example of key activities/dates when beneficiary goes into a deeming period:

a. Plan receives January month-end 834 enrollment file No Later Than (NLT) 1/28/17. HCP status = '41' or '61'.
b. Deeming period starts 2/1/17.
c. Plan mails Exhibit 22 or Exhibit 30a to beneficiary NLT 2/8/17 (10 calendar days after receipt of month-end 834 enrollment file).
d. Two month deeming period ends 3/31/17.

Note: Changes to the member's HCP status are reported in the month-end 834 enrollment file according to the DHCS published schedule maintained on the DHCS Website under APL 14-018:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-018.pdf.

2. DHCS will not send a disenrollment transaction to IFOX/CMS or MEDs for beneficiaries in the deeming period.
3. Medicare capitation payments will continue during the deeming period. Medi-Cal capitation payments will be suspended during the deeming period.

B. CMC Eligibility is not Reinstated

1. If the member does not regain CMC eligibility during the deeming period, the member will be disenrolled from the CMC effective the last day of the deeming period.
2. DHCS will send the CMC disenrollment transaction to IFOX/CMS and update MEDS no later than three business days following the last day of the deeming period.
3. For the non-County Organized Health System (COHS) plans, DHCS will send the disenrollment letter to the beneficiary (Exhibit 21) no later than three business days no later than three business days following the end of the deeming period. The COHS plans will send Exhibit 21 to beneficiaries within the same required timeframe.

Example of key dates when beneficiary is not reinstated prior to the end of the deeming period:

1. **Beneficiary has two-month deeming: 2/1/17 through 3/31/17.**
   a. March month-end 834 enrollment file (available NLT 3/28/17) shows beneficiary HCP status = '41' or '61' (no change)
   b. DHCS sends IFOX/CMS disenrollment transaction NLT 3/31/17.
   c. DHCS sends disenrollment letter (Exhibit 21) NLT 4/5/17.
   d. Plan receives disenrollment DTRR NLT 4/6/17.
   e. Member is defaulted into CMC affiliated Medi-Cal Managed Care plan with HCP status '05' or '59'.
   f. CMS will enroll member in Original Medicare and a Medicare drug plan. Beneficiaries can access LI NET for Part D prescriptions during any coverage gap.

C. CMC Eligibility is Reinstated

1. If the member regains CMC eligibility prior to the end of the deeming period, the member's HCP status will change to '51' (Enrollment activated from HCP hold- Supplemental capitation paid at the end of the month).

2. Medi-Cal capitation payments will be retroactively paid for the full two months of the deeming period.

II Beneficiary Communications and Noticing

1. As required in the CMC Enrollment / Disenrollment guidance, the CMC must send Exhibit 22 or Exhibit 30a to the beneficiary within 10 calendar days of learning of the loss of CMC eligibility (through the HCP Status code 41 or 61) on the month-end 834 enrollment file.

   - Exhibit 22 is sent for HCP status = 41
   - Exhibit 30a is sent for HCP status = 61

2. In addition to sending Exhibit 22 or Exhibit 30a, plans may contact the beneficiary directly to inform them about their change in status and encourage them to contact their county eligibility worker. Plans may warm transfer calls to the county offices as well.
3. Communication to beneficiaries from counties regarding their Medi-Cal eligibility will not change as a result of this process.

~~Policy #: CMC.4004~~
~~Title: **Member Disenrollment**~~
~~Department: Customer Service~~
~~Section: Not Applicable~~

~~CEO Approval: Michael Schrader~~

~~Effective Date: 07/01/15~~
~~Last Review Date: 07/01/16~~
~~Last Revised Date: 07/01/16~~

Policy #: CMC.4004
Title: **Member Disenrollment**
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CEO Approval: Michael Schrader

Effective Date: 07/01/15
Last Review Date: 09/07/17
Last Revised Date: 09/07/17

I. PURPOSE

This policy describes procedures for disenrolling a Member from the OneCare Connect program.

II. POLICY

A. Except as provided in this policy, OneCare Connect may not request or encourage any Member to disenroll from OneCare Connect.

1. CalOptima may not request disenrollment due to adverse changes in a Member's health status, a Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs.

B. A Member may voluntarily disenroll from OneCare Connect in any month and for any reason, in accordance with this policy.

C. CalOptima shall involuntarily disenroll a Member from OneCare Connect if:

1. The Member's change in residence ~~(including incarceration)~~ makes the Member ineligible to participate in OneCare Connect;

2. The Member loses entitlement to either Medicare Part A or Part B;

3. The Member loses entitlement to services under Medi-Cal or Medi-Cal eligibility changes (e.g., to a non-eligible aid code or adding Share of Cost (SOC) when not residing in a LTC facility or receiving In-Home Support Services (IHSS) or Multi Senior Services Program (MSSP);

4. The Member loses a state-specific eligibility qualification for OneCare Connect;

5. The Member is incarcerated;

6. The Member is not lawfully present in the United States;

~~6.~~7. The Member dies;

~~7.~~8. The Contract is terminated or CalOptima reduces its Service Area ~~to exclude~~such that the Member~~;~~ is no longer within the Service Area;

~~8.~~9. The individual materially misrepresents information to OneCare Connect regarding reimbursement for third party coverage; or

~~9.~~10. The individual has comprehensive health insurance other than Medicare or Medi-Cal.

D. ~~OneCare Connect~~CalOptima may request approval from the State and CMS ~~-~~to involuntarily disenroll a Member from ~~CalOptima~~ OneCare Connect, if the Member:

1. Engages in disruptive behavior; or

2. Provides fraudulent information on the Enrollment Form ~~or permits Abuse of the Member's OneCare Connect identification (ID) card.~~; or

3. Permits Abuse of the Member's OneCare Connect identification (ID) card.

E. CalOptima shall retain all OneCare Connect disenrollment ~~requests~~request for ~~the current Contract~~a period ~~and~~of ten (10) ~~prior periods.~~ years from the end of the contract period in which the request was made.

III. PROCEDURE

A. Voluntary Disenrollment

1. A Member may request to disenroll from OneCare Connect by:

a. Enrolling in another Medicare health or Part D plan, including a PACE organization;

b. Enrolling in another Medicare Medicaid Plan (MMP);

c. Calling 1-800-MEDICARE (1-800-633-4227); or

d. Giving or faxing a signed written disenrollment notice to ~~OneCare Connect~~CalOptima, or to the State.

2. If a Member verbally requests disenrollment from OneCare Connect, the CalOptima staff member receiving such request must instruct the Member to make the request in one (1) of the ways described above.

3. If a Member is unable to sign the written request to disenroll from OneCare Connect, an Authorized Representative shall sign the request. If an Authorized Representative signs the disenrollment request, the Authorized Representative shall attest that they have such authority to make the request and that proof of the authority is available upon request by CalOptima or CMS. If CalOptima has reason to believe that an individual making an Election on behalf of a Member may not be authorized under State law to do so, CalOptima shall contact CMS, in accordance with the Medicare Managed Care Manual.

4. The Member, or Authorized Representative, shall write the date they signed the disenrollment request on the disenrollment request. If the Member or Authorized Representative fails to include the date on the disenrollment request, OneCare Connect's mailroom shall stamp the date of receipt of the disenrollment request, and such date shall serve as the signature date.

5. If the Member, or Authorized Representative, fails to include a signature on the disenrollment request, CalOptima may verbally verify with the Member or Authorized Representative the request to disenroll. CalOptima shall document the verbal verification to complete the disenrollment request and shall retain such documentation in its records.

6. If CalOptima requests additional information to be submitted for the disenrollment request, CalOptima shall explain to the Member or Authorized Representative that the additional information must be received by the end of the calendar month in which the request to disenroll was received, or within twenty-one (21) calendar days after receipt of the disenrollment request for a disenrollment request to be considered complete (whichever is later). If CalOptima does not receive additional information within the allowable timeframe, CalOptima shall not disenroll the Member.

7. Notice Requirements

   a. If a Member requests disenrollment through CalOptima, CalOptima shall mail the Member *Exhibit 14, Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request ~~form~~ from Member* within ten (10) calendar days after receipt of the disenrollment request. The acknowledgement of disenrollment letter shall include an explanation of the effective date of the disenrollment. The notice shall also inform the disenrolling Member that it may take up to forty-five (45) calendar days for the Medicare computer records to be updated, and advise the Member ~~ask any providers to hold their Original Medicare~~to inform his or ~~Medi-Cal claims for up to one (1) month so that Medicare~~her provider the Member was just disenrolled from OneCare Connect and ~~Medi-Cal computer records can~~there may be ~~updated to show that the person is no longer enrolled in~~a short delay with updating the ~~plan so that claims are processed for payment and not denied.~~ Member's records.

   b. If a Member requests disenrollment through an entity other than CalOptima, as specified in this policy, CMS will notify CalOptima in the Daily Transaction Reply Report (DTRR). If CalOptima learns of the voluntary disenrollment from the DTRR (as opposed to a written request from the Member), CalOptima shall input the disenrollment in the OneCare Connect eligibility system and mail *Exhibit 16, Model Notice to Confirm Voluntary Disenrollment Following Receipt of Transaction Reply Report (TRR)* to the Member within ten (10) calendar days after the availability of the information on the DTRR from CMS.

8. Processing Request for Disenrollment

   a. The CalOptima mailroom shall stamp the date of receipt of a disenrollment request received from a Member, or Member's Authorized Representative, upon receipt of that request.

   b. CalOptima shall submit a disenrollment transaction to CMS within seven (7) calendar days after the date of receipt of a disenrollment request.

   ~~c. Members eligible for passive enrollment who Opt-Out shall be processed, in accordance with CalOptima Policy CMC.4006: Passive Enrollment, as follows:~~

~~i. For Members making a verbal request to Opt-Out, OneCare Connect shall ask the Member if they want to Opt-Out of future Passive Enrollments and document the Member's response.~~

~~ii. If the Member indicates they want to Opt-Out of future Passive Enrollments, CalOptima OneCare Connect shall submit the disenrollment transaction code, TC 51, to CMS showing an MMO Opt-Out Flag data element as "Y" = Opted out of Passive Enrollment in position 202.~~

~~iii. Such individual may enroll in a MMP in the future by submitting a voluntary enrollment request.~~

9. If a Member requests voluntary disenrollment from OneCare Connect, such disenrollment shall be effective on the first (1st) calendar day of the month after the month CalOptima receives a completed disenrollment request, unless otherwise stated in writing for a future date.

10. CalOptima may deny a voluntary request for disenrollment only when:

    a. The request was made by someone other than the Member, and that individual is not the Member's Authorized Representative, as described in this policy; or

    b. The request was incomplete, and the required information is not provided within the required ~~timeframe~~time frame.

11. If CalOptima receives a disenrollment request that OneCare Connect is required to deny, CalOptima shall mail *Exhibit 17, Model Notice for Denial of Disenrollment* to the Member within ten (10) calendar days after the receipt of the request and shall include the reason for the denial.

B. Involuntary Disenrollment

1. If CalOptima involuntarily disenrolls a Member for causes specified in this policy, CalOptima shall provide the Member with a disenrollment letter ~~prior to submitting the disenrollment transaction to CMS that:~~that:

    a. Advises the Member that CalOptima plans to disenroll the Member, and the reason for such disenrollment; and

    b. Explains the Member's right to file a Grievance, in accordance with CalOptima Policy CMC.9002: Member Grievance Process, except if the Contract is terminating as specified in this policy.

C. Involuntary Disenrollment for Change in Residence

1. CalOptima shall initiate disenrollment when a Member's permanent residence is confirmed outside of the Service Area or when a Member's ~~temporary~~ absence from the OneCare Connect Service Area exceeds ~~one (1) month~~six (6) consecutive months.

2. ~~OneCare Connect~~CalOptima may receive notice of a change in a Member's residence from DHCS, the Member, the Member's Authorized Representative, a DTRR from CMS, or other source.

a. DHCS ~~shall~~ will notify CalOptima of a potential move out of area with an HCP status code ~~59/~~61 in the monthly 834 eligibility file:

i. Within ten (10) calendar days of receiving HCP status code ~~59/~~61 CalOptima shall mail *Exhibit 30a,~~ Model Notice for Deemed Continued Eligibility due to Change in Medicaid Eligibility or Potential Move Out-of-Area* to the Member.

ii. A period of ~~one (1) calendar month~~two (2) months of deemed continued eligibility begins the first day of the calendar month following the month CalOptima receives the code ~~59/~~61.

iii. CalOptima shall make a minimum of three (3) telephonic attempts during the deemed continued eligibility period to inform the member of his/her eligibility status and provide the necessary resources so the member can attempt to regain eligibility.

~~iii.~~ If the month-end 834 enrollment file received by CalOptima at the end of the period of deemed continued eligibility shows no change in the Member's HCP Status code ~~59/61, CalOptima shall disenroll the Member effective at the end of the period of deemed continued eligibility.~~

~~iv. No later than three (3) business days following the last day of the deeming period~~61, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status.~~ no later than three (3) business days following the last day of the deeming period.~~.~~

iv. ~~.~~

v. Within three (3) business days following the ~~disenrollment effective date, CalOptima shall~~end of the period of deemed continued eligibility, DHCS will submit a disenrollment transaction to CMS, effective the ~~last~~first (1st) day of the calendar month from the end of the period of deemed continued eligibility.

vi. This section does not apply if CalOptima has confirmed the out-of-area move and will process the disenrollment as otherwise set forth in this policy.

b. If CalOptima is notified of a potential out-of-area change in residence through a source other than DHCS, the Member, or the Member's Authorized Representative, ~~OneCare Connect~~CalOptima shall not assume the move is permanent and shall not disenroll the Member until the Member, or Member's Authorized Representative, confirms the out-of-area move, or until six (6) consecutive months have elapsed following the date CalOptima OneCare Connect receives information regarding the Member's potential address change ~~or,~~ whichever is sooner.

i. ~~OneCare Connect~~CalOptima shall, within ten (10) calendar days of receipt of such notice, send the Member *Exhibit 30, a Notice to Research Potential Out of Area Status and Address Verification Form* to verify the change in address and whether it is temporary, or permanent.

ii. The Member shall have six (6) calendar months following the date of the notice to respond.

iii. If, at the end of the sixth (6th) calendar month, there is no response to Exhibit 30, and CalOptima has not received an HCP Status Code ~~59/~~61 from DHCS, ~~OneCare Connect~~CalOptima shall document this information in its records and forward the request to disenroll ~~the Member at the end of six (6) calendar months following the date Exhibit 30 was mailed.~~ to DHCS..

iv. Within the first ten (10) calendar days of the sixth (6th) calendar month following discovery of a potential out-of-area residence, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice of Disenrollment due to Loss of Medicaid Status or Other State-Specific Eligibility Status, or Out-of-Area Status.*

v. Within three (3) business days following the disenrollment effective date, ~~CalOptima shall~~DHCS will submit a disenrollment transaction to CMS, effective the ~~last~~first (1st) day of the calendar month following the end ~~-~~of the sixth (6th) month.

c. CalOptima shall accept verbal, or written, confirmation from the Member, or Member's Authorized Representative, of an address change.

i. If the confirmation indicates the permanent address is outside of the Service Area. CalOptima shall document this information in its records and ~~disenroll the Member effective the last day of the calendar month in which confirmation was received.~~forward the request to disenroll to DHCS. CalOptima shall mail *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* within ten (10) calendar days of the date the out-of-area address was confirmed.

d. ~~CalOptima shall~~DHCS will submit a disenrollment transaction to CMS, effective the ~~last~~first (1st) day of the calendar month ~~in which~~following the date ~~-~~CalOptima received the confirmation.

i. If the confirmation indicates the permanent address is within the OneCare Connect Service Area, CalOptima shall discontinue the disenrollment process.

~~e.~~ If an enrolling Member shows an address within the plan Service Area on the enrollment application, while the CMS or Medi-Cal records show an address outside of the plan Service Area, the Member's enrollment application serves as attestation of their current address.

~~f.~~e. ~~Following such enrollment, CalOptima should receive a Transaction Reply Report (TRR) from CMS listing the Member with Transaction Reply Code (TRC) 016 – Enrollment Accepted, Out of Area accompanied with a TRC 011 – Enrollment Accepted as Submitted. CalOptima shall not initiate the involuntary disenrollment process or attempt to contact the Member to verify their address, in these cases.~~

f. If CalOptima learns of a permanent change in address directly from the Member or Member's Authorized Representative, and that address is outside of the OneCare Connect Service Area, ~~OneCare Connect~~CalOptima shall document this information in its records and forward the request to disenroll ~~the Member and~~to DHCS.

g. CalOptima shall mail *Exhibit 20, Model Notice for Disenrollment Due to Confirmation of Out-of-Area Status (Upon New Address Verification from Member)* to the Member within ten (10) calendar days of receiving the information. ~~Generally, such~~

~~g.~~h. DHCS will submit a disenrollment ~~shall be~~transaction to CMS, effective the first (1st) day of the calendar month after the date the Member begins residing outside of OneCare Connect's Service Area and after the Member, or their Authorized Representative, notifies CalOptima that they have moved and no longer resides in the Service Area.

~~h.~~i. In the case of an individual who provides advance notice of the move, the disenrollment will be effective the first (1st) day of the calendar month following the month in which the individual indicates they will be moving.

~~i.~~j. In the case of incarcerated individuals, where CalOptima receives notification of the out-of-area status via a DTRR, ~~CalOptima shall~~DHCS will disenroll the Member on the first (1st) day of the calendar month following confirmation of current incarceration.

~~j.~~k. A Member who is incarcerated is considered out of the plan's Service Area, even if the correctional facility is located within the Service Area.

~~k.~~l. CalOptima is not required to contact the Member to confirm incarceration, but must still confirm incarceration using public sources such as a federal or state entity or other public records.

~~l.~~m. If CalOptima confirms a Member's current incarceration, but is unable to confirm the start date of the incarceration, ~~CalOptima shall~~DHCS will disenroll the Member prospectively effective the first (1st) of the calendar month following the date on which the current incarceration was confirmed.

~~m.~~n. If CalOptima confirms the Member's start date of the incarceration, ~~CalOptima shall~~DHCS will disenroll the Member effective the first (1st) day of the calendar month following the start date of the incarceration.

~~n.~~o. If the disenrollment effective date is outside of the current calendar month transaction submission timeframe as defined by CMS, ~~CalOptima~~DHCS must submit a retroactive disenrollment request to the Retroactive Processing Contractor (RPC~~,~~), unless the period of incarceration is already completed. If the period of incarceration is already complete, disenrollment is not necessary unless otherwise instructed by CMS.

~~o.~~p. If the Member establishes that a permanent move occurred retroactively and requests retroactive disenrollment (not earlier than the first (1st) day of the calendar month after the move), ~~CalOptima shall~~DHCS will submit this request to CMS or its designated ~~Retroactive Processing Contractor (~~RPC~~)~~ for consideration of retroactive action.

D. Involuntary Disenrollment for Loss of Entitlement to Medicare Part A or Part B

1. Upon notice from CMS, via the ~~TRR~~DTRR, that a Member's entitlement to Medicare Part A or Part B has ended, CalOptima shall ~~involuntarily disenroll the Member from OneCare Connect effective the first (1st) day of the calendar month following the last month of the Member's entitlement to Medicare Part A or Part B, whichever entitlement ends first, or~~update its eligibility systems with the date specified on the ~~TRR~~DTRR from CMS.

2. If a Member loses entitlement to Medicare Part A, CalOptima shall not:

   a. Allow the Member to remain a Member and receive Medicare Part B-only services; or

b. Offer the Member Part A-equivalent services for a premium.

3. If a Member loses entitlement to Medicare Part B, CalOptima shall not allow the Member to remain a Member and receive Medicare Part A-only services.

4. Notice Requirement

a. CalOptima shall mail the Member *Exhibit ~~19/20/21,~~24: Model Notice ~~for Disenrollment due to Loss~~Offer Beneficiary Services, Pending Correction of ~~Medicaid Status, Other State Specific Eligibility Status or Out-of-Area Status~~Erroneous Medicare Part A and/or Part B Termination* informing the Member of disenrollment due to loss of entitlement to Medicare Part A or Part B, within ten (10) calendar days from the date of discovery via the DTRR, so that any erroneous disenrollments can be corrected as soon as possible.

E. Involuntary Disenrollment for Loss of Entitlement to Services under Medi-Cal

1. Effective September 1, 2017, CalOptima shall involuntarily disenroll a Member who loses entitlement to Medi-Cal benefits or has a change in Medi-Cal status or due to loss of State-specific eligibility, following a period of ~~one (1~~two (2) calendar ~~month~~months of deemed continued eligibility.

2. For loss of Medi-Cal Eligibility, DHCS ~~shall notify~~ notifies CalOptima ~~of a loss of Medi-Cal eligibility~~ with an HCP status code ~~05/41~~041 in the monthly 834 eligibility file.

a. Within ten (10) calendar days of receiving HCP status code ~~05/41~~041, CalOptima shall mail the Member *Exhibit 22, Model Notice for Period of Deemed Continued Eligibility due to Loss of Medicaid.*

b. ~~A~~Effective September 1, 2017, a period of ~~one (1~~two (2) calendar ~~month~~months of deemed continued eligibility begins the first (1st) day of the calendar month following the month CalOptima receives the code ~~05/41~~041.

c. CalOptima shall make a minimum of three (3) telephonic attempts during the deemed continued eligibility period to inform the Member of his/her eligibility status and provide the necessary resources so the member can attempt to regain eligibility.

~~c.~~ If the month-end 834 enrollment file received by CalOptima at the end of the deeming month shows no change in the Member's HCP Status code ~~05/41, CalOptima shall disenroll the Member effective at the end of the period of deemed continued eligibility.~~

d. ~~If eligibility is not regained during the period of deemed continued eligibility~~041, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than three (3) business days following the last day of the deeming period.

e. The notice shall include the disenrollment effective date and the Medicare Special Election Period (SEP) for which the individual is eligible.

i. This section does not apply if CalOptima has confirmed with the Member (or Authorized Representative) that the Member has lost Medi-Cal eligibility and does not intend to reapply or seek redetermination prior to the start of the deeming period.

f. Within three (3) business days following the last day of the deeming period, submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month following the end of the period of deemed continued eligibility.

3. For Loss of Cal MediConnect Eligibility (including a change in circumstance such as a change in Medi-Cal ~~status~~aid code or ~~loss of State-specific eligibility status,~~move out of Service Area), DHCS ~~shall notify~~ notifies CalOptima ~~of a loss of eligibility~~ with an HCP status code ~~59/61~~061 in the monthly 834 eligibility file.

a. Within ten (10) calendar days of receiving HCP status code ~~59/61~~061, CalOptima shall mail the Member *Exhibit 30a, Model Notice for Deemed Eligibility due to Change in Medicaid Eligibility or Potential Move Out-of-Area.*

b. ~~A~~Effective September 1, 2017, a period of ~~one (1~~two (2) calendar ~~month~~months of deemed continued eligibility begins the first day of the calendar month following the month CalOptima receives the code ~~59/61~~061.

c. CalOptima shall make a minimum of three (3) telephonic attempts during the deemed continued eligibility period to inform the Member of his/her eligibility status and provide the necessary resources so the Member can attempt to regain eligibility.

~~c.~~d. If the month-end 834 enrollment file received by CalOptima at the end of the deeming month shows no change in the Member's HCP Status code ~~59/61~~061, CalOptima shall ~~disenroll~~mail the Member ~~effective at~~*Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than three (3) business days following the ~~end~~last day of the deeming period ~~of deemed continued eligibility~~.

e. The notice shall include the disenrollment effective date and the Medicare SEP for which the individual is eligible.

~~d.~~

~~e.~~f. ~~If eligibility is not regained during the period of deemed continued eligibility, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than~~Within three (3) business days following the last day of the deeming period~~.~~, DHCS will submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month following the end of the period of deemed continued eligibility.

~~f. The notice shall include the disenrollment effective date and the Medicare SEP for which the individual is eligible.~~

g. This section does not apply if CalOptima has confirmed with the Member (or authorized representative) that the Status ~~59/61~~061 code is correct prior to the start of the deeming period.

4. If CalOptima receives information from a source outside of CalOptima, other than DHCS, indicating loss of State-specific qualifications for OneCare Connect, CalOptima shall research to confirm the information.

a. If confirmed, CalOptima shall ~~proceed with~~document this information in its records and forward the ~~involuntary disenrollment process, and~~request to disenroll to DHCS.

~~a.~~b. CalOptima shall mail *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than three (3) business days following the date Medi-Cal or other State-specific eligibility requirement ended.

c. The notice shall include the disenrollment effective date and the Medicare SEP for which the individual is eligible.

d. DHCS will submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month following the loss of State-specific qualifications.

~~b.~~c. ~~The notice shall include the disenrollment effective date and the Medicare SEP for which the individual is eligible.~~

~~c.~~f. Exception: As stated in the DHCS OneCare Connect and Managed Long Term Services and Supports (MLTSS) Operations Meeting Frequently Asked Questions dated June 3, 2014, CalOptima shall not disenroll a Member from OneCare Connect or MLTSS for unmet Share of Cost (SOC) provided the Member is also participating in IHSS, MSSP or LTC.

~~5. An individual passively enrolled into OneCare Connect who loses eligibility and is subsequently disenrolled, may not again be passively enrolled into OneCare Connect upon regaining Medi-Cal eligibility in the same calendar year. Individuals may be enrolled passively only once in a calendar year.~~

F. Involuntary Disenrollment due to Death

~~1.~~ Upon ~~a Member's~~notice from CMS, via the DTRR, of the Member's death, ~~CMS shall disenroll the Member from OneCare Connect and shall notify~~ CalOptima ~~of such disenrollment in the DTRR.~~

~~Such disenrollment shall be effective the first (1st) day of the calendar month following~~shall update its eligibility systems with the date ~~of death.~~ specified on the DTRR.

~~2.~~1.

~~3.~~2. Within ten (10) calendar days of receipt of notice from CMS of a Member's death, CalOptima shall mail *Exhibit 23, Model Notice to Offer Beneficiary Services, Pending Correction for Erroneous Death Status* ~~-~~addressed to the estate of the Member so that any erroneous disenrollments can be corrected as soon as possible.

~~4.~~3. If CalOptima learns of a Member's death from another reliable source, CalOptima shall reach out to the Member's estate to advise them to notify Social Security and their Medi-Cal eligibility office of the Member's death. The disenrollment process shall not be initiated until notice of disenrollment is received in the CMS DTRR.

G. Involuntary Disenrollment for Termination or Non-renewal of the Contract:

1. CalOptima shall disenroll a Member from OneCare Connect if the Contract is terminated.

2. CalOptima shall notify all Members in writing of the effective date of the termination and shall include a description of alternatives for obtaining benefits under the Medicare program. Members who do not make an election for a Prescription Drug Plan (PDP) or Medicare Advantage-Prescription Drug (MA-PD) plan will be deemed to have elected and will result in a change of enrollment to Original Medicare and auto-enrollment by CMS into a Medicare Prescription Drug Plan, as well as access to the LI NET transitional PDP during any coverage gap.

H. Disenrollment due to Material Misrepresentation of Third Party Reimbursement

1. If a Member intentionally withholds or falsifies information about third-party reimbursement coverage, CMS requires the individual be disenrolled from the plan.

2. OneCare Connect Customer Service shall notify the Office of Compliance of such an event.

3. If the Office of Compliance determines it appropriate, CalOptima shall submit disenrollment for this reason to the Contract ~~Review~~Management Team for approval along with any information regarding the claim of material misrepresentation.

4. ~~If~~Should the request be~~-~~ approved, the disenrollment will be effective the first (1st) day of the calendar month ~~following~~after the month in which the Member is ~~notified~~given a written notice of ~~the~~ disenrollment or as ~~CMS specifies.~~provided by the CMT.

I. Optional Involuntary Disenrollment

1. CalOptima may request approval to disenroll a Member if:

a. The Member engages in disruptive behavior; or

b. The Member provides fraudulent information~~.~~.

2. ~~If CalOptima disenrolls a Member~~Should the disenrollment be approved by CMT for any of the aforementioned optional involuntary disenrollment reasons, ~~CalOptima shall provide the Member with a~~the disenrollment will be effective the first (1st) day of the calendar month after the month in which the Member is given a written notice of disenrollment or as provided by CMT. The disenrollment letter shall:

~~2.~~ Advise the Member that~~:~~

a. ~~Advises the Member that OneCare Connect~~ CalOptima plans to disenroll the Member from OneCare Connect and the reasons for such disenrollment;

b. ~~Provides~~Provide the effective date of disenrollment; and

c. ~~Explains~~Explain the Member's right to a hearing under the State's Grievance procedures, CalOptima Policy CMC.9002: Member Grievance Process.

3. Involuntary Disenrollment for Disruptive Behavior

a. CalOptima may request approval from CMS and DHCS~~-~~, through the CMT, to disenroll a Member if the Member's behavior is disruptive, unruly, abusive, or uncooperative to the

extent that the Member's continued enrollment in CalOptima OneCare Connect seriously impairs CalOptima's or a Contracted Provider's ability to furnish Covered Services to the Member or other Members, provided Member's behavior is determined to be unrelated to an adverse change in the Member's health status, or because of a Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs.

b. CalOptima shall not disenroll a Member from OneCare Connect because the Member:

i. Exercises the option to make treatment decisions with which OneCare Connect disagrees, including the option to receive no treatment or diagnostic testing; or

ii. Chooses not to comply with any treatment regimen developed by OneCare Connect or any Contracted Provider associated with OneCare Connect.

c. CalOptima shall make serious efforts to resolve problems presented by a Member prior to requesting approval from DHCS and CMS to disenroll the Member from OneCare Connect.

i. Such efforts to find a resolution must include providing reasonable accommodations, as determine by ~~the State~~DHCS or CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities;

ii. CalOptima must also inform the individual of their Grievance rights.

d. CalOptima shall provide three (3) notices for disenrollment due to disruptive behavior:

i. ~~—~~Advance notice to a disruptive Member, in writing, that continued disruptive behavior will result in involuntary disenrollment from OneCare Connect.

ii. If such behavior continues, CalOptima shall provide written notice of its intent to request CMS' and DHCS' permission to disenroll the Member from OneCare Connect.

iii. Planned action notice advising that CMS and DHCS have approved the request.

e. CalOptima shall submit documentation of the specific case to DHCS and CMS through the ~~State~~CMT for review~~. If~~, including the ~~State agrees with the request for involuntary disenrollment, the State must submit this~~ documentation ~~to CMS with a recommendation for approval. Such request shall include:~~listed below:

i. A thorough explanation of the reason for the disenrollment request, detailing how the Member's behavior has impacted OneCare Connect's ability to arrange for or provide services to the Member or other Members of the plan;

ii. Member information, including age, diagnosis, mental status, Functional Status, and a description of the Member's social support systems;

iii. ~~A statement~~Statements from the ~~Provider~~Providers describing their experience with the Member;

iv. Documentation of the Member's disruptive behavior;

v. Documentation of CalOptima's efforts to resolve the problem, including efforts to:

a) Provide reasonable accommodations for a Member with a disability, if applicable, in accordance with the Americans with Disabilities Act (ADA);

b) Establish that the Member's behavior is not related to the use or lack of use of medical services; and

c) Establish that the Member's behavior is not related to diminished mental capacity.

vi. A description of any extenuating circumstances as cited under Title 42, Code of Federal Regulations (C.F.R), Section 422.74 (d)(2)(iv);

vii. Copy of notice to the Member of the consequences of continued disruptive behavior;

viii. Copy of notice to the Member of CalOptima OneCare Connect's intent to request the Member's disenrollment; and

ix. Any information provided by the Member~~.~~ (e.g., complaints, statements).

f. ~~Upon~~ The CMT will make a decision within twenty (20) business days after the receipt of ~~approval from the CMS Regional Office with concurrence from~~all information required to complete its review.

~~f.~~ Should the ~~CMS central office, CalOptima shall provide a Planned Action Notice to the Member, in writing, that CMS and the State have~~request be approved, the ~~Member's~~ disenrollment ~~from OneCare Connect.~~

g. ~~CalOptima shall disenroll the Member~~ will be effective the first (1st) day of the calendar month after the month ~~it notifies~~in which CalOptima gives the Member a written notice of the disenrollment, or as provided by CMT.

h. A disenrollment processed under the disruptive behavior provision will always result in a change of enrollment to Original Medicare, and auto-enrollment by CMS into a Medicare Prescription Drug Plan, including to the LI NET traditional PDP during any coverage gap.

i. If the request for involuntary disenrollment for disruptive behavior is approved:

i. CMS and DHCS may require CalOptima to provide reasonable accommodations to the Member in such exceptional circumstances that CMS and DHCS deems necessary.

ii. CalOptima may request that CMS and DHCS consider prohibiting re-enrollment in the MMP. If this is not requested, and the Member is disenrolled due to disruptive behavior, the member may re-enroll into the MMP in the future.

J. Involuntary Disenrollment for Fraud and Abuse

~~a.~~1. CalOptima may request approval from the State and CMS ~~to disenroll~~through the CMT to cancel the enrollment of a Member who knowingly provides on the Enrollment Form fraudulent information that materially affects the determination of a Member's eligibility ~~for enrollment~~to enroll in OneCare Connect.

~~b.~~2. CalOptima may request approval from the State and CMS through the CMT to disenroll a Member who intentionally permits others to use their OneCare Connect identification (ID) card to obtain Covered Services.

~~c.~~3. With such a disenrollment request, CalOptima shall immediately notify the State and CMS so the Health and Human Services (HHS) Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.

~~d.~~4. If such disenrollment request is approved by CMS and the State, CalOptima shall notify the Member in writing of the disenrollment and the reason for the disenrollment. Such disenrollment shall be effective the first (1st) day of the calendar month after the month in which CalOptima gives the Member written notice and will result in a change of enrollment to Original Medicare and auto-enrollment by CMS into a Medicare Prescription Drug Plan, as well as access to the LI NET transitional PDP during any coverage gap.

K. Involuntary Disenrollment Due Unlawful Presence Status

1. CalOptima cannot retain a Member if CMS has determined that the Member is not lawfully present in the United States. CMS will notify CalOptima with specific Transaction Reply Code (TRC-) 349 via the Daily Transaction Reply Report (DTRR) that the Member is not lawfully present, and CMS will make the disenrollment effective the first (1st) day of the month following notification by CMS. CMS provides the official status to CalOptima, and CalOptima may not request any documentation of U.S. citizenship or alien status from a Member.

2. Within ten (10) calendar days following the receipt of notification (via DTRR) of the disenrollment due to unlawful presence, CalOptima shall provide a written notice to the Member so that the Member is aware of the loss of coverage in CalOptima and any erroneous disenrollments can be corrected as soon as possible.

~~K.~~L. Reinstatements may be necessary if a disenrollment is not legally valid.

1. CalOptima shall submit a reinstatement request to CMS if:

   a. Disenrollment occurred due to an erroneous death indicator;

   b. Disenrollment occurred due to erroneous loss of Medicare Part A or Part B;

   c. Disenrollment occurred due to an erroneous loss of entitlement of Medi-Cal eligibility or state specific eligibility criteria, as listed in CalOptima Policy CMC.4003: Member Enrollment (Voluntary);

   d. There is evidence that a Member did not intend to disenroll, e.g. if the Member cancelled a new enrollment in another plan; and

   e. Disenrollment occurred due to CalOptima, CMS, or State error.

2. If a Member contacts CalOptima and states that they were disenrolled from OneCare Connect for any of the reasons stated in Section III.E.1 of this policy, except III.E.1.d., and states that they wish to remain a Member, CalOptima shall instruct the Member, in writing within ten (10) calendar days of the Member's contact with CalOptima reporting the erroneous disenrollment, to continue using OneCare Connect Covered Services.

3. CalOptima shall indicate active coverage as of the date CalOptima instructs the Member to continue to use Covered Services.

4. If a Member is disenrolled due to any of the reasons stated in Section III.E.1 of this policy, CalOptima shall submit to CMS a request to reinstate the Member which shall include:

   a. A copy of the TRR from CMS showing the disenrollment;

   b. A copy of the disenrollment letter that CalOptima OneCare Connect sent to the Member;

   c. A copy of any correspondence from the Member disputing the disenrollment;

   d. A copy of the letter to the Member informing them to continue to use CalOptima OneCare Connect services until the issue is resolved, except for III.E.1.d.;

   e. Verification that the disenrollment was erroneous; and

   f. Within ten (10) calendar days of receipt of DTRR confirmation of the Member's reinstatement, CalOptima shall mail *Exhibit 27, Model Acknowledgement of Reinstatement* to the Member.

~~L.~~M. Cancellation of Voluntary Disenrollment

1. CalOptima may cancel a Member's disenrollment only if CalOptima makes the request prior to the effective date of the disenrollment, unless otherwise directed by CMS.

   a. If CalOptima receives a request for cancellation of disenrollment after it transmitted the disenrollment request to CMS, CalOptima shall submit a cancellation of disenrollment to reinstate a Member with no lapse in coverage.

   b. If CalOptima is unable to cancel the disenrollment transaction, CalOptima shall submit the request to cancel the action to the CMS Retroactive Processing Contractor (RPC) in order to cancel the disenrollment.

   c. CalOptima shall submit a transaction to cancel only those disenrollment transactions submitted to CMS.

   d. CalOptima shall mail *Exhibit 18, Model Acknowledgement of Request to Cancel Disenrollment* to the Member within ten (10) calendar days after receipt of a Member's request for cancellation of disenrollment, stating that the cancellation is being processed and the Member may continue using OneCare Connect Covered Services.

2. Within ten (10) calendar days of receipt of confirmation of the Member's reinstatement, CalOptima shall mail the Member *Exhibit 27, Model Acknowledgment of Reinstatement.*

3. If CalOptima receives a Member's request for cancellation of disenrollment after the effective date of disenrollment, and CMS does not allow the reinstatement, CalOptima shall instruct the Member to complete a new Enrollment form and re-enroll with OneCare Connect during an Election Period.

~~M.~~N. Retroactive Disenrollment

1. CMS may grant a retroactive disenrollment if:

   a. An enrollment was never legally valid, e.g. the result of fraudulent enrollment or misleading marketing practices;

   b. A valid request for disenrollment was properly made, but not processed or acted upon (whether due to system, plan or state error);

   c. The reason for the disenrollment is related to a permanent move out of the OneCare Connect Service Area; or

   d. The reason for the disenrollment is due to CalOptima's confirmation of an incarcerated status with a retroactive start date;

2. A Member or CalOptima may submit a request to CMS (or its Designee) for a retroactive disenrollment. CMS will notify DHCS.

3. If CalOptima submits a request for retroactive disenrollment, it shall include a copy or other record of the disenrollment request made by the individual and supporting evidence explaining why the disenrollment request was not processed correctly. CalOptima shall submit retroactive disenrollment requests to the CMS Retroactive Processing Contractor within the timeframe provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor. CMS will notify DHCS.

   a. If the reason is due to plan or state error, CalOptima must include clear information regarding what the plan or state has communicated to the affected individual throughout the period in question, including evidence that the individual was notified prospectively of the disenrollment and relevant information supporting the correction. This should include a copy of the disenrollment request and evidence of notices sent to the individual related to or caused by the error and which demonstrate that retroactive disenrollment is appropriate under the circumstances.

   b. If the reason for disenrollment is due to incarceration status with a retroactive start date, CalOptima must provide written confirmation of the incarceration status, including the start date. Such documentation may include documentation of telephonic communications.

IV. ATTACHMENTS~~/EXHIBITS~~

A. Exhibit 14~~–~~:Model Notice to Acknowledge Receipt of Voluntary Disenrollment from the Member
~~❖~~B. Exhibit 16:~~–~~Model Notice to Confirm Voluntary Disenrollment ~~from the Member and~~ Following Receipt of Transaction Reply Report (TRR) ~~(H8016_MM1013)~~
~~❖~~C. Exhibit 17:~~–~~Model Notice for Denial of Disenrollment ~~(H8016_MM1014)~~
~~❖~~D. Exhibit 18:~~–~~Model Acknowledgement of Request to Cancel Disenrollment ~~(H8016_MM1015)~~
E. Exhibit 19 ~~&~~:Model Notice for Disenrollment due to Out-of-Area Status (No Response to Request for Address Verification)
F. Exhibit 20~~&~~:Model Notice for Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member)
~~❖~~G. Exhibit 21:~~–~~Model Notice for Disenrollment due to Loss of Medicaid Status or Other State-Specific Eligibility Status ~~or Out-of-Area Status~~ - Notification of Involuntary Disenrollment ~~(H8016_MM1018)~~

H. Exhibit 22:Model Notice for Period of Deemed Continued Eligibility due to Loss of Medicaid
I. Exhibit 23 ~~&24 & 25: ~~:Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status~~, or~~
J. Exhibit 24:Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A~~/~~ and/or Part B Termination~~,~~
~~❖~~K. Exhibit 25:Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to State or Plan Error ~~(H8016_MM1019)~~
~~❖~~L. Exhibit 27: Model Acknowledgement of Reinstatement ~~(H8016_MM1023)~~
~~❖~~M. Exhibit 30: Model Notice to Research Potential Out of Area Status – Address Verification Form included ~~(H8016_MM1026)~~
~~❖~~N. Exhibit 30a: ~~MMP~~ Model Notice of Disenrollment following period of Deemed continued Eligibility due to change in Medicaid Eligibility or Potential Move out of Area ~~(H8016_1058)~~

V. REFERENCES

~~A.~~ CalOptima Policy CMC.~~1001: Glossary of Terms~~
~~B.~~A. ~~CalOptima Policy CMC.4006: Passive~~4003: Member Enrollment (Voluntary)
~~C.~~B. CalOptima Policy CMC.9002: Member Grievance Process
~~D.~~C. CalOptima Three-W~~w~~ay Contract with the ~~California Department of Health Care Services (DHCS) and the~~ Centers for Medicaid and Medicare Services (CMS) and the Department of Health Care Services (DHCS) for ~~OneCare Connect~~Cal MediConnect
D. Medicare–Medicaid Plan (MMP) Deeming Process for California, DHCS issued June 15, 2015
E. Medicare–Medicaid Plan (MMP) Enrollment and Disenrollment Guidance ~~Updated June 14, 2013~~(R~~r~~evised 9/2/2016)
F. OneCare Connect & Managed Long Term Services and Supports (MLTSS) Operations Meeting FAQ, June 3, 2014
~~G. MMP Deeming Process for California, DHCS issued June 15, 2015~~
~~H.~~G. Title 42, Code of Federal Regulations (C.F.R~~),~~.), §§422.66(b) and 422.74

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

~~None to Date~~

09/07/2017: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	07/01/2015	CMC.4004	Member Disenrollment	OneCare Connect
Revised	07/01/2016	CMC.4004	Member Disenrollment	OneCare Connect
Revised	09/07/2017	CMC.4004	Member Disenrollment	OneCare Connect

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Authorized Representative	For the purpose of this policy, an Authorized Representative is the same as Legal Representative. Centers for Medicare & Medicaid Services (CMS) defines Authorized/Legal Representative as an individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the state in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request, e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity.
Contract	The contract between United States Department of Health & Human Services Centers for Medicare & Medicaid Services, California Department of Health Care Services and Orange County Health Authority
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disenrollment	For the purposes of this policy, disenrollments are actions taken by the Member or plan after the effective date of enrollment. ~~Voluntary disenrollments may be accompanied by a request to Opt-Out of future Passive Enrollment requests for the OneCare Connect program.~~
Election	Enrollment in, or voluntary disenrollment from, a Medicare Advantage (MA) plan or Original Medicare.
Election Period	The time during which an eligible individual may elect a Medicare Advantage (MA) plan or Original Medicare. The type of Election period determines the effective date of MA coverage as well as the types of enrollment requests allowed.
Functional Status	An individuals' ability to perform normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well-being.
Grievance	Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action
In-Home Supportive Services (IHSS)	A program that provides in-home care for people who cannot remain in their own homes without assistance.
Member	An enrollee-beneficiary of the CalOptima OneCare Connect program.
Multi-Purpose Senior Services Program (MSSP)	A California-specific program, the 1915(c) Home and Community-Based Services Waiver that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 or older with

Term	Definition
	disabilities as an alternative to nursing facility placement.
~~Opt-Out~~	~~An individual's declination of Passive Enrollment received by CalOptima OneCare Connect prior to the Passive Enrollment effective date.~~
Original Medicare	The traditional Medicare Fee-for-Service program.
~~Passive Enrollment~~	~~An enrollment process through which an eligible individual is enrolled by DHCS into a Contractor's plan following a minimum 90-day advance notification that includes the opportunity for the Enrollee to choose another plan or Opt-Out prior to the effective date.~~
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.
Share of Cost (SOC)	The amount, set by Medi-Cal based on the Member's income, that the Member must contribute to the cost of their health care each month before Medi-Cal will pay.
Service Area	Orange County, California, and ten (10) air miles of any portion of Orange County, California.
Special Election Period	Election Period provided to individuals in situations where; 1. The individual has made a change in residence outside of the service area or continuation area or has experienced another change in circumstances as determined by Centers for Medicare & Medicaid Services (CMS) (other than termination for non-payment of premiums or disruptive behavior) that causes the individual to no longer be eligible to elect the Medicare Advantage plan; 2. CMS or the organization has terminated the Medicare Advantage organization's contract for the Medicare Advantage plan in the area in which the individual resides, or the organization has notified the individual of the impending termination of the plan or the impending discontinuation of the plan in the area in which the individual resides; 3. The individual demonstrates that the Medicare Advantage organization offering the Medicare Advantage plan substantially violated a material provision of its contract under Medicare Advantage in relation to the individual, or the Medicare Advantage organization (or its agent) materially misrepresented the plan when marketing the plan; 4. The individual is entitled to Medicare Part A and Part B and receives any type of assistance from Medi-Cal; or 5. The individual meets such other exceptional conditions as CMS may provide.

Policy #:	CMC.4004
Title:	**Member Disenrollment**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	07/01/15
Last Review Date:	09/07/17
Last Revised Date:	09/07/17

I. PURPOSE

This policy describes procedures for disenrolling a Member from the OneCare Connect program.

II. POLICY

A. Except as provided in this policy, OneCare Connect may not request or encourage any Member to disenroll from OneCare Connect.

1. CalOptima may not request disenrollment due to adverse changes in a Member's health status, a Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs.

B. A Member may voluntarily disenroll from OneCare Connect in any month and for any reason, in accordance with this policy.

C. CalOptima shall involuntarily disenroll a Member from OneCare Connect if:

1. The Member's change in residence makes the Member ineligible to participate in OneCare Connect;

2. The Member loses entitlement to either Medicare Part A or Part B;

3. The Member loses entitlement to services under Medi-Cal or Medi-Cal eligibility changes (e.g., to a non-eligible aid code or adding Share of Cost (SOC) when not residing in a LTC facility or receiving In-Home Support Services (IHSS) or Multi Senior Services Program (MSSP);

4. The Member loses a state-specific eligibility qualification for OneCare Connect;

5. The Member is incarcerated;

6. The Member is not lawfully present in the United States;

7. The Member dies;

8. The Contract is terminated or CalOptima reduces its Service Area such that the Member is no longer within the Service Area;

9. The individual materially misrepresents information to OneCare Connect regarding reimbursement for third party coverage; or

10. The individual has comprehensive health insurance other than Medicare or Medi-Cal.

D. CalOptima may request approval from the State and CMS to involuntarily disenroll a Member from OneCare Connect, if the Member:

1. Engages in disruptive behavior; or

2. Provides fraudulent information on the Enrollment Form; or

3. Permits Abuse of the Member's OneCare Connect identification (ID) card.

E. CalOptima shall retain all OneCare Connect disenrollment request for a period of ten (10) years from the end of the contract period in which the request was made.

III. PROCEDURE

A. Voluntary Disenrollment

1. A Member may request to disenroll from OneCare Connect by:

   a. Enrolling in another Medicare health or Part D plan, including a PACE organization;

   b. Enrolling in another Medicare Medicaid Plan (MMP);

   c. Calling 1-800-MEDICARE (1-800-633-4227); or

   d. Giving or faxing a signed written disenrollment notice to CalOptima, or to the State.

2. If a Member verbally requests disenrollment from OneCare Connect, the CalOptima staff member receiving such request must instruct the Member to make the request in one (1) of the ways described above.

3. If a Member is unable to sign the written request to disenroll from OneCare Connect, an Authorized Representative shall sign the request. If an Authorized Representative signs the disenrollment request, the Authorized Representative shall attest that they have such authority to make the request and that proof of the authority is available upon request by CalOptima or CMS. If CalOptima has reason to believe that an individual making an Election on behalf of a Member may not be authorized under State law to do so, CalOptima shall contact CMS, in accordance with the Medicare Managed Care Manual.

4. The Member, or Authorized Representative, shall write the date they signed the disenrollment request on the disenrollment request. If the Member or Authorized Representative fails to include the date on the disenrollment request, OneCare Connect's mailroom shall stamp the date of receipt of the disenrollment request, and such date shall serve as the signature date.

5. If the Member, or Authorized Representative, fails to include a signature on the disenrollment request, CalOptima may verbally verify with the Member or Authorized Representative the request to disenroll. CalOptima shall document the verbal verification to complete the disenrollment request and shall retain such documentation in its records.

6. If CalOptima requests additional information to be submitted for the disenrollment request, CalOptima shall explain to the Member or Authorized Representative that the additional information must be received by the end of the calendar month in which the request to disenroll was received, or within twenty-one (21) calendar days after receipt of the disenrollment request

for a disenrollment request to be considered complete (whichever is later). If CalOptima does not receive additional information within the allowable timeframe, CalOptima shall not disenroll the Member.

7. Notice Requirements

   a. If a Member requests disenrollment through CalOptima, CalOptima shall mail the Member *Exhibit 14, Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member* within ten (10) calendar days after receipt of the disenrollment request. The acknowledgement of disenrollment letter shall include an explanation of the effective date of the disenrollment. The notice shall also inform the disenrolling Member that it may take up to forty-five (45) calendar days for the Medicare computer records to be updated, and advise the Member to inform his or her provider the Member was just disenrolled from OneCare Connect and there may be a short delay with updating the Member's records.

   b. If a Member requests disenrollment through an entity other than CalOptima, as specified in this policy, CMS will notify CalOptima in the Daily Transaction Reply Report (DTRR). If CalOptima learns of the voluntary disenrollment from the DTRR (as opposed to a written request from the Member), CalOptima shall input the disenrollment in the OneCare Connect eligibility system and mail *Exhibit 16, Model Notice to Confirm Voluntary Disenrollment Following Receipt of Transaction Reply Report (TRR)* to the Member within ten (10) calendar days after the availability of the information on the DTRR from CMS.

8. Processing Request for Disenrollment

   a. The CalOptima mailroom shall stamp the date of receipt of a disenrollment request received from a Member, or Member's Authorized Representative, upon receipt of that request.

   b. CalOptima shall submit a disenrollment transaction to CMS within seven (7) calendar days after the date of receipt of a disenrollment request.

9. If a Member requests voluntary disenrollment from OneCare Connect, such disenrollment shall be effective on the first (1st) calendar day of the month after the month CalOptima receives a completed disenrollment request, unless otherwise stated in writing for a future date.

10. CalOptima may deny a voluntary request for disenrollment only when:

    a. The request was made by someone other than the Member, and that individual is not the Member's Authorized Representative, as described in this policy; or

    b. The request was incomplete, and the required information is not provided within the required time frame.

11. If CalOptima receives a disenrollment request that OneCare Connect is required to deny, CalOptima shall mail *Exhibit 17, Model Notice for Denial of Disenrollment* to the Member within ten (10) calendar days after the receipt of the request and shall include the reason for the denial.

B. Involuntary Disenrollment

1. If CalOptima involuntarily disenrolls a Member for causes specified in this policy, CalOptima shall provide the Member with a disenrollment letter that:

a. Advises the Member that CalOptima plans to disenroll the Member, and the reason for such disenrollment; and

b. Explains the Member's right to file a Grievance, in accordance with CalOptima Policy CMC.9002: Member Grievance Process, except if the Contract is terminating as specified in this policy.

C. Involuntary Disenrollment for Change in Residence

1. CalOptima shall initiate disenrollment when a Member's permanent residence is confirmed outside of the Service Area or when a Member's absence from the OneCare Connect Service Area exceeds six (6) consecutive months.

2. CalOptima may receive notice of a change in a Member's residence from DHCS, the Member, the Member's Authorized Representative, a DTRR from CMS, or other source.

a. DHCS will notify CalOptima of a potential move out of area with an HCP status code 61 in the monthly 834 eligibility file:

i. Within ten (10) calendar days of receiving HCP status code 61 CalOptima shall mail *Exhibit 30a, Model Notice for Deemed Continued Eligibility due to Change in Medicaid Eligibility or Potential Move Out-of-Area* to the Member.

ii. A period of two (2) months of deemed continued eligibility begins the first day of the calendar month following the month CalOptima receives the code 61.

iii. CalOptima shall make a minimum of three (3) telephonic attempts during the deemed continued eligibility period to inform the member of his/her eligibility status and provide the necessary resources so the member can attempt to regain eligibility.

iv. If the month-end 834 enrollment file received by CalOptima at the end of the period of deemed continued eligibility shows no change in the Member's HCP Status code 61, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than three (3) business days following the last day of the deeming period.

v. Within three (3) business days following the end of the period of deemed continued eligibility, DHCS will submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month from the end of the period of deemed continued eligibility.

vi. This section does not apply if CalOptima has confirmed the out-of-area move and will process the disenrollment as otherwise set forth in this policy.

b. If CalOptima is notified of a potential out-of-area change in residence through a source other than DHCS, the Member, or the Member's Authorized Representative, CalOptima shall not assume the move is permanent and shall not disenroll the Member until the Member, or Member's Authorized Representative, confirms the out-of-area move, or until six (6) consecutive months have elapsed following the date CalOptima OneCare Connect receives information regarding the Member's potential address change, whichever is sooner.

i. CalOptima shall, within ten (10) calendar days of receipt of such notice, send the Member *Exhibit 30, a Notice to Research Potential Out of Area Status and Address Verification Form* to verify the change in address and whether it is temporary, or permanent.

ii. The Member shall have six (6) calendar months following the date of the notice to respond.

iii. If, at the end of the sixth (6^{th}) calendar month, there is no response to Exhibit 30, and CalOptima has not received an HCP Status Code 61 from DHCS, CalOptima shall document this information in its records and forward the request to disenroll to DHCS..

iv. Within the first ten (10) calendar days of the sixth (6^{th}) calendar month following discovery of a potential out-of-area residence, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice of Disenrollment due to Loss of Medicaid Status or Other State-Specific Eligibility Status, or Out-of-Area Status.*

v. Within three (3) business days following the disenrollment effective date, DHCS will submit a disenrollment transaction to CMS, effective the first (1^{st}) day of the calendar month following the end of the sixth (6^{th}) month.

c. CalOptima shall accept verbal, or written, confirmation from the Member, or Member's Authorized Representative, of an address change.

i. If the confirmation indicates the permanent address is outside of the Service Area. CalOptima shall document this information in its records and forward the request to disenroll to DHCS. CalOptima shall mail *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* within ten (10) calendar days of the date the out-of-area address was confirmed.

d. DHCS will submit a disenrollment transaction to CMS, effective the first (1^{st}) day of the calendar month following the date CalOptima received the confirmation.

i. If the confirmation indicates the permanent address is within the OneCare Connect Service Area, CalOptima shall discontinue the disenrollment process.

e. If an enrolling Member shows an address within the plan Service Area on the enrollment application, while the CMS or Medi-Cal records show an address outside of the plan Service Area, the Member's enrollment application serves as attestation of their current address.

f. If CalOptima learns of a permanent change in address directly from the Member or Member's Authorized Representative, and that address is outside of the OneCare Connect Service Area, CalOptima shall document this information in its records and forward the request to disenroll to DHCS.

g. CalOptima shall mail *Exhibit 20, Model Notice for Disenrollment Due to Confirmation of Out-of-Area Status (Upon New Address Verification from Member)* to the Member within ten (10) calendar days of receiving the information.

h. DHCS will submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month after the date the Member begins residing outside of OneCare Connect's Service Area and after the Member, or their Authorized Representative, notifies CalOptima that they have moved and no longer resides in the Service Area.

i. In the case of an individual who provides advance notice of the move, the disenrollment will be effective the first (1st) day of the calendar month following the month in which the individual indicates they will be moving.

j. In the case of incarcerated individuals, where CalOptima receives notification of the out-of-area status via a DTRR, DHCS will disenroll the Member on the first (1st) day of the calendar month following confirmation of current incarceration.

k. A Member who is incarcerated is considered out of the plan's Service Area, even if the correctional facility is located within the Service Area.

l. CalOptima is not required to contact the Member to confirm incarceration, but must still confirm incarceration using public sources such as a federal or state entity or other public records.

m. If CalOptima confirms a Member's current incarceration, but is unable to confirm the start date of the incarceration, DHCS will disenroll the Member prospectively effective the first (1st) of the calendar month following the date on which the current incarceration was confirmed.

n. If CalOptima confirms the Member's start date of the incarceration, DHCS will disenroll the Member effective the first (1st) day of the calendar month following the start date of the incarceration.

o. If the disenrollment effective date is outside of the current calendar month transaction submission timeframe as defined by CMS, DHCS must submit a retroactive disenrollment request to the Retroactive Processing Contractor (RPC), unless the period of incarceration is already completed. If the period of incarceration is already complete, disenrollment is not necessary unless otherwise instructed by CMS.

p. If the Member establishes that a permanent move occurred retroactively and requests retroactive disenrollment (not earlier than the first (1st) day of the calendar month after the move), DHCS will submit this request to CMS or its designated RPC for consideration of retroactive action.

D. Involuntary Disenrollment for Loss of Entitlement to Medicare Part A or Part B

1. Upon notice from CMS, via the DTRR, that a Member's entitlement to Medicare Part A or Part B has ended, CalOptima shall update its eligibility systems with the date specified on the DTRR from CMS.

2. If a Member loses entitlement to Medicare Part A, CalOptima shall not:

a. Allow the Member to remain a Member and receive Medicare Part B-only services; or

b. Offer the Member Part A-equivalent services for a premium.

3. If a Member loses entitlement to Medicare Part B, CalOptima shall not allow the Member to remain a Member and receive Medicare Part A-only services.

4. Notice Requirement

   a. CalOptima shall mail the Member *Exhibit 24: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination* informing the Member of disenrollment due to loss of entitlement to Medicare Part A or Part B, within ten (10) calendar days from the date of discovery via the DTRR, so that any erroneous disenrollments can be corrected as soon as possible.

E. Involuntary Disenrollment for Loss of Entitlement to Services under Medi-Cal

1. Effective September 1, 2017, CalOptima shall involuntarily disenroll a Member who loses entitlement to Medi-Cal benefits or has a change in Medi-Cal status or due to loss of State-specific eligibility, following a period of two (2) calendar months of deemed continued eligibility.

2. For loss of Medi-Cal Eligibility, DHCS notifies CalOptima with an HCP status code 041 in the monthly 834 eligibility file.

   a. Within ten (10) calendar days of receiving HCP status code 041, CalOptima shall mail the Member *Exhibit 22, Model Notice for Period of Deemed Continued Eligibility due to Loss of Medicaid.*

   b. Effective September 1, 2017, a period of two (2) calendar months of deemed continued eligibility begins the first (1st) day of the calendar month following the month CalOptima receives the code 041.

   c. CalOptima shall make a minimum of three (3) telephonic attempts during the deemed continued eligibility period to inform the Member of his/her eligibility status and provide the necessary resources so the member can attempt to regain eligibility.

   d. If the month-end 834 enrollment file received by CalOptima at the end of the deeming month shows no change in the Member's HCP Status code 041, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than three (3) business days following the last day of the deeming period.

   e. The notice shall include the disenrollment effective date and the Medicare Special Election Period (SEP) for which the individual is eligible.

      i. This section does not apply if CalOptima has confirmed with the Member (or Authorized Representative) that the Member has lost Medi-Cal eligibility and does not intend to reapply or seek redetermination prior to the start of the deeming period.

   f. Within three (3) business days following the last day of the deeming period, submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month following the end of the period of deemed continued eligibility.

3. For Loss of Cal MediConnect Eligibility (including a change in circumstance such as a change in Medi-Cal aid code or move out of Service Area), DHCS notifies CalOptima with an HCP status code 061 in the monthly 834 eligibility file.

a. Within ten (10) calendar days of receiving HCP status code 061, CalOptima shall mail the Member *Exhibit 30a, Model Notice for Deemed Eligibility due to Change in Medicaid Eligibility or Potential Move Out-of-Area.*

b. Effective September 1, 2017, a period of two (2) calendar months of deemed continued eligibility begins the first day of the calendar month following the month CalOptima receives the code 061.

c. CalOptima shall make a minimum of three (3) telephonic attempts during the deemed continued eligibility period to inform the Member of his/her eligibility status and provide the necessary resources so the Member can attempt to regain eligibility.

d. If the month-end 834 enrollment file received by CalOptima at the end of the deeming month shows no change in the Member's HCP Status code 061, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than three (3) business days following the last day of the deeming period.

e. The notice shall include the disenrollment effective date and the Medicare SEP for which the individual is eligible.

f. Within three (3) business days following the last day of the deeming period, DHCS will submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month following the end of the period of deemed continued eligibility.

g. This section does not apply if CalOptima has confirmed with the Member (or authorized representative) that the Status 061 code is correct prior to the start of the deeming period.

4. If CalOptima receives information from a source outside of CalOptima, other than DHCS, indicating loss of State-specific qualifications for OneCare Connect, CalOptima shall research to confirm the information.

a. If confirmed, CalOptima shall document this information in its records and forward the request to disenroll to DHCS.

b. CalOptima shall mail *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than three (3) business days following the date Medi-Cal or other State-specific eligibility requirement ended.

c. The notice shall include the disenrollment effective date and the Medicare SEP for which the individual is eligible.

d. DHCS will submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month following the loss of State-specific qualifications.

e. Exception: As stated in the DHCS OneCare Connect and Managed Long Term Services and Supports (MLTSS) Operations Meeting Frequently Asked Questions dated June 3, 2014, CalOptima shall not disenroll a Member from OneCare Connect or MLTSS for unmet Share of Cost (SOC) provided the Member is also participating in IHSS, MSSP or LTC.

F. Involuntary Disenrollment due to Death

1. Upon notice from CMS, via the DTRR, of the Member's death, CalOptima shall update its eligibility systems with the date specified on the DTRR.

2. Within ten (10) calendar days of receipt of notice from CMS of a Member's death, CalOptima shall mail *Exhibit 23, Model Notice to Offer Beneficiary Services, Pending Correction for Erroneous Death Status* addressed to the estate of the Member so that any erroneous disenrollments can be corrected as soon as possible.

3. If CalOptima learns of a Member's death from another reliable source, CalOptima shall reach out to the Member's estate to advise them to notify Social Security and their Medi-Cal eligibility office of the Member's death. The disenrollment process shall not be initiated until notice of disenrollment is received in the CMS DTRR.

G. Involuntary Disenrollment for Termination or Non-renewal of the Contract:

1. CalOptima shall disenroll a Member from OneCare Connect if the Contract is terminated.

2. CalOptima shall notify all Members in writing of the effective date of the termination and shall include a description of alternatives for obtaining benefits under the Medicare program. Members who do not make an election for a Prescription Drug Plan (PDP) or Medicare Advantage-Prescription Drug (MA-PD) plan will be deemed to have elected and will result in a change of enrollment to Original Medicare and auto-enrollment by CMS into a Medicare Prescription Drug Plan, as well as access to the LI NET transitional PDP during any coverage gap.

H. Disenrollment due to Material Misrepresentation of Third Party Reimbursement

1. If a Member intentionally withholds or falsifies information about third-party reimbursement coverage, CMS requires the individual be disenrolled from the plan.

2. OneCare Connect Customer Service shall notify the Office of Compliance of such an event.

3. If the Office of Compliance determines it appropriate, CalOptima shall submit disenrollment for this reason to the Contract Management Team for approval along with any information regarding the claim of material misrepresentation.

4. Should the request be approved, the disenrollment will be effective the first (1st) day of the calendar month after the month in which the Member is given a written notice of disenrollment or as provided by the CMT.

I. Optional Involuntary Disenrollment

1. CalOptima may request approval to disenroll a Member if:

   a. The Member engages in disruptive behavior; or

   b. The Member provides fraudulent information.

2. Should the disenrollment be approved by CMT for any of the aforementioned optional involuntary disenrollment reasons, the disenrollment will be effective the first (1st) day of the

calendar month after the month in which the Member is given a written notice of disenrollment or as provided by CMT. The disenrollment letter shall:

a. Advise the Member that CalOptima plans to disenroll the Member from OneCare Connect and the reasons for such disenrollment;

b. Provide the effective date of disenrollment; and

c. Explain the Member's right to a hearing under the State's Grievance procedures, CalOptima Policy CMC.9002: Member Grievance Process.

3. Involuntary Disenrollment for Disruptive Behavior

a. CalOptima may request approval from CMS and DHCS, through the CMT, to disenroll a Member if the Member's behavior is disruptive, unruly, abusive, or uncooperative to the extent that the Member's continued enrollment in CalOptima OneCare Connect seriously impairs CalOptima's or a Contracted Provider's ability to furnish Covered Services to the Member or other Members, provided Member's behavior is determined to be unrelated to an adverse change in the Member's health status, or because of a Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs.

b. CalOptima shall not disenroll a Member from OneCare Connect because the Member:

i. Exercises the option to make treatment decisions with which OneCare Connect disagrees, including the option to receive no treatment or diagnostic testing; or

ii. Chooses not to comply with any treatment regimen developed by OneCare Connect or any Contracted Provider associated with OneCare Connect.

c. CalOptima shall make serious efforts to resolve problems presented by a Member prior to requesting approval from DHCS and CMS to disenroll the Member from OneCare Connect.

i. Such efforts to find a resolution must include providing reasonable accommodations, as determine by DHCS or CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities;

ii. CalOptima must also inform the individual of their Grievance rights.

d. CalOptima shall provide three (3) notices for disenrollment due to disruptive behavior:

i. Advance notice to a disruptive Member, in writing, that continued disruptive behavior will result in involuntary disenrollment from OneCare Connect.

ii. If such behavior continues, CalOptima shall provide written notice of its intent to request CMS' and DHCS' permission to disenroll the Member from OneCare Connect.

iii. Planned action notice advising that CMS and DHCS have approved the request.

e. CalOptima shall submit documentation of the specific case to DHCS and CMS through the CMT for review, including the documentation listed below:

i. A thorough explanation of the reason for the disenrollment request, detailing how the Member's behavior has impacted OneCare Connect's ability to arrange for or provide services to the Member or other Members of the plan;

ii. Member information, including age, diagnosis, mental status, Functional Status, and a description of the Member's social support systems;

iii. Statements from the Providers describing their experience with the Member;

iv. Documentation of the Member's disruptive behavior;

v. Documentation of CalOptima's efforts to resolve the problem, including efforts to:

a) Provide reasonable accommodations for a Member with a disability, if applicable, in accordance with the Americans with Disabilities Act (ADA);

b) Establish that the Member's behavior is not related to the use or lack of use of medical services; and

c) Establish that the Member's behavior is not related to diminished mental capacity.

vi. A description of any extenuating circumstances as cited under Title 42, Code of Federal Regulations (C.F.R), Section 422.74 (d)(2)(iv);

vii. Copy of notice to the Member of the consequences of continued disruptive behavior;

viii. Copy of notice to the Member of CalOptima OneCare Connect's intent to request the Member's disenrollment; and

ix. Any information provided by the Member (e.g., complaints, statements).

f. The CMT will make a decision within twenty (20) business days after the receipt of all information required to complete its review.

g. Should the request be approved, the disenrollment will be effective the first (1st) day of the calendar month after the month in which CalOptima gives the Member a written notice of the disenrollment, or as provided by CMT.

h. A disenrollment processed under the disruptive behavior provision will always result in a change of enrollment to Original Medicare, and auto-enrollment by CMS into a Medicare Prescription Drug Plan, including to the LI NET traditional PDP during any coverage gap.

i. If the request for involuntary disenrollment for disruptive behavior is approved:

i. CMS and DHCS may require CalOptima to provide reasonable accommodations to the Member in such exceptional circumstances that CMS and DHCS deems necessary.

ii. CalOptima may request that CMS and DHCS consider prohibiting re-enrollment in the MMP. If this is not requested, and the Member is disenrolled due to disruptive behavior, the member may re-enroll into the MMP in the future.

J. Involuntary Disenrollment for Fraud and Abuse

1. CalOptima may request approval from the State and CMS through the CMT to cancel the enrollment of a Member who knowingly provides on the Enrollment Form fraudulent information that materially affects the determination of a Member's eligibility to enroll in OneCare Connect.

2. CalOptima may request approval from the State and CMS through the CMT to disenroll a Member who intentionally permits others to use their OneCare Connect identification (ID) card to obtain Covered Services.

3. With such a disenrollment request, CalOptima shall immediately notify the State and CMS so the Health and Human Services (HHS) Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.

4. If such disenrollment request is approved by CMS and the State, CalOptima shall notify the Member in writing of the disenrollment and the reason for the disenrollment. Such disenrollment shall be effective the first (1st) day of the calendar month after the month in which CalOptima gives the Member written notice and will result in a change of enrollment to Original Medicare and auto-enrollment by CMS into a Medicare Prescription Drug Plan, as well as access to the LI NET transitional PDP during any coverage gap.

K. Involuntary Disenrollment Due Unlawful Presence Status

1. CalOptima cannot retain a Member if CMS has determined that the Member is not lawfully present in the United States. CMS will notify CalOptima with specific Transaction Reply Code (TRC) 349 via the Daily Transaction Reply Report (DTRR) that the Member is not lawfully present, and CMS will make the disenrollment effective the first (1st) day of the month following notification by CMS. CMS provides the official status to CalOptima, and CalOptima may not request any documentation of U.S. citizenship or alien status from a Member.

2. Within ten (10) calendar days following the receipt of notification (via DTRR) of the disenrollment due to unlawful presence, CalOptima shall provide a written notice to the Member so that the Member is aware of the loss of coverage in CalOptima and any erroneous disenrollments can be corrected as soon as possible.

L. Reinstatements may be necessary if a disenrollment is not legally valid.

1. CalOptima shall submit a reinstatement request to CMS if:

   a. Disenrollment occurred due to an erroneous death indicator;

   b. Disenrollment occurred due to erroneous loss of Medicare Part A or Part B;

   c. Disenrollment occurred due to an erroneous loss of entitlement of Medi-Cal eligibility or state specific eligibility criteria, as listed in CalOptima Policy CMC.4003: Member Enrollment (Voluntary);

   d. There is evidence that a Member did not intend to disenroll, e.g. if the Member cancelled a new enrollment in another plan; and

   e. Disenrollment occurred due to CalOptima, CMS, or State error.

2. If a Member contacts CalOptima and states that they were disenrolled from OneCare Connect for any of the reasons stated in Section III.E.1 of this policy, except III.E.1.d., and states that they wish to remain a Member, CalOptima shall instruct the Member, in writing within ten (10) calendar days of the Member's contact with CalOptima reporting the erroneous disenrollment, to continue using OneCare Connect Covered Services.

3. CalOptima shall indicate active coverage as of the date CalOptima instructs the Member to continue to use Covered Services.

4. If a Member is disenrolled due to any of the reasons stated in Section III.E.1 of this policy, CalOptima shall submit to CMS a request to reinstate the Member which shall include:

   a. A copy of the TRR from CMS showing the disenrollment;

   b. A copy of the disenrollment letter that CalOptima OneCare Connect sent to the Member;

   c. A copy of any correspondence from the Member disputing the disenrollment;

   d. A copy of the letter to the Member informing them to continue to use CalOptima OneCare Connect services until the issue is resolved, except for III.E.1.d.;

   e. Verification that the disenrollment was erroneous; and

   f. Within ten (10) calendar days of receipt of DTRR confirmation of the Member's reinstatement, CalOptima shall mail *Exhibit 27, Model Acknowledgement of Reinstatement* to the Member.

M. Cancellation of Voluntary Disenrollment

1. CalOptima may cancel a Member's disenrollment only if CalOptima makes the request prior to the effective date of the disenrollment, unless otherwise directed by CMS.

   a. If CalOptima receives a request for cancellation of disenrollment after it transmitted the disenrollment request to CMS, CalOptima shall submit a cancellation of disenrollment to reinstate a Member with no lapse in coverage.

   b. If CalOptima is unable to cancel the disenrollment transaction, CalOptima shall submit the request to cancel the action to the CMS Retroactive Processing Contractor (RPC) in order to cancel the disenrollment.

   c. CalOptima shall submit a transaction to cancel only those disenrollment transactions submitted to CMS.

   d. CalOptima shall mail *Exhibit 18, Model Acknowledgement of Request to Cancel Disenrollment* to the Member within ten (10) calendar days after receipt of a Member's request for cancellation of disenrollment, stating that the cancellation is being processed and the Member may continue using OneCare Connect Covered Services.

2. Within ten (10) calendar days of receipt of confirmation of the Member's reinstatement, CalOptima shall mail the Member *Exhibit 27, Model Acknowledgment of Reinstatement*.

3. If CalOptima receives a Member's request for cancellation of disenrollment after the effective date of disenrollment, and CMS does not allow the reinstatement, CalOptima shall instruct the Member to complete a new Enrollment form and re-enroll with OneCare Connect during an Election Period.

N. Retroactive Disenrollment

1. CMS may grant a retroactive disenrollment if:

   a. An enrollment was never legally valid, e.g. the result of fraudulent enrollment or misleading marketing practices;

   b. A valid request for disenrollment was properly made, but not processed or acted upon (whether due to system, plan or state error);

   c. The reason for the disenrollment is related to a permanent move out of the OneCare Connect Service Area; or

   d. The reason for the disenrollment is due to CalOptima's confirmation of an incarcerated status with a retroactive start date;

2. A Member or CalOptima may submit a request to CMS (or its Designee) for a retroactive disenrollment. CMS will notify DHCS.

3. If CalOptima submits a request for retroactive disenrollment, it shall include a copy or other record of the disenrollment request made by the individual and supporting evidence explaining why the disenrollment request was not processed correctly. CalOptima shall submit retroactive disenrollment requests to the CMS Retroactive Processing Contractor within the timeframe provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor. CMS will notify DHCS.

   a. If the reason is due to plan or state error, CalOptima must include clear information regarding what the plan or state has communicated to the affected individual throughout the period in question, including evidence that the individual was notified prospectively of the disenrollment and relevant information supporting the correction. This should include a copy of the disenrollment request and evidence of notices sent to the individual related to or caused by the error and which demonstrate that retroactive disenrollment is appropriate under the circumstances.

   b. If the reason for disenrollment is due to incarceration status with a retroactive start date, CalOptima must provide written confirmation of the incarceration status, including the start date. Such documentation may include documentation of telephonic communications.

IV. ATTACHMENTS

A. Exhibit 14:Model Notice to Acknowledge Receipt of Voluntary Disenrollment from the Member
B. Exhibit 16:Model Notice to Confirm Voluntary Disenrollment Following Receipt of Transaction Reply Report (TRR)
C. Exhibit 17:Model Notice for Denial of Disenrollment
D. Exhibit 18:Model Acknowledgement of Request to Cancel Disenrollment
E. Exhibit 19:Model Notice for Disenrollment due to Out-of-Area Status (No Response to Request for Address Verification)

F. Exhibit 20:Model Notice for Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member)
G. Exhibit 21:Model Notice for Disenrollment due to Loss of Medicaid Status or Other State-Specific Eligibility Status - Notification of Involuntary Disenrollment
H. Exhibit 22:Model Notice for Period of Deemed Continued Eligibility due to Loss of Medicaid
I. Exhibit 23:Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status
J. Exhibit 24:Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination
K. Exhibit 25:Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to State or Plan Error
L. Exhibit 27: Model Acknowledgement of Reinstatement
M. Exhibit 30: Model Notice to Research Potential Out of Area Status – Address Verification Form included
N. Exhibit 30a:Model Notice of Disenrollment following period of Deemed continued Eligibility due to change in Medicaid Eligibility or Potential Move out of Area

V. REFERENCES

A. CalOptima Policy CMC.4003: Member Enrollment (Voluntary)
B. CalOptima Policy CMC.9002: Member Grievance Process
C. CalOptima Three-Way Contract with the Centers for Medicaid and Medicare Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. Medicare–Medicaid Plan (MMP) Deeming Process for California, DHCS issued June 15, 2015
E. Medicare–Medicaid Plan (MMP) Enrollment and Disenrollment Guidance (Revised 9/2/2016)
F. OneCare Connect & Managed Long Term Services and Supports (MLTSS) Operations Meeting FAQ, June 3, 2014
G. Title 42, Code of Federal Regulations (C.F.R.), §§422.66(b) and 422.74

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

09/07/2017: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	07/01/2015	CMC.4004	Member Disenrollment	OneCare Connect
Revised	07/01/2016	CMC.4004	Member Disenrollment	OneCare Connect
Revised	09/07/2017	CMC.4004	Member Disenrollment	OneCare Connect

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Authorized Representative	For the purpose of this policy, an Authorized Representative is the same as Legal Representative. Centers for Medicare & Medicaid Services (CMS) defines Authorized/Legal Representative as an individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the state in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request, e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity.
Contract	The contract between United States Department of Health & Human Services Centers for Medicare & Medicaid Services, California Department of Health Care Services and Orange County Health Authority
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disenrollment	For the purposes of this policy, disenrollments are actions taken by the Member or plan after the effective date of enrollment.
Election	Enrollment in, or voluntary disenrollment from, a Medicare Advantage (MA) plan or Original Medicare.
Election Period	The time during which an eligible individual may elect a Medicare Advantage (MA) plan or Original Medicare. The type of Election period determines the effective date of MA coverage as well as the types of enrollment requests allowed.
Functional Status	An individuals' ability to perform normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well-being.
Grievance	Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action
In-Home Supportive Services (IHSS)	A program that provides in-home care for people who cannot remain in their own homes without assistance.
Member	An enrollee-beneficiary of the CalOptima OneCare Connect program.
Multi-Purpose Senior Services Program (MSSP)	A California-specific program, the 1915(c) Home and Community-Based Services Waiver that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 or older with disabilities as an alternative to nursing facility placement.
Original Medicare	The traditional Medicare Fee-for-Service program.

Term	Definition
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.
Share of Cost (SOC)	The amount, set by Medi-Cal based on the Member's income, that the Member must contribute to the cost of their health care each month before Medi-Cal will pay.
Service Area	Orange County, California, and ten (10) air miles of any portion of Orange County, California.
Special Election Period	Election Period provided to individuals in situations where; 1. The individual has made a change in residence outside of the service area or continuation area or has experienced another change in circumstances as determined by Centers for Medicare & Medicaid Services (CMS) (other than termination for non-payment of premiums or disruptive behavior) that causes the individual to no longer be eligible to elect the Medicare Advantage plan; 2. CMS or the organization has terminated the Medicare Advantage organization's contract for the Medicare Advantage plan in the area in which the individual resides, or the organization has notified the individual of the impending termination of the plan or the impending discontinuation of the plan in the area in which the individual resides; 3. The individual demonstrates that the Medicare Advantage organization offering the Medicare Advantage plan substantially violated a material provision of its contract under Medicare Advantage in relation to the individual, or the Medicare Advantage organization (or its agent) materially misrepresented the plan when marketing the plan; 4. The individual is entitled to Medicare Part A and Part B and receives any type of assistance from Medi-Cal; or 5. The individual meets such other exceptional conditions as CMS may provide.

1

<Date>

<Name>
<Address>
<City>, <State> <ZIP>

<Name>:

We got your request to disenroll from OneCare Connect Cal MediConnect (Medicare-Medicaid Plan).

You'll be disenrolled from OneCare Connect on <**date**>. OneCare Connect will not pay for your Medi-Cal and Medicare health services and prescription drugs after <**date**>.

You'll be covered by Original Medicare starting <date>.

You'll get your Medicare health services through Original Medicare starting <date> if you don't enroll in a Medicare health plan. When you see a provider through Original Medicare, you should use your red, white, and blue Medicare card to get health care services.

If you have questions about Medicare plans in your area, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

IMPORTANT: You need to choose a Medicare Prescription Drug Plan. When OneCare Connect services end on <date>, OneCare Connect prescription drug coverage ends too. You can enroll in a Medicare Advantage plan that includes prescription drug coverage or a Medicare Prescription Drug Plan.

- If you don't select a new prescription drug plan, Medicare will enroll you in one.
- If you don't want to join a Medicare prescription drug plan, you must call 1-800- MEDICARE.
- If you need help comparing prescription drug plans or would like to discuss other enrollment choices, you can speak with a California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222, 8:00am to 4:00pm, 5 days a week.
- If you don't want California to enroll you in another Medicare-Medicaid Plan in the future, you must call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. If you have questions or would like to join a Medicare

Advantage or Medicare prescription drug plans, visit www.Medicare.gov, or call toll-free number 1- 800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You must choose a Medi-Cal health plan to get your Medi-Cal benefits.

You will continue to receive your Medi-Cal services, including Long Term Services and Supports (LTSS) that help with on-going personal care needs through CalOptima.

Your health coverage change will become effective soon.

It may take up to 45 days for your records to be updated. If your providers need to send claims, tell them that you just left OneCare Connect and there may be a short delay in updating your records.

Who should I call if I have questions about OneCare Connect?

If you have questions, call OneCare Connect Customer Service 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. You can visit www.caloptima.org/onecareconnect. You can also call OneCare Connect Customer Service at 1-855-705-8823.

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823. TTY users should call 1-800-735-2929. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week. For complaints, difficulty accessing care or other similar issues call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week.

If you have questions about Medicare or Medi-Cal?

- If you have questions about Medicare, visit www.Medicare.gov, or call toll free 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1- 877-486-2048.
- If you have questions about Medi-Cal call 1-800-281-9799, Monday - Friday 7:00 am - 5:00 pm.

For more information, visit www.caloptima.org/onecareconnect. **If you have questions**, call OneCare Connect at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Back to Agenda

Para más información, visite www.caloptima.org/onecareconnect. **Si tiene preguntas,** llame a OneCare Connect al 1-855-705-8823, las 24 horas al día, los 7 días de la semana. Usuarios de la línea TTY deben llamar al 1-800-735-2929. Esta llamada es gratuita. Puede obtener esta información gratis en otros idiomas y formatos, como en letra grande, braille y audio.

Để biết thêm chi tiết, xin vào thăm trang mạng www.caloptima.org/onecareconnect. **Nếu quý vị có thắc mắc,** hãy gọi OneCare Connect ở số 1-855-705-8823, 24 giờ một ngày, 7 ngày một tuần. Thành viên sử dụng máy TTY nên gọi ở số 1-800-735-2929. Cuộc gọi này là miễn phí. Quý vị có thể nhận thông tin này miễn phí bằng những ngôn ngữ và hình thức khác, như chữ in khổ lớn, chữ nổi Braille, và đĩa thu âm.

자세한 정보는 웹사이트 www.caloptima.org/onecareconnect 를 방문하십시오. **질문이 있으시면**, OneCare Connect 번호 1-855-705-8823 으로 주 7 일 24 시간 전화하십시오. TTY 사용자는 1-800-735-2929 로 전화하십시오. 통화는 무료입니다. 큰글자, 점자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실수 있습니다.

برای اطلاعات بیشتر، به سایت www.caloptima.org/onecareconnect **لطفاً اگر پرسشی دارید،** مراجعه نمایید. تماس 1-855-705-8823 از طریق شماره OneCare Connect طی 24 ساعت شبانه روز، در 7 روز هفته با تماس بگیرند. این تماس رایگان است. شما می توانید 1-800-735-2929کاربران TTY می توانند با شماره بگیرید. این اطلاعات را بطور رایگان در فرمهای دیگر، از قبیل چاپ درشت، خط بریل و صوتی دریافت کنید.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

Back to Agenda

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-855-705-8823** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم

1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Punjabi: ਧਿਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল্য কৱনঃ যিদ আপিন বাংলা, কথা বলেত পারেন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল আেছ। েফান কৱন **1-855-705-8823**(TTY: **1-800-735-2929**)

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Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

Back to Agenda

«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

«First1» «Last2»:

You're OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) coverage is ending. You'll no longer be in OneCare Connect as of «Term_date».

If you think there was a mistake:
If you didn't ask to leave OneCare Connect and want to stay in OneCare Connect, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929.

Who should I call if I have questions about OneCare Connect?

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. You can visit www.caloptima.org/onecareconnect. You can also call OneCare Connect Customer Service at 1-855-705-8823.

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week. For complaints, difficulty accessing care or other similar issues call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week.

For more information, visit www.caloptima.org/onecareconnect**. If you have questions,** call OneCare Connect at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

H8016_MM17_62 Approved (11/21/16)

Back to Agenda

Para más información, visite www.caloptima.org/onecareconnect. **Si tiene preguntas,** llame a OneCare Connect al 1-855-705-8823, las 24 horas al día, los 7 días de la semana. Usuarios de la línea TTY deben llamar al 1-800-735-2929. Esta llamada es gratuita. Puede obtener esta información gratis en otros idiomas y formatos, como en letra grande, braille y audio.

Để biết thêm chi tiết, xin vào thăm trang mạng www.caloptima.org/onecareconnect. **Nếu quý vị có thắc mắc,** hãy gọi OneCare Connect ở số 1-855-705-8823, 24 giờ một ngày, 7 ngày một tuần. Thành viên sử dụng máy TTY nên gọi ở số 1-800-735-2929. Cuộc gọi này là miễn phí. Quý vị có thể nhận thông tin này miễn phí bằng những ngôn ngữ và hình thức khác, như chữ in khổ lớn, chữ nổi Braille, và đĩa thu âm.

자세한 정보는 웹사이트 www.caloptima.org/onecareconnect 를 방문하십시오. **질문이 있으시면**, OneCare Connect 번호 1-855-705-8823 으로 주 7 일 24 시간 전화하십시오. TTY 사용자는 1-800-735-2929 로 전화하십시오. 통화는 무료입니다. 큰글자, 점자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실수 있습니다.

برای اطلاعات بیشتر، به سایت www.caloptima.org/onecareconnect **لطفاً اگر پرسشی دارید،** مراجعه نمایید. تماس 1-855-705-8823 از طریق شماره OneCare Connect طی 24 ساعت شبانه روز، در 7 روز هفته با تماس بگیرند. این تماس رایگان است. شما می توانید 1-800-735-2929کاربران TTY می توانند با شماره بگیرید. این اطلاعات را بطور رایگان در فرمهای دیگر، از قبیل چاپ درشت، خط بریل و صوتی دریافت کنید.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

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Back to Agenda

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-855-705-8823** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

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Back to Agenda

«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

«First1» «Last2»:

You've asked to be disenrolled from OneCare Connect Cal MediConnect (Medicare-Medicaid Plan). We can't process your request to disenroll from OneCare Connect because:

[You didn't send us the information we needed by «Due_Date_for_Requested_Info».

Or

The request was made by someone other than you and that person isn't your authorized representative.]

If you think we made a mistake or you have questions:

- If you have any questions about the information in this notice, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. The call is free. TTY users should call 1-800-735-2929.
- For questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week.
- For complaints, difficulty accessing care or other similar issues you can call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week for more questions about the enrollment.
- For information on your Medicare coverage, visit www.Medicare.gov, or call toll-free number1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

For more information, visit www.caloptima.org/onecareconnect. **If you have questions**, call OneCare Connect at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

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مراجعه نمایید. **اگر پرسشی دارید،** لطفاً www.caloptima.org/onecareconnect **برای اطلاعات بیشتر،** به سایت تماس 1-855-705-8823 از طریق شماره OneCare Connect طی 24 ساعت شبانه روز، در 7 روز هفته با تماس بگیرند. این تماس رایگان است. شما می توانید 1-800-735-2929 کاربران TTY می توانند با شماره بگیرید. این اطلاعات را بطور رایگان در فرمهای دیگر، از قبیل چاپ درشت، خط بریل و صوتی دریافت کنید.

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Back to Agenda

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Farsi:

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1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

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Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

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Back to Agenda

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

Back to Agenda

«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

«First1» «Last2»:

You're enrolled in OneCare Connect Cal MediConnect (Medicare-Medicaid Plan).
We've got your request to cancel your disenrollment from OneCare Connect. You'll continue to get your health and prescription drug services through OneCare Connect. Keep using OneCare Connect primary care providers for your health care services and a network pharmacy for your drugs.

IMPORTANT: You need to cancel other Medicare or prescription drug plan coverage before it starts.
If you've recently applied to join a Medicare health or prescription drug plan, but you want to remain in OneCare Connect, you must call the other plan and tell them to stop processing your application.

Who should I call if I have questions about OneCare Connect?
If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. You can visit www.caloptima.org/onecareconnect. You can also call OneCare Connect Customer Service at 1-855-705-8823.

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877-486-2048.

For more information, visit www.caloptima.org/onecareconnect**. If you have questions,** call OneCare Connect at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Para más información, visite www.caloptima.org/onecareconnect. **Si tiene preguntas,** llame a OneCare Connect al 1-855-705-8823, las 24 horas al día, los 7 días de la semana. Usuarios de la línea TTY deben llamar al 1-800-735-2929. Esta llamada es gratuita. Puede obtener esta información gratis en otros idiomas y formatos, como en letra grande, braille y audio.

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اگر پرسشی دارید، لطفاً www.caloptima.org/onecareconnect **برای اطلاعات بیشتر**، به سایت مراجعه نمایید. تماس 1-855-705-8823 از طریق شماره OneCare Connect طی 24 ساعت شبانه روز، در7 روز هفته با تماس بگیرند. این تماس رایگان است. شما می توانید 1-800-735-2929کاربران TTY می توانند با شماره بگیرید. این اطلاعات را بطور رایگان در فرمهای دیگر، از قبیل چاپ درشت، خط بریل و صوتی دریافت کنید.

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Back to Agenda

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Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

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Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

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ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم

1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পারেন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল আেছ। ফান করন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

Back to Agenda

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

Back to Agenda

«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

«First1» «Last2»:

IMPORTANT: Your health care & prescription drug coverage will change on «Effective_date».

On «Date_Notice_Sent», you were sent a notice asking if you moved out of the OneCare Connect service area. Because you didn't reply, you've been disenrolled from OneCare Connect on «Term_date». This means that beginning «Effective_date», OneCare Connect will no longer cover any health care services or prescription drugs you get.

To be a member of OneCare Connect, you must live in the OneCare Connect service area and can only temporarily leave the service area for up to 6 months in a row. This is because OneCare Connect is providing coverage to you as part of Cal-Medi Connect Program. The Cal-Medi Connect Program is not offered nationwide. This program is only offered through OneCare Connect in certain services areas within your State

You'll be covered by Original Medicare starting «Effective_date».

- You'll get your Medicare health care services through Original Medicare starting «Effective_date» if you don't enroll in a Medicare health plan. When you see a provider through Original Medicare, you should use your red, white, and blue Medicare card to get health care services.
- You have the option to enroll in another Medicare health plan. If you have questions about Medicare plans in your area, visit www.Medicare.gov, or call toll-free number 1- 800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You may need to choose a new Medicaid plan.
You will continue to receive your Medi-Cal benefits through CalOptima. If you moved to a different State, you'll need to apply for Medicaid in that State.

Your prescription drug coverage has also changed.
Your drug coverage through OneCare Connect ended on «Term_date». If you want prescription drug coverage, you need to join a Medicare Prescription Drug Plan or a Medicare Advantage plan with prescription drug coverage. If you don't choose a Medicare drug plan, Medicare will choose one for you.

You can join a new Medicare plan.
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If you don't agree with your disenrollment in OneCare Connect, you can file a grievance asking us to reconsider our decision. Please call OneCare Connect Customer Service at 1-855-705-8823. TTY users should call 1-800-735-2929 for information about how to file a grievance.

Who should I call if I have questions about OneCare Connect?
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If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week. For complaints, difficulty accessing care or other similar issues call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week.

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Back to Agenda

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Back to Agenda

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Back to Agenda

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Back to Agenda

800-735-2929. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Para más información, visite www.caloptima.org/onecareconnect. **Si tiene preguntas,** llame a OneCare Connect al 1-855-705-8823, las 24 horas al día, los 7 días de la semana. Usuarios de la línea TTY deben llamar al 1-800-735-2929. Esta llamada es gratuita. Puede obtener esta información gratis en otros idiomas y formatos, como en letra grande, braille y audio.

Để biết thêm chi tiết, xin vào thăm trang mạng www.caloptima.org/onecareconnect. **Nếu quý vị có thắc mắc,** hãy gọi OneCare Connect ở số 1-855-705-8823, 24 giờ một ngày, 7 ngày một tuần. Thành viên sử dụng máy TTY nên gọi ở số 1-800-735-2929. Cuộc gọi này là miễn phí. Quý vị có thể nhận thông tin này miễn phí bằng những ngôn ngữ và hình thức khác, như chữ in khổ lớn, chữ nổi Braille, và đĩa thu âm.

자세한 정보는 웹사이트 www.caloptima.org/onecareconnect 를 방문하십시오. **질문이 있으시면**, OneCare Connect 번호 1-855-705-8823 으로 주 7 일 24 시간 전화하십시오. TTY 사용자는 1-800-735-2929 로 전화하십시오. 통화는 무료입니다. 큰글자, 점자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실수 있습니다.

مراجعه نمایید. **اگر پرسشی دارید،** لطفاً www.caloptima.org/onecareconnect **برای اطلاعات بیشتر،** به سایت تماس 1-855-705-8823 از طریق شماره OneCare Connect طی 24 ساعت شبانه روز، در 7 روز هفته با تماس بگیرند. این تماس رایگان است. شما می توانید 1-800-735-2929 کاربران TTY می توانند با شماره بگیرید. این اطلاعات را بطور رایگان در فرمهای دیگر، از قبیل چاپ درشت، خط بریل و صوتی دریافت کنید.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

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Back to Agenda

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

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Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

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Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم

1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Punjabi: ਧਿਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল্য কৱনঃ যিদ আপিন বাংলা, কথা বলেত পাের্ন, তাহেল িনঃখৱচায় ভাষা সহায়তা পিৱেষবা উপল ৱোছ। ের্ফান কৱন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

Back to Agenda

[Exhibit 20: Model Notice for Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member)]

<Date>

<Name>
<Address>
<City>, <State> <ZIP>

<Name>:

IMPORTANT: Your health care & prescription drug coverage has changed.
Thank you for telling us your new address. Your permanent address is outside the OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) area. To stay a member of OneCare Connect, you must live in the OneCare Connect service area, but you can temporarily leave the service area for up to 6 months in a row. This is because OneCare Connect is providing coverage to you as part of Cal-Medi Connect Program. The Cal-Medi Connect Program is not offered nationwide. This program is only offered through OneCare Connect in certain services areas within your State. You will no longer be a member of OneCare Connect as of <**disenrollment effective date**>. Because you've been disenrolled, OneCare Connect won't cover any health care services or prescription drugs you get after <**effective date**>.

You'll be covered by Original Medicare starting <effective date>.

- You'll get your Medicare health care services through Original Medicare starting <**effective date**> if you don't enroll in a Medicare health plan. When you see a provider through Original Medicare, you should use your red, white, and blue Medicare card to get health care services.
- You have the option to enroll in another Medicare health plan. If you have questions about Medicare plans in your area, visit www.Medicare.gov, or call toll-free number 1- 800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You may need to choose a new Medicaid plan.
You will continue to receive your Medi-Cal benefits through CalOptima. If you moved to a different State, you'll need to apply for Medicaid in that State.

Your prescription drug coverage has also changed.
Your drug coverage through OneCare Connect ended on <**effective date**>. If you want prescription drug coverage, you need to join a Medicare Prescription Drug Plan or a Medicare

Advantage plan with prescription drug coverage. If you don't choose a Medicare drug plan, Medicare will choose one for you.

You can join a new Medicare plan.
If you don't want health coverage through Original Medicare, you can join a new plan that serves the area where you now live. Call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week for information about plans that serve your area. TTY users should call 1-877-486-2048.

What to do if you disagree with your disenrollment from OneCare Connect.
If you don't agree with your disenrollment in OneCare Connect, you can file a grievance asking us to reconsider our decision. Please call OneCare Connect Customer Service at 1-855-705-8823. TTY users should call 1-800-735-2929 for information about how to file a grievance.

If you've moved, you must also tell Social Security & Medi-Cal your new address.
If you've moved, call Social Security at 1-800-772-1213 (Monday to Friday 7am – 7pm) and tell them your new address. TTY users should call 1-800-325-0778. The call is free. You can also change your address and phone number by going to my Social Security account at: https://www.ssa.gov/myaccount/. You can also OneCare Connect Customer Service at 1-855-705-8823. TTY users should call 1-877-486-2048.

Call Medi-Cal at 800-772-1213 to tell them your new address and to find out your choices for getting Medicaid benefits. If you've already called Social Security and Medicaid and told them your new address, you don't need to call again.

Who should I call if I have questions about OneCare Connect?
If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. You can visit www.caloptima.org/onecareconnect. You can also call OneCare Connect Customer Service at 1-855-705-8823.

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week. For complaints, difficulty accessing care or other similar issues call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week.

For information on your Medicare coverage, visit www.Medicare.gov , or call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate

Back to Agenda

on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-855-705-8823** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم

1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Back to Agenda

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পারেন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল আেছ। ফান করন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

Back to Agenda

«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

«First1» «Last2»:

Your health & prescription drug coverage is changing.
[Insert if individual lost Medicaid status: Your OneCare Connect health and prescription drug coverage will end on «Term_date» because you no longer qualify for Medi-Cal. OneCare Connect can cover your health and prescription drug benefits only if you're eligible for both Medicare and Medi-Cal.]

[Insert if individual lost State-specific status: Your OneCare Connect health and prescription drug coverage will end on «Term_date» because you no longer qualify to be enrolled OneCare Connect. OneCare Connect can cover your health and prescription drug benefits only if you're eligible for both Medicare and Medi-Cal and meet state-specific eligibility criteria.]

You'll be in Original Medicare and have a Medicare Prescription Drug Plan.

- When your OneCare Connect services end on «Term_date», OneCare Connect prescription drug coverage ends too. Medicare will enroll you in Original Medicare and in a Medicare Prescription Drug Plan.
- If you need help comparing prescription drug plans or would like to discuss other enrollment choices, you can speak with a your California Health Insurance Counseling & Advocacy Program (HICAP) counselor at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week.
- If you have questions or don't want Medicare to enroll you in a drug plan, you must call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- **If you need to fill any covered prescriptions before your new Medicare Prescription Drug Plan coverage starts**, call Medicare's Limited Income NET program (also called LINET) at 1-800-783-1307, Monday through Friday, 5:00 a.m. to 8:00 p.m. PST. TTY users should call 1-877-801-0369. The call is free. You can also visit www.humana.com/pharmacists.

What to do if you want stay in OneCare Connect.

OneCare Connect can only cover your health services until «Term_date». If you think you might still qualify for Medi-Cal, please call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. This call is free. If you have questions about how to re-apply for Medi-Cal call 1-800-281-9799, Monday - Friday 7:00 am - 5:00 pm.

You can join another Medicare plan if you don't get your Medicaid back.

- Because you no longer qualify for Medi-Cal and you're no longer eligible for OneCare Connect after «Term_date» due to you losing your Medicaid, you have up to 2 months after «Term_date» to join a Medicare health plan or Medicare prescription drug plan.
- Your new Medicare coverage will begin the 1st of the following month after you enrolled in a new Medicare health plan or Prescription Drug plan. If you don't take any action, OneCare Connect will continue to cover your Medicare benefits until «Term_date».
- You can only make changes to your Medicare Prescription Drug Plan or Medicare health plan coverage during Open Enrollment. Open Enrollment happens every year from October 15 through December 7.
- There are exceptions to when you can make changes. You can leave a plan at other times during the year if:
  - You move out of the plan's service area,
  - You want to join a plan in your area with a 5-star rating, or
  - You qualify for Extra Help paying for prescription drug coverage. If you are getting Extra Help with your prescription drug costs, you may join or leave a plan at any time. If your Extra Help ends, you can still make a change for two months after you find out that you are not getting Extra Help.

Who should I call if I have questions about OneCare Connect?
If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. You can visit www.caloptima.org/onecareconnect. You can also call OneCare Connect Customer Service at 1-855-705-8823.

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Back to Agenda

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باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

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Back to Agenda

(الهاتف النصي/خط الاتصال لضعاف السمع **1-855-705-8823**) (**1-800-735-2929**: TTY

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

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Back to Agenda

«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

Important Information – Keep This Notice for Your Records

«First1» «Last2»:

You no longer qualify for OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan).
OneCare Connect, your Cal MediConnect plan, can no longer cover your health and prescription drug benefits because you are no longer eligible for Medi-Cal.

Even though you're no longer eligible for Medi-Cal, you may keep getting your benefits from OneCare Connect until «Term_Date». To stay a member of OneCare Connect, you must qualify for Medi-Cal again by «Term_Date».

If you believe you are still eligible for Medi-Cal, you must contact your county social worker at 1-800-281-9799 immediately.

How long will I have coverage?
OneCare Connect will keep covering your Medicare-Medi-Cal plan benefits until «Term_Date». You have until «Term_Date» to again qualify for Medi-Cal.

Which services will not be covered?
Cal MediConnect does not cover dental services offered by the Denti-Cal program and Mental Health Services offered by the county. These are Medi-Cal benefits covered outside of the Cal MediConnect program. Because you are no longer eligible for Medi-Cal, you may not be eligible for Denti-Cal or County Mental Health Services. To verify coverage of these benefits please contact your county social worker at 1-800-281-9799.

When will my coverage end?

If you don't qualify for Medi-Cal by «Term_Date», you'll be disenrolled from OneCare Connect and you'll get coverage through Original Medicare and a Medicare Prescription Drug Plan starting «Effective_Date».

What do I do if my coverage ends?
If you're disenrolled from OneCare Connect, Medicare will enroll you in Original Medicare and a Medicare Prescription Drug Plan. You don't need to do anything for this to happen. If you don't want Medicare to enroll you in a drug plan or if you have questions, call 1-800-MEDICARE(1-800-633-4227), 24 hours a day, 7 days a week. Call 1-877-486-2048 if you use TTY.

You can also contact OneCare Connect to find out about other Medicare health or Prescription Drug Plans that they offer based on your Medicare or Medi-Cal eligibility. Please call OneCare Connect's Customer Service for more information at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users should call 1-800-735-2929..

Can I join another Medicare plan?
Yes. Because you no longer qualify for Medi-Cal and are no longer eligible for OneCare Connect after «Term_Date», you have a special opportunity to join a Medicare health or Prescription Drug Plan. This opportunity begins now and ends when you enroll in a different plan or on «M_2Mos_after_term_date», whichever is earlier. If you choose this option, your new Medicare health or drug coverage will begin the 1st day of the following month after you enroll in the new plan.

After «M_2Mos_after_term_date»**, you can only make changes to your Medicare coverage during certain times of the year.** From October 15 through December 7 each year, you can enroll in a new Medicare health or Prescription Drug Plan for coverage starting January 1 of the following year.

Can I join another Medicare plan at some other time?
Yes. You can leave a plan and join a new one at other times during the year for special reasons, including:

- You move out of the plan's service area.
- You want to join a plan with a 5-star rating in your area.
- You qualify for Extra Help paying for prescription drug coverage. If you're getting Extra Help with your drug costs, you may join or leave a plan at any time. If your Extra Help ends, you can still make a change for 2 months after you find out you're no longer getting Extra Help.

Back to Agenda

Who should I contact if I have questions?
For questions about OneCare Connect:

- Call OneCare Connect Customer Service at **1-855-705-8823**, 24 hours a day, 7 days a week..
- Call 1-800-735-2929 if you use TTY.
- Visit www.caloptima.org/onecareconnect.

For questions about **Medicare**:

- Call 1-800-633-4227 (1-800-MEDICARE), 24 hours a day, 7 days a week.
- Call 1-877-486-2048 if you use TTY.
- Visit the Medicare home page at http://www.medicare.gov.

For questions about your **Medi-Cal eligibility,** call 1-800-281-9799.

Get free help with Cal MediConnect plan problems and complaints by calling the Cal MediConnect Ombudsman at 1-855-501-3077, Monday to Friday, 9 a.m. to 5 p.m.**. Call 1-855-847-7914 if you use TTY. The call is free.**

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

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Back to Agenda

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Back to Agenda

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Back to Agenda

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Back to Agenda

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Back to Agenda

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Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم

1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Back to Agenda

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পারেন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল আেছ। ফান করন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

Back to Agenda

[Exhibit 24: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination]

<Date>

<Name>
<Address>
<City>, <State> <ZIP>

<Name>:

[IMPORTANT: Your Medicare coverage has been corrected.]
Or
[IMPORTANT: Your Medicare coverage may end. Act now.]

We learned that your Medicare coverage has ended as of <**date**>. You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of OneCare Connect.

Social Security and Medicare will correct your record.

Or

To stay in OneCare Connect, do these 2 things no later than <insert the date that is 60 days from date of disenrollment notice>:

1. Call Social Security at 1-800-772-1213 (Monday to Friday 7am – 7pm) to have them fix your records. TTY users should call 1-800-325-0778. Ask Social Security to give you a notice that says they've fixed your records.
2. Send a copy of Social Security's letter to your County Social Services Eligibility Worker.
3. When we get this notice, we'll share this information with Medicare and Medicaid.

Please keep using your OneCare Connect primary care providers for your health care services and your network pharmacy while your record is being corrected by Social Security and Medicare.

If you don't have Medicare Part [**insert "A" and/or "B" as appropriate**], or if you don't send proof that you have Medicare by [**insert date: 60 days from date of disenrollment notice**], you'll have to pay for any health care service and prescription drug coverage you got after <**disenrollment date**>.

If you have any questions about this notice, call Social Security at 1-800-772-1213 (Monday to

Friday 7am – 7pm) to have them fix the error in your records. TTY users should call 1-800-325-0778.

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823. TTY users should call 1-800-735-2929. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week. For complaints, difficulty accessing care or other similar issues, call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week. For more information, visit www.caloptima.org/onecareconnect**.**

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-855-705-8823** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

H8016_MM17_70

Back to Agenda

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H8016_MM17_70

Back to Agenda

«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

«First1» «Last2»:

You've been re-enrolled in OneCare Connect as of «Effective_date».

Thank you for letting us know you still want to be a member of OneCare Connect. By mistake, we [**select one based on the circumstance: disenrolled you from or cancelled your enrollment in**] our plan. [**Insert brief summary of the State/plan error that caused the disenrollment.**] We've corrected our records to show that you're still a member of OneCare Connect.

Please keep using your OneCare Connect primary care providers for your health services and network pharmacy for your prescriptions.

Keep using the OneCare Connect plan
Below are instructions on how to access the following items you already got when you were enrolled before:

- List of Covered Drugs (also called a "formulary") *[visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.]*
- Provider and Pharmacy Directory *[visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.]*
- Member Handbook (Evidence of Coverage) *[visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.]*
- Summary of Benefits with the welcome mailing: Summary of Benefits *[visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.]*

Who should I call if I have questions about OneCare Connect?

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. You can visit www.caloptima.org/onecareconnect. You can also call OneCare Connect Customer Service at 1-855-705-8823.

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week. For complaints, difficulty accessing care or other similar issues call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week. For more information, visit www.caloptima.org/onecareconnect.

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Farsi:

Back to Agenda

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

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Back to Agenda

«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

«First1» «Last2»:

The state has enrolled you back in OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) as of «Effective_date».
There will be no break in your health services and prescription drug coverage. You should keep using OneCare Connect primary care providers for your health care services and network pharmacy for your prescription drugs.

Keep using the OneCare Connect Member ID Card that you currently have.

Below are instructions on how to access the following items you already got when you were enrolled before:

- List of Covered Drugs (also called a "formulary"): visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.
- Provider and Pharmacy Directory: visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.
- Member Handbook (Evidence of Coverage: visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.
- Summary of Benefits with the welcome mailing: Summary of Benefits: visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.

Who should I call if I have questions about OneCare Connect?
If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. You can visit www.caloptima.org/onecareconnect.

If you have questions, call OneCare Connect at 1-855-705-8823. TTY users should call 1-800-735-292. For general questions about other enrollment choices, you can also call your

California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week.. For complaints, difficulty accessing care or other similar issues you can call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week.

For more information, visit www.caloptima.org/onecareconnect. **If you have questions**, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Para más información, visite www.caloptima.org/onecareconnect. **Si tiene preguntas,** llame a OneCare Connect al 1-855-705-8823, las 24 horas al día, los 7 días de la semana. Usuarios de la línea TTY deben llamar al 1-800-735-2929. Esta llamada es gratuita. Puede obtener esta información gratis en otros idiomas y formatos, como en letra grande, braille y audio.

Để biết thêm chi tiết, xin vào thăm trang mạng www.caloptima.org/onecareconnect. **Nếu quý vị có thắc mắc,** hãy gọi OneCare Connect ở số 1-855-705-8823, 24 giờ một ngày, 7 ngày một tuần. Thành viên sử dụng máy TTY nên gọi ở số 1-800-735-2929. Cuộc gọi này là miễn phí. Quý vị có thể nhận thông tin này miễn phí bằng những ngôn ngữ và hình thức khác, như chữ in khổ lớn, chữ nổi Braille, và đĩa thu âm.

자세한 정보는 웹사이트 www.caloptima.org/onecareconnect 를 방문하십시오. **질문이 있으시면**, OneCare Connect 번호 1-855-705-8823 으로 주 7 일 24 시간 전화하십시오. TTY 사용자는 1-800-735-2929 로 전화하십시오. 통화는 무료입니다. 큰글자, 점자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실수 있습니다.

برای اطلاعات بیشتر، به سایت www.caloptima.org/onecareconnect لطفاً **اگر پرسشی دارید**، مراجعه نمایید. تماس 1-855-705-8823 از طریق شماره OneCare Connect طی 24 ساعت شبانه روز، در7 روز هفته با تماس بگیرند. این تماس رایگان است. شما می توانید 1-800-735-2929کاربران TTY می توانند با شماره بگیرید. این اطلاعات را بطور رایگان در فرمهای دیگر، از قبیل چاپ درشت، خط بریل و صوتی دریافت کنید.

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Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-855-705-8823** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:
ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم
1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল□য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পা◌েরন, তাহেল ি◌নঃখরচায় ভাষা সহায়তা পিরেষবা উপল□ আেছ। ◌েফান করন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

«First1» «Last2»:

IMPORTANT: We need your address.

If you don't contact us to verify your address, you will be disenrolled from OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) effective «DER_eff_date». This means that you will no longer be able to get health services or prescription drug coverage through OneCare Connect as of «DER_eff_date».

If you've moved, you may no longer live in OneCare Connect's service area. Please provide your new address by «M_1_day_prior»**.**

- **How to provide your address**
  Call **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users should call 1-800-735-2929. The call is free.
- Fill out the "Address Verification Form" and return it in the enclosed envelope or by fax.

Your permanent address must be inside OneCare Connect's service area.

You can be away from OneCare Connect's service area for up to 6 months in a row and still stay a member of OneCare Connect. If you move and your new address is outside the service area, or if you leave the area for more than 6 months in a row, you'll be disenrolled from OneCare Connect's health services and prescription drug coverage. If you're disenrolled, you may be able to join a plan that serves the area where you now live.

You must also tell Social Security about your address change.

If you've moved and haven't told Social Security your new address, call toll-free number 1-800-772-1213 (Monday to Friday 7am – 7pm). TTY users should call 1-800-325-0778. The call is free. You can also change your address and phone number by going to my Social Security account at: https://www.ssa.gov/myaccount/

Who should I call if I have questions about OneCare Connect?

If you have questions, you can visit www.caloptima.org/onecareconnect or call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929.

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929.. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 24 hours a day, 7 days a week. For complaints, difficulty accessing care or other similar issues you can contact your California Ombudsman at 1-855-501-3077, 24 hours a day, 7 days a week

For more information, visit www.caloptima.org/onecareconnect. **If you have questions,** call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Para más información, visite www.caloptima.org/onecareconnect. **Si tiene preguntas,** llame a OneCare Connect al 1-855-705-8823, las 24 horas al día, los 7 días de la semana. Usuarios de la línea TTY deben llamar al 1-800-735-2929. Esta llamada es gratuita. Puede obtener esta información gratis en otros idiomas y formatos, como en letra grande, braille y audio.

Để biết thêm chi tiết, xin vào thăm trang mạng www.caloptima.org/onecareconnect. **Nếu quý vị có thắc mắc,** hãy gọi OneCare Connect ở số 1-855-705-8823, 24 giờ một ngày, 7 ngày một tuần. Thành viên sử dụng máy TTY nên gọi ở số 1-800-735-2929. Cuộc gọi này là miễn phí. Quý vị có thể nhận thông tin này miễn phí bằng những ngôn ngữ và hình thức khác, như chữ in khổ lớn, chữ nổi Braille, và đĩa thu âm.

자세한 정보는 웹사이트 www.caloptima.org/onecareconnect 를 방문하십시오. **질문이 있으시면**, OneCare Connect 번호 1-855-705-8823 으로 주 7 일 24 시간 전화하십시오. TTY 사용자는 1-800-735-2929 로 전화하십시오. 통화는 무료입니다. 큰글자, 점자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실수 있습니다.

برای اطلاعات بیشتر، به سایت www.caloptima.org/onecareconnect **لطفاً اگر پرسشی دارید،** مراجعه نمایید. تماس 1-855-705-8823 از طریق شماره OneCare Connect طی 24 ساعت شبانه روز، در 7 روز هفته با تماس بگیرند. این تماس رایگان است. شما می توانید 1-800-735-2929 کاربران TTY می توانند با شماره بگیرید. این اطلاعات را بطور رایگان در فرمهای دیگر، از قبیل چاپ درشت، خط بریل و صوتی دریافت کنید.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate

H8016_MM

Back to Agenda

on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)

Vietnamese: CHÚ Ý: Nếu bạn nói T

iếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

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Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

H8016_MM

Back to Agenda

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

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ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم

1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পা েরন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল ে আছ। ে ফান করন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

H8016_MM

Back to Agenda

Address Verification Form

What is your permanent address?

Provide the permanent address where you live. This can't be a P.O. box.

Address

City State Zip Code

County Phone

What is your temporary address?

(You may skip this section if you're living at your permanent address.)
Provide your temporary address. This can't be a P.O. box.

Address

City State Zip Code

County Phone

When did you begin living at this address?
When do you think you'll go back to your permanent address?

Where you would like to get your mail?

Address

City State Zip Code

Send us the form in one of two ways:

1. Mail your completed form to OneCare Connect 505 City Parkway West, Orange, CA 92868.
2. Fax your completed form to 714-246-8580.

For more information, visit www.caloptima.org/onecareconnect. **If you have questions**, call OneCare Connect at 1-855-705-8823, 24 hours a day, 7 days a week. The call is free.

H8016_MM

Back to Agenda

H8016_MM

Back to Agenda

«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

Important Information – Keep This Notice for Your Records

«First1» «Last2»:

You no longer qualify for OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan).
OneCare Connect, your Cal MediConnect plan, can no longer cover your health and prescription drug benefits because you are no longer eligible. This may be for one of the following reasons:

1. Your Medi-Cal eligibility status has changed; or

2. We got information that you may have moved out of OneCare Connect's service area.

If you believe you are still eligible for Cal MediConnect, you must contact your Orange County Social Services Agency at 1-800-281-9799 (Monday through Friday, 8 a.m. to 5 p.m.) immediately. TDD/TTY users can call 1-800-735-2929.

Even though you're no longer eligible for Cal MediConnect, you may keep getting your benefits from OneCare Connect until **«Term_date».** To stay a member of OneCare Connect, you must qualify for Cal MediConnect again by «Term_date».

How long will I have coverage?
OneCare Connect will keep covering your benefits until **«Term_date»**. You have until **«Term_date»** to again qualify for Cal MediConnect.

When will my coverage end?
If you don't qualify for Cal MediConnect by **«Term_date»**, you'll be disenrolled from OneCare Connect and you'll get coverage through Original Medicare and a Medicare Prescription Drug Plan starting **«Effective_date»**.

If you don't contact us to confirm your address or your change in Medi-Cal eligibility status, you will be disenrolled from OneCare Connect effective «Term_date». This means that you will no longer be able to get health services or prescription drug coverage through OneCare Connect as of this date.

If you've moved, you may no longer live in OneCare Connect's service area. Please provide your new address by **«Term_date»** in one of the following ways:

1. Call 1-855-705-8823, 24 hours a day, 7 days a week. TDD/TTY users should call 1-800-735-2929.; or

2. Contact Orange County Social Services Agency at 1-800-281-9799 (Monday through Friday, 8 a.m. to 5 p.m.) immediately. TDD/TTY users can call 1-800-735-2929. immediately.

Your permanent address must be inside OneCare Connect's service area.
The state has indicated that you have moved outside OneCare Connect's service area. You'll be disenrolled from OneCare Connect's health services and prescription drug coverage on **«Term_date»**, unless you call your Orange County Social Services Agency at 1-800-281-9799 (Monday through Friday, 8 a.m. to 5 p.m.) TDD/TTY users can call 1-800-735-2929 to indicate you still live in OneCare Connect's service area. If you have moved, you'll be able to join a plan that serves the area where you now live.

You must also tell Social Security & your Medi-Cal County Eligibility Office about your address change.
If you've moved and haven't told Social Security your new address, call 1-800-772-1213, Monday through Friday from 7:00 a.m. to 7:00 p.m. Call 1-800-325-0778 if you use TTY. Also, call your Medi-Cal County Eligibility Office at 1-800-281-9799 (Monday through Friday, 8 a.m. to 5 p.m.) TDD/TTY users can call 1-800-735-2929 to tell them your new address and to find out your options for getting Medi-Cal benefits.

What do I do if my coverage ends?
If you're disenrolled from OneCare Connect, Medicare will enroll you in Original Medicare and a Medicare Prescription Drug Plan. You don't need to do anything for this to happen. If you don't want Medicare to enroll you in a drug plan or if you have questions, call 1-800-MEDICARE
(1-800-633-4227), 24 hours a day, 7 days a week. Call 1-877-486-2048 if you use TTY.

You can also contact OneCare Connect to find out about other Medicare health or Prescription Drug Plans that they offer based on your Medicare or Medi-Cal eligibility. Please call OneCare

Back to Agenda

Connect's Customer Service for more information at 1-855-705-8823, 24 hours a day, 7 days a week. TDD/TTY users should call 1-800-735-2929.

After «M_2_mons_after_term_date», you can only make changes to your Medicare coverage during certain times of the year. From October 15 through December 7 each year, you can enroll in a new Medicare health or Prescription Drug Plan for coverage starting January 1 of the following year.

Can I join another Medicare plan at some other time?
Yes. You can leave a plan and join a new one at other times during the year for special reasons, including:

- You move out of the plan's service area.
- You want to join a plan with a 5-star rating in your area.
- You qualify for Extra Help paying for prescription drug coverage. If you're getting Extra Help with your drug costs, you may join or leave a plan at any time. If your Extra Help ends, you can still make a change for 2 months after you find out you're no longer getting Extra Help.

Who should I contact if I have questions?
For questions about OneCare Connect:

Call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week.

- Visit www.caloptima.org/onecareconnect..

For questions about **Medicare**:

- Call 1-800-633-4227 (1-800-MEDICARE), 24 hours a day, 7 days a week.
- Call TTY 1-877-486-2048 if you use TTY.
- Visit the Medicare home page at http://www.medicare.gov.

For questions about your **Medi-Cal eligibility**, call
Orange County Social Services Agency at 1-800-281-9799 (Monday through Friday, 8 a.m. to 5 p.m.) TDD/TTY users can call 1-800-735-2929.

Back to Agenda

Get free help with Cal MediConnect plan problems and complaints by calling the Cal MediConnect Ombudsman at 1-855-501-3077. The call is free.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

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Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):

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توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
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Back to Agenda

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注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:
ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**) **1-855-705-8823**

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল্য় করনঃ যিদ আপিন বাংলা, কথা বলেত পারেন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল ে আছ। ফান করন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

Back to Agenda

CalOptima Board Action Agenda Referral

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for remaining Intergovernmental Transfers (IGT) 2 and 3 recuperative care program funds, in an amount not to exceed $619,300, less any recuperative care funds paid from this pool to hospitals subsequent to July 31, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Authority (OCHCA) to utilize remaining IGT 2 and 3 Recuperative Care IGT project funds for recuperative care under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members; and
3. Authorize expanded use of the above-referenced CalOptima IGT recuperative care funds to include CalOptima Medi-Cal members referred to the County's recuperative care services program from a broader range of settings, including but not limited to, nursing homes and clinics and from public health nurses, in addition to those referred from the CalOptima contracted hospital setting, subject to amendment of the Department of Health Care Services (DHCS)/County of Orange WPC Pilot Contract ("DHCS/County Contract"), or other written approval from DHCS, reflecting this broader range of settings.

Background

Recuperative Care is a program that provides short-term shelter with medical oversight and case management to homeless persons who are recovering from an acute illness or injury and whose conditions would be exacerbated by living on the street.

At its December 4, 2014, and October 1, 2015, meetings, the CalOptima Board of Directors authorized the expenditure of IGT funds for recuperative care services for Medi-Cal members and amendment of hospital contracts to facilitate referrals to and limited reimbursement for recuperative care services. As a result, CalOptima currently provides reimbursement to contracted hospitals for recuperative care services at a rate of up to $150 per day for up to 15 days per member. The total amount of IGT funds that have been allocated for recuperative care is $1,000,000, with $500,000 from IGT 2 and $500,000 from IGT 3. The program launched in May 2015 and as of July 31, 2017, $380,700 has been spent.

The current CalOptima recuperative care program is available for homeless CalOptima members immediately upon discharge from an inpatient hospitalization or emergency room visit and includes: temporary shelter, medical oversight, case management/social services, meals and supplies, referral to safe housing or shelters upon discharge, and communication and follow-up with referring hospitals.

Back to Agenda

On December 30, 2015, DHCS received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015, to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

Since the beginning of 2016, OCHCA has collaborated with other county agencies, hospitals, community clinics, community-based organizations, CalOptima and others to design and submit an application to DHCS for WPC in Orange County. The WPC application, approved by DHCS in October 2016, includes provisions for recuperative care. The WPC recuperative care program serves CalOptima members discharged from hospitals (inpatient stays and emergency room visits) and skilled nursing facilities, as well as those directly referred from clinics and OCHCA public health nurses. The DHCS/County Contract, executed in June 2017, states that "if the beneficiary is being admitted into recuperative care directly from a hospital contracted with CalOptima, CalOptima will pay [assuming available funds] for up to 15 days of recuperative care, depending on the medical need. The WPC will pick up payment for recuperative/respite care after CalOptima stops payment up to day 90 of the beneficiary's stay. If the beneficiary is admitted from a non-hospital setting, then the WPC pilot will be responsible for reimbursement for the entire 90-day stay."

Discussion

WPC Pilots must include strategies to increase integration among county agencies, health plans, providers, and other entities within each participating county. Orange County's WPC Pilot is intended to focus on improving outcomes for participants who are homeless and frequently visit local hospital emergency departments. By leveraging existing programs and offering new and enhanced services, the intent of the WPC pilot is to improve access to medical care, social services and housing for participants. Over the course of the program, the WPC Pilot is expected to reduce emergency department and hospital visits, increase visits to primary care/other providers and help participants find permanent housing.

Recuperative care is a critical component of Orange County's WPC Pilot. Depending on member need, as determined on a case-by-case basis, the County's recuperative care program will be responsible for paying for recuperative care services for up to 90 days and is available for homeless Medi-Cal members being discharged from hospitals and skilled nursing facilities. Further, it is available to homeless Medi-Cal members referred by a clinic or public health nurses who might otherwise go to the hospital for care that could be provided in a residential or clinic setting. As indicated above, pursuant to the terms of the DHCS/County Contract, funds provided by CalOptima are only being used for up to the first 15 days of WPC services to Medi-Cal beneficiaries who are being admitted into recuperative care directly from a hospital contracted with CalOptima.

Hospitals currently participating in CalOptima's recuperative care IGT initiative have entered into a Recuperative Care addenda to their existing CalOptima contracts. This allows hospitals to receive reimbursement from CalOptima for up to 15 days of recuperative care at up to $150 per day. As proposed, staff is seeking authority to redirect remaining CalOptima IGT 2 and 3 recuperative care

funding from CalOptima's existing hospital-based program to the County's WPC program. While the WPC permits stays of up to 90 days, the County must "pick up payment for recuperative/respite care after CalOptima stops payment." Consistent with the WPC Pilot, CalOptima would continue to make the IGT funds allocated for recuperative care available up to a maximum of $150/day for up to 15 days per member for qualifying members transitioning to recuperative care from a hospital setting, contingent upon member need and availability of funds, pursuant to the program approved by DHCS. Qualifying recuperative care services resulting from referrals from skilled nursing facilities, clinics, and public health nurses are currently the financial responsibility of the County, and the current DHCS/County Contract indicates that CalOptima is not involved in funding recuperative care services for Members entering recuperative care from these settings.

Staff seeks authority to enter into a grant agreement with the County to redirect the remaining available IGT 2 and 3 recuperative care funds to the County's recuperative care program as discussed above. As a part of the grant agreement, the reimbursement process for recuperative care will be changed. Hospitals will no longer be expected to directly pay for and then seek reimbursement from CalOptima for referrals of homeless CalOptima members to recuperative care. As proposed, OCHCA will invoice CalOptima for up to the first 15 days of recuperative care services referred from a hospital or emergency room (at a rate of up to $150/day).

Once the grant agreement with the County is in place, CalOptima contracted hospitals will no longer be eligible to obtain reimbursement for recuperative care services from CalOptima for the duration of the WPC Pilot. However, until such time, to the extent that funds remain available, CalOptima will continue to reimburse hospitals that bill CalOptima directly for reimbursement for qualifying members. CalOptima and OCHCA staff will coordinate and maintain processes to ensure no duplication of payments.

As indicated, CalOptima funding for the program is limited to those funds remaining from those allocated to the existing CalOptima recuperative care program operated through its contracted hospitals, and invoice payments will be made only until those funds are exhausted.

Potential Broadening of Eligibility Categories. While the current DHCS/County Contract specifies that CalOptima funds are to be used exclusively for homeless members discharged from CalOptima-contracted hospitals to a recuperative care setting, the County is proposing to allow for the use of CalOptima funds for services to members admitted to recuperative care from other settings including skilled nursing facilities and clinics and by public health nurses, in addition to members referred from contracted hospitals. This proposed approach could increase the flexibility in administration of the program, and broaden the range of members covered by the allocated funding. Staff is requesting, subject to amendment of the DHCS/County Contract, that the Board authorize broader use of the remaining IGT 2 and 3 funds allocated for recuperative care, consistent with an amendment of the DHCS/County Contract, or other written approval from DHCS, allowing such use of CalOptima funds. As proposed, the maximum $150 daily payment rate and 15 day maximum stay currently applicable to referrals from contracted hospitals would also apply to referrals from such additional sources.

Back to Agenda

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Of the $1.0 million in IGT funds approved by the Board for recuperative care, remains available as of July 31, 2017. Payments for recuperative care services provided under this staff recommendation are contingent upon availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working "Better. Together." CalOptima, as the community health plan for Orange County, is committed to working with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services for Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 4, 2014, Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
2. Board Action dated October 1, 2015, Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion

Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

Back to Agenda

CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose, and authorize hospital contract amendments as necessary to implement the proposed modifications to the recuperative care program.

Rev. 10/1/15

Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

Back to Agenda

- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

Back to Agenda

These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

/s/ Michael Schrader — **Authorized Signature**

9/25/2015 — **Date**

Back to Agenda

IGT Progress Report and Proposal

Board of Directors Meeting
October 1, 2015

Lindsey Angelats
Dir, Strategic Development

Back to Agenda

IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

Back to Agenda

Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

Back to Agenda

IGT Investment Parameters and Requirements

- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

Back to Agenda

Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents ~~23%~~ between 2-3% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

Back to Agenda

Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

Back to Agenda

Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

Back to Agenda

Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

Back to Agenda

IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

Back to Agenda

policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

Back to Agenda

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

Back to Agenda

Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — *8/31/2017*
Authorized Signature — **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Specific to the CalOptima PACE Program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an amendment of the Program of All Inclusive Care (PACE) contract between CalOptima and the Regents of the University of California on behalf of the University of California Irvine, School of Medicine, Geriatric Program (UCI) for physician and non-physician medical practitioner (NPMP) services to amend the scope of work, compensation terms, and to add an incentive program, upon regulatory approval.
2. Establish maximum hourly rates for PACE Physician and Non-physician Providers.
3. Authorize the implementation of an incentive program for UCI PACE PCP services, in accordance with the attached CalOptima PACE PCP Incentive Program Grid, subject to any necessary regulatory agency approval.
4. Authorize contracting with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent participants from unnecessarily being confined to an institution and to maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents

The PACE program requires that a number of services are provided at a PACE Center. The Center is a medically-intensive care coordination facility that provides a number of services, including Primary Care, to participants.

At the November 3, 2011 Board of Directors Meeting, Staff received authorization to enter into new provider and vendor contracts as necessary for the operation of PACE. CalOptima subsequently executed a contract with UCI to provide Primary Care services at the PACE center effective March 15, 2013 ("Contract"). Compensation to UCI for this service is on an hourly basis. Subsequently, the Contract was amended in October of 2013 to add on-call services and in December of 2013 to revise

Back to Agenda

the hourly rate. In July 2014, the Contract was amended to revise the hourly rate and to add an hourly rate for non-physician medical practitioners (NPMPs).

UCI's Department of Family Medicine Division of Geriatric Medicine and Gerontology has provided Primary Care services to PACE since the opening of the Center. The Department not only provides expertise in geriatric medicine but also a significant amount of staffing depth with currently eleven faculty members. It also provides the opportunity for geriatric fellows and residents to experience care in a PACE setting. This is positive for UCI in attracting fellows, resident and faculty. It is a benefit for Orange County in that physicians often remain in the area where they train. And it is a benefit for CalOptima PACE in that members receive care from practitioners dedicated to this population and who are up to date on current trends in geriatrics. The relationship between the parties has been positive and mutually beneficial. Staff wishes to continue its relationship with UCI.

Discussion

UCI Compensation: At the inception of the Primary Care contract with UCI, Staff negotiated an hourly rate for the provision of services. UCI only receives compensation for services rendered. Although Staff received authorization to complete a contract for Primary Care services at the November 3, 2011 Board meetingThe method of compensation is in the form of an hourly rate for the services of physicians and NPMPs. On-call services are contracted on a per on-call period. On-call periods are based on the non-PACE Center hours during Monday - Friday (4:30 p.m. to 8:00 a.m.) and per day on weekends and holidays (8:00 a.m. to 8:00 a.m.).

UCI has notified CalOptima of a need to increase the hourly rates it receives for the provision of services to the PACE Center. The costs associated with the provision of services by UCI have increased. In addition, staff is recommending contracting with additional providers of primary care services to provide appropriate coverage for the ongoing operation of PACE (see below). It is recommended that the Board establish a maximum hourly rate for PACE physician and non-physician services, and authorize staff to enter into appropriate contracts at rates up to the Board-established maximum. Staff is recommending a maximum rate for physician services of $200.00 per hour, and a maximum rate for non-physician primary care services of $130.00 per hour. The actual rates within the allowable range would be set based on the provider's training, experience, and other resources brought to the provision of the services at the PACE Center (e.g., UCI has requested to provide additional services using Fellows and residents at no cost to CalOptima).

UCI Incentives: Staff requests authorization to add an incentive program for UCI at PACE to focus on increasing patient satisfaction; increasing accuracy of documentation of participant care; and reducing inappropriate inpatient admissions. Please note that the implementation of the incentive plan is subject to regulatory approvals. A detailed grid of the proposed program is attached to this COBAR.

- Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with the medical care provided at the PACE center. Participant medical care and overall

satisfaction with PACE are measured. UCI is eligible to receive an incentive based on a 90% or higher participant satisfaction score.

- Physician documentation of patient care is essential the delivery of quality care and insures appropriate payment from State and federal entities. CalOptima Staff, using audit processes that align with industry standards, will audit physician documentation biannually. UCI will receive additional compensation based on positive results of the audit as reflected on the attached grid.

- As the primary care provider for PACE participants, UCI primary care providers are essential in appropriately assessing a participant's condition and avoiding unnecessary inpatient admissions. Participation in the concurrent review process helps prevent under and over utilization of services. Assisting in the transition of care for a participant from an acute care setting assures the member will continue to receive the care they need and will reduce readmissions. If successful in reducing bed days per thousand per year to the levels identified in the incentive grid attached, UCI will be eligible for a portion of the savings attributed to inpatient costs for PACE. The target bed days per thousand per year are based on CalPACE benchmarks.

Revision to the Scope of Work: Staff requests authority to revise the scope of work to modify responsibilities and qualifications of the physician and NPMP rendering Primary Care services and add responsibilities for UCI to provide clinical Medical Director services. UCI may incorporate care provided by Fellows and residents at the PACE clinic, under the condition that these services are overseen by an onsite contracted UCI physician. The Fellows and residents will be provided at no cost to CalOptima and will enhance the number of providers rendering services at the PACE center.

Updating of Contract Form: In addition to the above changes, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract also be included.

Additional Authority to Contract: Staff requests authority to contract with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE. Additional providers include, but are not limited to, local Primary Care physicians, Locum Tenens and NPMPs. These providers will be paid at the CalOptima fee schedule.

Fiscal Impact

The recommended action to revise the rate paid to UCI effective September 1, 2017 through June 30, 2018, modify the compensation methodology for on-call services, and implement an incentive payment program is an unbudgeted item. Based on current utilization, funding for the recommended action will increase medical expenses by $80,000, thereby reducing budgeted income for the PACE program to

$131,373 for Fiscal Year 2017-18. Management will include updated PACE medical expenses in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends this action to maintain the contractual relationship with UCI for the provision of Primary Care services to CalOptima PACE and to ensure coverage of Primary Care services for PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated November 3, 2011, Authorize the Chief Executive Office to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE.
2. CalOptima PACE PCP Incentive Program Grid

/s/ Michael Schrader — *9/1/2017*

Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2011
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. B. Authorize the Chief Executive Officer (CEO) to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE

Contact

Peerapong Tantameng, Manager, PACE (714) 246-8400

Recommended Action

Authorize the CEO, with the assistance of legal counsel, to amend existing medical provider and administrative support vendor contracts to include PACE, and to enter into new medical provider and administrative support vendor contracts as necessary for operation of PACE within the parameters of the Board-approved operating budget.

Background

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program will be the first PACE program offered to Orange County residents. Also, CalOptima will be the first County Organized Health System to offer a PACE program to its members.

The hub of a PACE program is the PACE Center, a medically-intensive care coordination facility that provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide a full range of necessary services outside of the PACE Center setting to ensure the proper continuum of care, including, but not limited to:

- Transportation to the PACE center and to medical appointments
- Skilled and personal home care
- Inpatient, outpatient, and specialty care
- Nursing home care, both short and long-term
- Home-delivered meals
- Durable medical equipment

Discussion

On October 7, 2010, the CalOptima Board of Directors authorized the CEO to submit CalOptima's PACE application to the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). At that time, staff committed to returning to Board to obtain authority to implement operational items for PACE and which are

Back to Agenda

required by federal and state regulations, including the execution of contracts with the necessary providers and vendors, many of which are subject to state licensure requirements, to adequately serve CalOptima members who enroll in PACE.

CalOptima staff now seeks authority to amend existing agreements and enter into new agreements with providers and vendors, subject to regulatory approval of CalOptima's PACE program, to offer the necessary medical, social, and community-based services required of a PACE program, including but not limited to the following types of medical providers and administrative support vendors:

- Medical Director;
- PACE Center-based practitioners, including the primary care physician and rehabilitation therapists;
- Medical specialists for the PACE provider network;
- Hospitals;
- Ancillary health services, including dental, audiology, optometry, podiatry, speech therapy, and behavioral health;
- Nursing facilities, for both acute and long-term care;
- Laboratory services;
- Durable medical equipment;
- Home care and home health;
- Transportation;
- Meal service; and
- Electronic Health Record system

Fortunately, many of the provider network needs for PACE can be addressed by amending contracts with providers within the designated PACE service area who are already contracted with CalOptima under its other lines of business. While provider and vendor contracts must include certain regulatory terms that are required by DHCS and CMS, many of these terms are similar to those required for CalOptima's current Medi-Cal and OneCare programs. However, because CalOptima will be a new entrant into the PACE program, staff anticipates that, within the bounds of regulatory and budgetary limitations, there may be a need for variations among agreements based upon the type of provider or vendor, PACE regulatory requirements, and unique institutional requirements that providers or vendors may have in finalizing CalOptima agreements. Staff's proposed strategy is to approach providers and vendors with uniform sets of terms and conditions to minimize the number and scope of variances between contracts. Staff will update the Board of Directors on the progress of the contracting efforts as they move forward.

Back to Agenda

Fiscal Impact
It is anticipated that the amendments and new contracts to be negotiated with medical providers and vendors for administrative services will be consistent with the projected expenses reflected in the operational budget for PACE approved by the Board on June 2, 2011.

Rationale for Recommendation
As a new entrant to the PACE market and given the tight timeline for bringing up the PACE program, CalOptima will need to both amend contracts with existing medical providers and administrative support vendors, as well as enter into agreements with new medical providers and administrative support vendors. Through this process, staff plans to put in place the various contractual relationships that are necessary for the proper operation of the CalOptima PACE program.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Chambers — *10/28/11*
Authorized Signature — **Date**

Back to Agenda

CalOptima PACE PCP Incentive Program

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Coding Accuracy Rate	Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis.	CY	Biannually	The CalOptima Coding Department will audit charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits.	<75%	$0 PMPM	April
					75-89%	$0.5 PMPM	April
					>/= 90%	$1 PMPM	April
CalOptima PACE Actual Inpatient Performance	Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP.	CY for 1st 6 Months of 2018	Audited CY Performance for the 1st 6 Months of 2018	PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016.	Incentive Begins at BD / K / Y equivalent of 2,300	Total potential: $19.30 PMPM or ~ $30,000***	October, 2018
					Incentive ends at BD / K / Y equivalent of 2,000		
		FY Starting July 1st, 2018	Audited FY Performance	Will be determined by budget and CalPACE updated averages	TBD	TBD	October, 2019
					TBD	TBD	

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.
*** Potential incenitve was estimated based on the projected member months from January, 2018 to June, 2018.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

13. Consider Authorizing Request for Waiver Allowing Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contact

Richard Helmer, Chief Medical Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer to file a waiver request for CalOptima's Program of All-Inclusive Care for the Elderly (PACE) for Section 903 of the Benefits Improvement and Protection Act (BIPA) of 2000, to the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) in order to allow Community Based Physicians (CBP) to serve as the primary care provider, in collaboration with the PACE interdisciplinary team; and
2. ~~Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into contracts with CBPs to provide such services, subject to the requested waiver first being granted.~~ *Continued to future Board meeting.*

Rev. 9/7/17

Background/Discussion

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. The CalOptima PACE Center provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location.

In many cases, potential PACE-eligible participants wish to keep their existing primary care physician due to geographic considerations, as well as cultural and linguistic competencies. Notably, CalOptima PACE currently serves participants who speak 22 different languages, highlighting the diverse Orange County community. Participants may travel up to 15 miles or up to one hour in a vehicle to see their primary care physician. Allowing CalOptima PACE to contract with community-based physicians will allow CalOptima to enroll PACE participants who wish to access the PACE model of care, while maintaining their existing relationship with their primary care physician – in their neighborhood and language.

Section 903 of BIPA allows for specific modifications or waivers of certain regulatory provision to meet the needs of PACE organizations. As such, CalOptima PACE is requesting for a waiver of the regulatory sections listed below from Title 42: Public Health,§460 – PACE, in order to allow a CBP to serve as the primary care provider on the interdisciplinary team:

Back to Agenda

- § 460.102(a) *Basic requirement.* A PACE organization must meet the following requirements: (1) Establish an interdisciplinary team at each PACE center to comprehensively assess and meet the individual needs of each participant.

- § 460.102(d)(3) The members of the interdisciplinary team must serve primarily PACE participants.

This waiver request is to allow CBPs to serve as a primary care provider, as set forth in the PACE regulation, by providing primary care services in their respective clinic settings while also serving non-PACE participants.

Filing of a 903 BIPA Waiver application will not add to PACE expenditures. In fact, it will likely remove a primary barrier to enrollment by allowing participant access to primary care outside of PACE center-based physicians, likely resulting in increased enrollment growth.

If the waiver is approved, then staff would seek to contract with appropriate qualified primary care providers, in accordance with the current contracting and rate strategies used for other CalOptima-contracted Medicare primary care physicians (e.g., CalOptima Care Network PCPs for OneCare/OneCare Connect).

Fiscal Impact
The Fiscal Year 2017-18 CalOptima Operating Budget, approved by the Board on June 1, 2017, included projected expenses of approximately $730,000 for PACE primary care physician services. The recommended action to file a waiver request to allow CBPs to serve as the primary care providers for PACE participants is budget neutral. Staff anticipates CBPs will provide services where a PACE physician would typically be needed, and that the average cost per visit for CBP services will be less than the current PACE Center-based physician services

Rationale for Recommendation
This waiver would provide greater flexibility for PACE centers to contract with community-based primary care physicians, increasing access to participants to receive care in their neighborhood and their language, while also potentially eliminating a barrier to enrollment in PACE.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *8/31/2017*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
14. Consider Extension of Deadline for Intergovernmental Transfer (IGT) Project with University of California, Irvine (UCI) Health's Observation Stay Pilot Program

Contact
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400
Dr. Richard Bock, Deputy Chief Medical Officer, (714) 246-8400

Recommended Action
Extend deadline for CalOptima and UCI Health to reach an agreement on project terms under IGT 4 for the UCI Health Observation Stay Pilot Program to December 31, 2017.

Background
For decades, hospitals and emergency departments (EDs) have faced the many challenges of overcrowding, overutilization, escalating health care costs and avoidable admissions. To address these issues, several hospitals have formed ED observation units (EDOUs) to care for patients with an expected length of stay (LOS) of less than 24 hours. The average LOS for admitted patients to the EDOU is typically 15–20 hours, whereas the average LOS for admitted inpatients is five days.

Observation units are clinical areas in the hospital or ED where patients are monitored for observation care. The Centers for Medicare & Medicaid Services (CMS) defines observation care as "a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the ED and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge."[1]

Third-party payers, such as Medicare, recognize the importance of observation services, or extended stays of up to 24 hours in EDs. They have created reimbursement strategies that appropriately compensate physicians and institutions for this care. However, some state Medicaid programs, including Medi-Cal and CalOptima, have not established clear guidelines for observation services. As a result, many patients are inappropriately admitted to hospitals in our region when they could have been better served with an efficient EDOU stay of less than 24 hours.

UCI Health established an EDOU program in June 2015 that has successfully treated more than 5,800 patients during a 17-month period (with more than 45% of these patients covered by CalOptima). Several studies, including some initiated by UCI's faculty, have highlighted the benefits of an organized EDOU program in emergency medicine with specific protocol-driven care. UCI Health currently tracks the protocol diagnosis, time, final disposition and care of patients who are admitted

[1] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf

Back to Agenda

to their EDOU on a monthly basis. Based on UCI Health's historical case data and growing use of EDOU protocols, leaders estimate that 180–200 CalOptima patients meet criteria for EDOU admission each month.

Discussion

At the December 1, 2016 CalOptima Board of Directors meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation stay pilot program at UCI Health for CalOptima Medi-Cal members, subject to the parties agreeing to program terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to December 31, 2017.

The funds will support a pilot project with UCI Health to test the cost-effectiveness of EDOUs and demonstrate the potential return on investment. This project will include tracking of specific CalOptima member information, including diagnosis, protocol, time in EDOU, discharge diagnosis, discharge status and readmission rates. UCI Health and CalOptima will conduct a monthly utilization review. If terms cannot be reached by December 31, 2017, staff will return to the Board with further recommendations.

Fiscal Impact

The recommended action has no fiscal impact on CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of operating "Better. Together.", CalOptima is committed to working with Orange County's provider and community partners to improve the availability, access and quality of health care services available to Medi-Cal beneficiaries.

Concurrence

Gary Crockett, Chief Counsel

Attachment

None

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
15. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Events

Contact
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Authorize the expenditure for CalOptima's participation in the following events:
    a. Up to $6,000 and staff participation at the Vietnamese Cultural Center's 2017 Mid-Autumn Festival on Sunday, October 1, 2017 at Mile Square Park in Fountain Valley;
    b. Up to $3,000 and staff participation at the Vietnamese Physician Association of Southern California (VPASC) Foundation's Free Health Fair on Sunday, October 15, 2017 at the Westminster Rose Center in Westminster;
    c. Up to $2,500 and staff participation at the 8th Annual Alzheimer's Orange County Latino Conference on Saturday, November 4, 2017 at Templo Calvario Church in Santa Ana;
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures.

Background
CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion
Staff recommends the authorization of expenditures for participation in the following community events to provide outreach and education about CalOptima's programs and services to our Vietnamese-speaking members, Spanish-speaking members and seniors. Participation in these events will provide opportunities to increase access to health care services while strengthening relationships with our community partners.

Back to Agenda

Vietnamese Cultural Center's 2017 Mid-Autumn Festival. The Vietnamese Cultural Center's 2017 Mid-Autumn Festival is a traditional festival for the Vietnamese community also known as "Children's Day." The Mid-Autumn Festival celebrates three fundamental concepts: Gathering, Thanksgiving, and Praying. Children light lanterns and participate in a parade as part of tradition. CalOptima has participated in the Mid-Autumn Festival for two years: 2015 at a $5,720 sponsorship level and 2016 at a $5,250 Sponsorship level. Staff recommends CalOptima's continued support for this event at a $6,000 level for 2017. Staff will have an opportunity to share information about all CalOptima's programs and services with Vietnamese-speaking members and also outreach to potential members.

VPASC Foundation's Free Health Fair. The VPASC Foundation's Free Health Fair will provide an opportunity to strengthen CalOptima's relationship with Vietnamese healthcare professionals including physicians, specialists and others serving our members. The VPASC is a non-profit organization established to improve the quality of health care to the underserved communities of Orange County by providing free public education seminars and free annual health fairs. The health fair brings together hundreds of healthcare professionals including doctors, dentists, pharmacists, nurses and dental assistants to provide free medical services. These services will include flu shots, screenings for blood pressure, blood glucose, vision, hepatitis B/C, and breast and colon cancer. Dental services will include dental exams, fillings, and extractions. Volunteer physicians will be on-site to provide health education on topics such as management of coronary artery disease, hypertension, strokes, high cholesterol, diabetes and hepatitis B. The event is open to the public and all services including medical, dental and health education will be provided at no cost. CalOptima participated for the first time in 2016 at a $2,000 sponsorship level. Staff recommends CalOptima's continued support for this event at a $3,000 sponsorship level for 2017. Sponsorship costs have increased by $1,000.

Both the Vietnamese Cultural Center's Mid-Autumn Festival and VPASC Foundation's Free Health Fair will provide opportunities for outreach and education about CalOptima's programs and services to our Vietnamese-speaking members, who comprise approximately ten percent of CalOptim's total membership. These two events will take place locally near the largest Vietnamese community in Orange County and will draw from communities throughout the county.

8th Annual Alzheimer's Orange County Latino Conference. The 8th Annual Alzheimer's Orange County Latino Conference provides an opportunity to highlight the OneCare Connect and PACE programs with our Latino community. Staff will have the opportunity to provide outreach and education to Spanish- speaking members, who comprise approximately thirty percent of CalOptima's total membership, as well as outreach to potential members. This event provides information, resources and support to meet the needs of Spanish-speaking seniors and their caregivers through sharing information about Alzheimer's disease, updates on current research and providing practical information about aging well and disease prevention. Attendees will have access to free health screenings, health information and resources. This conference is free to the public and continues to grow in participation. CalOptima has participated in the Alzheimer's Orange County Latino Conference for two years: 2015 at a $50 sponsorship level and 2016 at a $500 sponsorship level. Staff recommends CalOptima's continued support for this event at a $2,500 sponsorship level for 2017.

Back to Agenda

a. The Vietnamese Cultural Center's 2017 Mid-Autumn Festival in Fountain Valley includes a $6,000 financial commitment for the following: Opportunity for CalOptima's Chief Executive Officer to be a part of the event program, one (1) 10x10 exhibitor space, logo on promotional flyers and 1,500 lanterns to be distributed at the event, one (1) CalOptima banner on the stage at the festival. Employee time will be used to participate in this event. The anticipated number of attendees is more than 3,000 throughout the day.

b. The VPASC Foundation Free Health Fair in Westminster includes a $3,000 financial commitment for the following: one (1) exhibitor table, 5'x3' CalOptima banner display, and CalOptima brochures in each attendee's gift bag. Additional marketing benefits includes radio and newspaper recognition, CalOptima logo on the VPASC website, social media (Facebook, Instagram, Twitter), and e-mail blast. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services, potentially increasing awareness of programs, and utilization of primary and preventive care services. During last year's health fair, over 1,200 individuals were served. VPASC is estimating that this year's event will serve over 1,500 individuals.

c. The 8th Annual Alzheimer's Orange County Latino Conference in Santa Ana includes a $2,500 financial commitment for the following: Opportunity for CalOptima's Chief Executive Officer to give a welcome presentation during the opening ceremony, one (1) exhibitor table, acknowledgement in press releases and advertisements one month prior to conference on radio, magazine, website and newspaper, CalOptima's logo displayed at conference and event agenda, looping video acknowledgement at front entrance, CalOptima's brochure in participants' bag, lunch for two (2) and Certificate of Recognition. Employee time will be used to participate in this event. Employees will have an opportunity to promote the OneCare Connect and PACE programs with seniors and caregivers in the Latino community. Over 500 participants are anticipated to attend this event.

CalOptima staff has reviewed the request, and it meets the consideration for participation as required in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability;
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations department. The Community Relations department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

Back to Agenda

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended actions of $11,500 is included as part of the Community Events budget under the CalOptima Fiscal Year 2017-18 Operating Budget approved by the CalOptima Board of Directors on June 1, 2017.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to support community and provider activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, or promote health and wellness.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. 2017 Vietnamese Cultural Center Mid-Autumn Festival Sponsorship Request Letter
2. 2017 VPASC Free Health Fair Sponsorship Package
3. 8th Annual Alzheimer's Latino Conference Sponsorship Package

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

Back to Agenda

August 11, 2017

Ms. Lisa Nguyen
Sr. Community Relations Specialist
CalOptima
505 City Parkway West
Orange, CA 92868

Re: Sponsorship for the 2017 Mid-Autumn Festival – Sunday, October 1, 2017

Dear Ms. Nguyen,

On behalf of the Vietnamese Cultural Center, we would like to thank you for your support and participation in last year's Mid-Autumn Festival held at Mile Square Park in Fountain Valley. As you might remember the 2016 event had approximately 3,000 attendees throughout the day and was a great success.

The Mid-Autumn Festival is a traditional festival for the Vietnamese community also known as "Children's Day." The Mid-Autumn Festival celebrates three fundamental concepts: Gathering, Thanksgiving and Praying. During this time various activities are held to celebrate, such as harvesting rice before the 15th of the eight lunar months, provide offerings to the God of Earth, setting up platforms with light lanterns during the evening. The Mid-Autumn Festival is a day where families gather and enjoy time with their children. The tradition of brightly lit lanterns lends to the legend that Cuoi floated to the moon on a banyan tree and was stranded there. Children light lanterns and participate in a procession to show Cuoi the way back to Earth.

This year, the 2017 Mid-Autumn Festival event will take place on Sunday, October 1, 2017 at Mile Square Park in Fountain Valley from 6:30 PM – 8:30 PM. We anticipate a greater attendance at the event this year, of which will consist of families with children and older adults.

We ask for CalOptima's participation and sponsorship in the amount of **around $6,000.00 for about 1500 lanterns** for the 2017 Mid-Autumn Festival.

I also look forward to your CEO, Michael Schrader to be a part of the event program on stage. Should you have any questions regarding the event, please contact me at (714) 548-4845 or by e-mail at promath10@yahoo.com. The Vietnamese Cultural Center appreciates CalOptima's support.

Sincerely,

Pho Huynh

Pho Huynh
Program Director
Vietnamese Cultural Center

Back to Agenda

Vietnamese Physician Association of Southern California (VPASC) Foundation

a 501(c)(3) nonprofit organization
Tax ID # 45-3844398
64 Bridgeport Road, Newport Coast, CA 92657
E-mail: info@vpasc.org

May 16, 2017

Dear Business Leaders:

"I can do things you cannot, you can do things I cannot; together we can do great things." Mother Teresa

Thank you for giving our group this opportunity to work with you. Together we can create a healthier community.

The Vietnamese Physician Association of Southern California (VPASC) Foundation is a California 501(c)(3) nonprofit organization originally incorporated in 2011. Our primary mission is to improve the quality of health care in the underserved communities of Orange County through free public education seminars and free annual health fairs.

Each year at our VPASC Free Health Fair, our group brings together hundreds of health care professionals (doctors, dentists, pharmacists, nurses, dental assistants), students, volunteers, and community businesses to provide much-needed medical screenings, dental treatments, and preventative health education free of charge to the medically underserved population.

This year … our **2017 VPASC Free Health Fair** will be held on
Date: Sunday October 15, 2017
Time: 9 AM – 2 PM
Location: Westminster Rose Center
14140 All American Way
Westminster, CA 92683

Among the free medical services that will be available are free flu shots, blood pressure check for hypertension, blood glucose check for diabetes, vision check for glaucoma, and screenings for hepatitis B/C, breast cancer, and colon cancer.

Dental services will include dental exam, fillings, and extractions.

Health education lectures will be given by our volunteer physicians on important topics such as management of coronary artery disease, hypertension, strokes, high cholesterol, diabetes, and hepatitis B.

Back to Agenda

Our health fairs have always been very successful and well attended. Last year, we doubled the attendance to 1,200 patients. This year, we hope to increase the attendance to over 1,500 patients.

As always, our health fair is free and open to the public.

These public service activities are made possible only by the generous donation, sponsorship, and support of distinguished businesses in the community such as yours.

We hope that you are as passionate about bringing medical health services to the community as we are. We would appreciate if your institution will help us fund the 2017 VPASC Free Health Fair.

Attached you will find the preliminary health fair flyer and the sponsorship level proposal.

We thank you for your time and consideration.

Sincerely,

Luan Nguyen, M.D.
Chairman of Health Fair Planning Committee
Vietnamese Physician Association of Southern California Foundation

Back to Agenda

TITLE SPONSORSHIP $ 20,000

The ONLY Sponsor Name Logo on 6 Major Banners (6' x 4.5') posted around Little Saigon

The ONLY Name/Logo display at the CENTER of all Health Fair Flyers

The ONLY Sponsor allowed to Cut Ribbon and Speak at Opening Ceremony

The ONLY Sponsor Name Logo on Volunteer Tshirt

Television Radio/Newspaper recognition as EXCLUSIVE TITLE SPONSOR

1 Display Table/Booth AT ENTRANCE of Health Fair / 1 Sponsor Banner (up to 12' x 3') display inside site

Business cards/brochures in attendee gift bag

Email Blast Website / Social Media (FaceBook Instagram Twitter)

PLATINUM SPONSORSHIP $ 5,000

Name on the bottom section of all Health Fair Flyers

Television Radio/Newspaper Recognition

1 Display Table/Booth at site of Health Fair 1 Sponsor Banner (up to 8' x 3') display inside site

Business cards/brochures in attendee gift bag

Email Blast Website Social Media (FaceBook/Instagram/Twitter)

DIAMOND SPONSORSHIP $ 3,000

Name on the bottom section of all Health Fair Flyers

Radio Newspaper Recognition

1 Display Table/Booth at site of Health Fair / 1 Sponsor Banner (up to 5' x) display inside site

Business cards/brochures in attendee gift bag

Email Blast / Website / Social Media (FaceBook Instagram Twitter)

BOOTH PARTICIPATION $ 1,000

1 Display Table/Booth at site of Health Fair

Business cards/brochures in attendee gift bag

Blast / Website / Social Media (FaceBook/Instagram Twitter)

Sponsors please provide own banners, business cards, and brochures to VPASC by October 6, 2017.

Please make checks payable to: VPASC Foundation - 501(c)(3) - Tax ID#: 45-3844398

Thank you for your time and generosity.

Back to Agenda

Vietnamese **P**hysician **A**ssociation of **S**outhern **C**alifornia

FOUNDATION

"One life to share. One family to love. One community to serve."

FREE HEALTH FAIR

Hội Chợ Y Tế Miễn Phí

SUNDAY, October 15, 2017

9 AM – 2 PM

Westminster Rose Center

[illegible] all American Way, Westminster, CA 92683

MEDICAL SERVICES:

[illegible] / Chích Ngừa Cúm **(while supplies last)**

Blood Pressure Check / Đo Huyết Áp

Blood Cholesterol Check / Đo Lượng Mỡ Trong Máu

Blood Glucose Check / Đo Lượng Đường Trong Máu

HEPATITIS B/C SCREENING / Truy Tầm Viêm Gan B/C **(9am-1pm only)**

Vision and GLAUCOMA Testing / Khám Mắt & Đo Áp Suất Mắt

Osteoporosis / BONE DENSITY TESTING / Đo Rỗng Xương

Hearing Screening / Khám Thính Lực

Heart / Cardiovascular Diseases / Tham Khảo Bệnh Tim/ EKG

Breast Cancer Screening Consultation / Tham Khảo & Truy Tầm Ung Thư

Colon Cancer Consultation / Tham Khảo Ung Thư Ruột Già

DENTAL SERVICES:

Exam, filling, extraction / Khám, Trám và Nhổ Răng

[illegible] / Thuyết Trình Về Bệnh Viêm Gan B,
Cao Huyết Áp, Tiêu Đường, Đau Nhức

Tham Khảo & Chữa Trị Miễn Phí

Back to Agenda

Alzheimer's | ORANGE COUNTY

July, 03 2017

To whom it may concern,

For individuals suffering from chronic health conditions, getting quality healthcare is much more than just a visit to the doctor or simply taking medication, it is also having access to education and resources needed to deal with the disease on a daily basis. This is especially true with senior patients who are suffering with Alzheimer's disease and who must often rely completely on their family members to take care of them. These caregivers can often feel very isolated as they struggle with meeting the overwhelming needs of their loved one inflicted with the disease, and at the same time meet their financial and personal responsibilities for themselves and others in their family. This can place a heavy burden on any family, but particularly challenging to those with limited financial, education and other social service resources.

The Alzheimer's Orange County Latino Outreach program has always believed that education and support from the community is the key to addressing this problem. That is why in addition to providing ongoing education and support to families for the past 7 years, this program has partnered with numerous community organizations to join forces and meet the needs of the Spanish speaking community with an annual conference. **This year's conference will be held on Saturday November 04, 2017 at Templo Calvario Church located in Santa Ana, California from 7:30 a.m. to 2:00 p.m.** This one day conference is free to the public and is an opportunity for caregivers and families who want to learn more about Alzheimer's disease to get updates about current research, as well as receiving practical information about aging well and disease prevention. Conference attendees will also have access to free health screenings, health information and resources, as well as entertainment and prizes. Each year this conference continues to grow, benefiting so many people in the Hispanic Community.

This year Alzheimer's Orange County is proud to announce that they are expecting 500 people to attend the conference. However, this conference was only able to become what it is today because of corporate and community sponsors. By participating in and supporting this year's annual conference, you or your organization will enable Alzheimer's Orange County to continue the good work of the Latino Outreach Program. Sponsor recognition is outlined in the material provided.

Thank you for your kind consideration of this request. If you need further information, please do not hesitate to contact Norma Castellano at (949) 757-3755 or by email norma castellano@alzoc.org.

Most Sincerely,

Norma Castellano

Norma Castellano
Multicultural Program Coordinador

Alzheimer's Orange County
Tax ID # 95-3702013

Rama Meka

Conference Volunteer Committee Member

Back to Agenda

Alzheimer's | ORANGE COUNTY

8th Annual Alzheimer's Latino Conference Sponsorship Levels

Diamond Sponsor - $2500

- Opportunity to give a welcome presentation to participants on behalf of the corporation during opening ceremony
- Acknowledgement in press releases and advertisements 1 month prior to conference (radio, magazine, website, and newspaper)
- Corporate logo prominently placed around conference and on the agenda
- Corporate logo placed in looping video acknowledgments at the front entrance
- Information in goody bag
- Opportunity for a table at the information fair with corporate signage
- Lunch for 2
- Certificate of recognition

Gold Sponsor- $1500

- Recognition at the event during opening ceremonies
- Acknowledgement in press releases and advertisements 1 month prior to conference (radio, magazine, website, and newspaper)
- Corporate logo prominently placed around conference and on the agenda
- Corporate logo placed in looping video acknowledgments at the front entrance
- Information in goody bag
- Opportunity for a table at the information fair with corporate signage
- Lunch for 2
- Certificate of recognition

Silver - $500

- Recognition at the event during opening ceremonies
- Corporate logo placed around conference and on the agenda
- Information in goody bag
- Opportunity for a table at the information fair with corporate signage
- Lunch for 2
- Certificate of recognition

Bronze Sponsorship for Non-Profit Organizations - $100

- Information in goody bag
- Opportunity for a table at the information fair with corporate signage
- Lunch for 2
- Certificate of recognition

Back to Agenda

Alzheimer's | ORANGE COUNTY

Alzheimer's Latino Conference
8th Annual
"Knowledge today is Hope for the Future"
Saturday November 04, 2017
7:30 AM to 2:00PM
Templo Calvario
2501 W.5th Street, Santa Ana CA 92703

We cordially invite you to attend the Alzheimer's Latino Conference. Every year this event is organized to support a good cause in collaboration with other organizations. In the past years this event was successful in providing education and resources to over 450 people. We are inviting several local organizations and families to participate in the event. To make this event successful, we are seeking support from organizations like yours. We are very hopeful that you will extend your generous support to our cause. Please let us know if you would care to join us. A response would be greatly appreciated by September 29, 2017.
We are looking forward to your positive response.

Please mail your check payable to the Alzheimer's Orange County along with this form to:

Alzheimer's Orange County Latino Conference
Attention: Norma Castellano
2515 Mc Cabe Way, Suite 200
Irvine, CA 92614
Office (949) 757-3767 Fax (949)757-3765
Email: norma.castellano@alzoc.org

PLEASE PRINT CLEARLY

Organization Name: _____

Contact Person: _____

Telephone: _____ **Fax Number:** _____ **E-mail:** _____

____ **My organization will attend.**
____ **My organization will not attend.**

Service(s) provided: _ _____

_____

# of employees attending: _____ **Sponsorship level** _____

Please return by September 29, 2017

Tax ID # 95-3702013

Back to Agenda

Continued to a future Board meeting

AGENDA ITEM 16 TO FOLLOW CLOSED SESSION

Consider Chief Executive Officer Performance Review and Compensation

Back to Agenda

Board of Directors Meeting
September 7, 2017

Member Advisory Committee Update

The Member Advisory Committee (MAC) did not meet in August, as the committee meets bi-monthly. MAC will provide an update at the October 5, 2017 Board of Directors meeting.

The September 14, 2017 MAC meeting will be a Joint MAC/Provider Advisory Committee (PAC) meeting. In preparation for the joint meeting, MAC Members Patty Mouton and Christine Tolbert met with representatives of the PAC to determine an agenda for the meeting, which will focus on issues around homelessness.

The MAC appreciates the opportunity to provide the CalOptima Board with input and updates on the MAC's activities.

Back to Agenda

Board of Directors Meeting
September 7, 2017

Provider Advisory Committee (PAC) Update

August 10, 2017 PAC Meeting

Thirteen (13) PAC members were in attendance at the August PAC meeting.

The PAC said farewell to Barry Ross, who had been a member of the PAC since 2011 as the Community Health Centers representative. The PAC also welcomed Craig Myers who was a former member of the PAC as the Hospital Representative from 2011-2013. Mr. Myers now holds seat that was vacated by Mr. Ross.

Michael Schrader, Chief Executive Officer, provided updates on healthcare reform and Magellan. Mr. Schrader also updated the PAC on the three-way non-binding Master Services Agreement that was approved by the Board. This agreement is between LA Care, Inland Empire Health Plan and CalOptima to allow for partnership and engagement with University of California (UC) Health. The purpose of this agreement is to work with the UC system to contract with several of the UC Healthcare System hospitals such as UC Davis, UC Irvine and UCLA.

Ladan Khamseh, Chief Operating Officer, discussed the OneCare Connect (OCC) current 30 day deeming period and noted that DHCS is now requiring the health plans to extend the deeming period to two months. Ms. Khamseh also updated the PAC on the non-medical transportation benefit that went into effect on July 1, 2017 for CalOptima Medi-Cal members.

Richard Helmer, M.D., Chief Medical Officer, briefed the PAC members on the process to allow for the credentialing of Optometrists who are not contracted with VSP. Dr. Helmer noted that he may convene an ad hoc to review payment methodology to insure we are paying Optometrists properly. Member Nishimoto volunteered to be on the ad hoc in his role as the Non-Medical Practitioner representative on the PAC as well as a licensed Optometrist. Dr. Helmer also discussed the Request for Information (RFI) that was released for PACE alternative care settings as well as an RFI for perinatal services to ensure CalOptima is meeting their goal to its members.

Arif Shaikh, Director, Government Affairs, provided the PAC with a review of current Congressional healthcare reform efforts. Cheryl Meronk, Director, Strategic Planning presented on the Intergovernmental Transfer (IGT) funding past and present and the most recently approved IGT 6 and 7.

PAC also received the following updates from CalOptima executive staff at the August 10, 2017 PAC meeting: review of the June 2017 financial statements from Interim Chief Financial Officer, Nancy Huang, Program Implementation updates from Candice Gomez, Executive Director, Program Implementation and the annual HEDIS results from Kelly Rex-Kimmet, Director, Quality Initiatives.

Back to Agenda

Chair Miranti shared the draft Ad Hoc MAC/PAC agenda for the upcoming meeting on September 14th and encouraged all members to attend this meeting and provide their input on the important topics we will be discussing.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's current activities.

Back to Agenda

Board of Directors Meeting
September 7, 2017

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
Member Advisory Committee Update

At the July 27, 2017 OneCare Connect Member Advisory Committee (OCC MAC) meeting, MAC received the following informational presentations. Dr. Sharps, Medical Director, Behavioral Health, presented a reminder on how to access behavioral health benefits for Medi-Cal and OneCare Connect members. In addition, he provided an overview on access to geropsychiatric beds in Orange County. Cheryl Meronk, Director, Strategic Development, provided an overview of CalOptima's approach to community engagement: 1) create programs and information that help the community access quality health care; 2) maintain strong relationships with community stakeholders; and 3) be a responsible steward by providing grants and supporting the community through health education and other informational events. Cynthia Valencia, Supervisor, OneCare Customer Service, presented an overview of the OneCare Connect New Member Orientation (NMO). Ms. Valencia explained the purpose of the NMO is the following: to provide CalOptima members with an overview of their benefits; select a primary care provider; learn how to access services; and learn about member rights.

Member Ted Chigaros presented an overview on post-acute care and skilled nursing facilities (SNFs), explaining the process that an OneCare Connect member undergoes to be admitted to a SNF. In addition, Member Chigaros mentioned end-of-life matters in SNFs, which elicited discussion from OCC MAC members.

Also at the July meeting, OCC MAC members received an update on the Congressional health care reform efforts.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

Back to Agenda

A Public Agency

CalOptima

Better. Together.

Financial Summary

July 2017

Board of Directors Meeting

September 7, 2017

Nancy Huang

Interim Chief Financial Officer

Back to Agenda

FY 2017-18: Consolidated Enrollment

- July 2017 MTD:
  - Overall enrollment was 787,686 member months
    - Actual lower than budget by 14,030 or 1.7%
      - Medi-Cal: unfavorable variance of 13,958 members
        - TANF unfavorable variance of 13,884 members
        - SPD unfavorable variance of 2,641 members
        - Medi-Cal Expansion (MCE) favorable variance of 2,458 members
      - OneCare Connect: unfavorable variance of 123 members
    - 0.2% or 1,380 decrease from prior month
      - Medi-Cal: decrease of 1,489 from June
      - OneCare Connect: decrease of 140 from June
      - OneCare: increase of 246 from June
      - PACE: increase of 3 from June

FY 2017-18: Consolidated Revenues

- July 2017 MTD:
  - Actual higher than budget by $3.1 million or 1.1%
    - Medi-Cal: favorable to budget by $3.7 million or 1.5%
      - Unfavorable volume variance of $4.4 million
      - Favorable price variance of $8.0 million due to:
        - $4.5 million for Coordinated Care Initiative (CCI) revenue and In-Home Supportive Services (IHSS)
        - $1.9 million of FY 2017 LTC related revenue recognized for members with Non-LTC aid codes
        - $1.5 million of FY 2017 Behavioral Health Treatment (BHT) revenue
    - OneCare Connect: unfavorable to budget by $0.8 million or 3.0%
      - Unfavorable volume variance of $0.2 million due to lower enrollment
      - Unfavorable price variance of $0.6 million due to Part D

FY 2017-18: Consolidated Medical Expenses

- July 2017 MTD:
  - ➢ Actual higher than budget by $9.0 million or 3.5%
    - Medi-Cal: unfavorable variance of $9.8 million
      - MLTSS unfavorable variance of $6.1 million
        - ➢ LTC unfavorable variance of $3.5 million adjustment of IHSS expense corresponding with the favorable CCI revenue variance
        - ➢ Nursing facility unfavorable variance of $2.0 million
      - Provider Capitation unfavorable variance of $0.9 million due to BHT capitation
      - Facilities expenses unfavorable variance of $1.1 million due to Hospital Shared Risk
    - OneCare Connect: favorable variance of $0.4 million
      - Favorable volume variance of $0.2 million due to lower enrollment
      - Favorable price variance of $0.2 million in Rx

- Medical Loss Ratio (MLR)
  - ➢ July 2017 MTD: Actual: 97.6% Budget: 95.4%

FY 2017-18: Consolidated Administrative Expenses

- July 2017 MTD:
  - ➢ Actual lower than budget by $3.4 million or 27.8%
    - Salaries and Benefits: favorable variance of $1.1 million due to open positions
      - Medi-Cal: 35 open positions
      - OneCare Connect: 4 open positions
    - Purchased Services: favorable variance of $1.1 million due to Mental Health Contract amendment recorded in Medical
    - Other categories: favorable variance of $1.1 million

- Administrative Loss Ratio (ALR):
  - ➢ July 2017 MTD: Actual: 3.2% Budget: 4.4%

Back to Agenda

FY 2017-18: Change in Net Assets

- July 2017 MTD:
  - $0.6 million surplus
  - $0.2 million unfavorable to budget
    - Higher than budgeted revenue of $3.1 million
    - Higher than budgeted medical expenses of $9.0 million
    - Lower than budgeted administrative expenses of $3.4 million
    - Higher than budgeted investment and other income of $2.5 million

Enrollment Summary: July 2017

	Month-to-Date			
Enrollment (By Aid Category)	**Actual**	**Budget**	**Variance**	**%**
Aged	60,963	61,853	(890)	(1.4%)
BCCTP	627	618	9	1.5%
Disabled	46,984	48,744	(1,760)	(3.6%)
TANF Child	324,532	330,072	(5,540)	(1.7%)
TANF Adult	95,766	104,110	(8,344)	(8.0%)
LTC	3,377	3,268	109	3.3%
MCE	238,490	236,032	2,458	1.0%
Medi-Cal	**770,739**	**784,697**	**(13,958)**	**(1.8%)**
OneCare Connect	**15,365**	**15,488**	**(123)**	**(0.8%)**
PACE	**215**	**216**	**(1)**	**(0.5%)**
OneCare	**1,367**	**1,315**	**52**	**4.0%**
CalOptima Total	**787,686**	**801,716**	**(14,030)**	**(1.7%)**

Enrollment (By Network)				
HMO	170,752	173,966	(3,214)	(1.8%)
PHC	222,601	227,238	(4,637)	(2.0%)
Shared Risk Group	203,214	210,648	(7,434)	(3.5%)
Fee for Service	174,172	172,847	1,325	0.8%
Medi-Cal	**770,739**	**784,697**	**(13,958)**	**(1.8%)**
OneCare Connect	**15,365**	**15,488**	**(123)**	**(0.8%)**
PACE	**215**	**216**	**(1)**	**(0.5%)**
OneCare	**1,367**	**1,315**	**52**	**4.0%**
CalOptima Total	**787,686**	**801,716**	**(14,030)**	**(1.7%)**

Back to Agenda

Financial Highlights: July 2017

	Month-to-Date			
	Actual	Budget	$ Variance	% Variance
Member Months	787,686	801,716	(14,030)	(1.7%)
Revenues	276,803,657	273,738,545	3,065,112	1.1%
Medical Expenses	270,136,964	261,093,434	(9,043,530)	(3.5%)
Administrative Expenses	8,731,762	12,088,105	3,356,343	27.8%
Operating Margin	**(2,065,069)**	**557,006**	**(2,622,075)**	**(470.7%)**
Non Operating Income (Loss)	2,709,910	252,544	2,457,366	973.0%
Change in Net Assets	**644,841**	**809,550**	**(164,709)**	**(20.3%)**
Medical Loss Ratio	97.6%	95.4%	(2.2%)	
Administrative Loss Ratio	3.2%	4.4%	1.3%	
Operating Margin Ratio	(0.7%)	0.2%	(0.9%)	
Total Operating	100.0%	100.0%		

Back to Agenda

Consolidated Performance Actual vs. Budget: July 2017 (in millions)

	MONTH-TO-DATE		
	Actual	Budget	Variance
Medi-Cal	(1.9)	1.4	(3.4)
OCC	(0.5)	(0.6)	0.1
OneCare	0.0	(0.2)	0.2
PACE	0.3	(0.1)	0.4
Operating	**(2.1)**	**0.6**	**(2.6)**
Inv./Rental Inc, MCO tax	2.7	0.3	2.5
Non-Operating	**2.7**	**0.3**	**2.5**
TOTAL	**0.6**	**0.8**	**(0.2)**

Back to Agenda

Consolidated Revenue & Expense: July 2017 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	532,249	238,490	770,739	15,365	1,367	215	787,686
REVENUES							
Capitation Revenue	$ 147,148,251	$ 101,311,804	$ 248,460,055	$ 25,492,870	$ 1,348,574	$ 1,502,158	$ 276,803,657
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	147,148,251	101,311,804	248,460,055	25,492,870	1,348,574	1,502,158	276,803,657
MEDICAL EXPENSES							
Provider Capitation	38,252,454	49,812,008	88,064,462	9,846,523	400,462	-	98,311,447
Facilities	24,090,011	20,888,338	44,978,348	2,480,464	394,962	202,365	48,056,139
Ancillary	-	-	-	584,735	31,515	-	616,250
Skilled Nursing	-	-	-	-	27,268	-	27,268
Professional Claims	7,184,543	8,072,631	15,257,174	-	-	243,696	15,500,870
Prescription Drugs	17,693,301	18,439,029	36,132,330	5,033,741	425,143	93,462	41,684,675
Long-term Care Facility Payments	53,169,264	2,490,933	55,660,197	5,231,479	-	(11,203)	60,880,473
Medical Management	2,810,261	-	2,810,261	1,064,319	28,294	424,452	4,327,325
Reinsurance & Other	73,685	265,957	339,642	260,312	8,663	123,900	732,517
Total Medical Expenses	143,273,518	99,968,896	243,242,414	24,501,572	1,316,306	1,076,672	270,136,964
Medical Loss Ratio	**97.4%**	**98.7%**	**97.9%**	**96.1%**	**97.6%**	**71.7%**	**97.6%**
GROSS MARGIN	**3,874,733**	**1,342,908**	**5,217,641**	**991,298**	**32,268**	**425,485**	**6,666,693**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			4,975,290	728,583	27,705	71,692	5,803,270
Professional fees			172,345	-	0	1,557	173,902
Purchased services			608,528	89,340	10,735	5,858	714,461
Printing and Postage			167,600	12,798	6,442	215	187,054
Depreciation and Amortization			375,995	-	-	2,096	378,092
Other expenses			1,101,679	29,387	0	3,874	1,134,941
Indirect cost allocation, Occupancy expense			(279,013)	584,428	31,910	2,718	340,043
Total Administrative Expenses			7,122,425	1,444,536	76,791	88,009	8,731,762
Admin Loss Ratio			**2.9%**	**5.7%**	**5.7%**	**5.9%**	**3.2%**
INCOME (LOSS) FROM OPERATIONS			(1,904,784)	(453,238)	(44,523)	337,476	(2,065,069)
INVESTMENT INCOME			-	-	-	-	2,709,333
NET RENTAL INCOME			-	-	-	-	3,170
NET GRANT INCOME			(2,666)	-	-	-	(2,666)
OTHER INCOME			73	-	-	-	73
CHANGE IN NET ASSETS			**$ (1,907,377)**	**$ (453,238)**	**$ (44,523)**	**$ 337,476**	**$ 644,841**
BUDGETED CHANGE IN ASSETS			1,443,045	(594,005)	(219,575)	(72,459)	809,550
VARIANCE TO BUDGET - FAV (UNFAV)			(3,350,421)	140,767	175,051	409,935	(164,709)

Back to Agenda

CalOptima A Public Agency Better. Together.

Balance Sheet: As of July 2017

ASSETS			LIABILITIES & FUND BALANCES		
Current Assets			Current Liabilities		
	Operating Cash	$520,629,891		Accounts payable	$19,191,148
	Investments	1,042,089,960		Medical claims liability	1,256,027,205
	Capitation receivable	555,427,127		Accrued payroll liabilities	9,641,084
	Receivables - Other	20,691,018		Deferred revenue	110,962,533
	Prepaid Expenses	5,183,841		Deferred lease obligations	190,764
				Capitation and withholds	589,500,324
	Total Current Assets	**2,144,021,837**		**Total Current Liabilities**	**1,985,513,058**
Capital Assets	Furniture and equipment	33,437,912	Other employment benefits liability		28,767,486
	Leasehold improvements	5,884,660			
	505 City Parkway West	49,422,364	Net Pension Liabilities		16,144,973
		88,744,936	Long Term Liabilities		100,000
	Less: accumulated depreciation	(35,029,816)			
	Capital assets, net	**53,715,120**	**TOTAL LIABILITIES**		**2,030,525,517**
Other Assets	Restricted deposit & Other	300,000	Deferred inflows of Resources - Excess Earnings		-
			Deferred inflows of Resources - Changes in Assumptions		1,340,010
	Board-designated assets				
	Cash and cash equivalents	29,002,485	Tangible net equity (TNE)		89,980,450
	Long term investments	507,352,179	Funds in excess of TNE		624,122,783
	Total Board-designated Assets	536,354,664			
	Total Other Assets	**536,654,664**	**Net Assets**		**714,103,233**
	Deferred outflows of Resources - Pension Contributions	5,234,198			
	Deferred outflows of Resources - Difference in Experience	1,072,771			
	Deferred outflows of Resources - Excess Earnings	5,270,171			
TOTAL ASSETS & OUTFLOWS		**2,745,968,760**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**		**2,745,968,760**

Back to Agenda

CalOptima A Public Agency Better. Together.

Board Designated Reserve and TNE Analysis
As of July 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,551,672				
	Tier 1 - Logan Circle	146,259,887				
	Tier 1 - Wells Capital	146,315,362				
Board-designated Reserve		439,126,921	310,823,204	482,596,199	128,303,717	(43,469,278)
TNE Requirement	Tier 2 - Logan Circle	97,227,743	89,980,450	89,980,450	7,247,293	7,247,293
	Consolidated:	536,354,664	400,803,654	572,576,648	135,551,010	(36,221,985)
	Current reserve level	*1.87*	*1.40*	*2.00*		

Back to Agenda

UNAUDITED FINANCIAL STATEMENTS

July 2017

Back to Agenda

Table of Contents

Back to Agenda

CalOptima - Consolidated
Financial Highlights
For the One Month Ended July 31, 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
787,686	801,716	(14,030)	(1.7%)	Member Months	787,686	801,716	(14,030)	(1.7%)
276,803,657	273,738,545	3,065,112	1.1%	Revenues	276,803,657	273,738,545	3,065,112	1.1%
270,136,964	261,093,434	(9,043,530)	(3.5%)	Medical Expenses	270,136,964	261,093,434	(9,043,530)	(3.5%)
8,731,762	12,088,105	3,356,343	27.8%	Administrative Expenses	8,731,762	12,088,105	3,356,343	27.8%
(2,065,069)	**557,006**	**(2,622,075)**	**(470.7%)**	**Operating Margin**	**(2,065,069)**	**557,006**	**(2,622,075)**	**(470.7%)**
2,709,910	252,544	2,457,366	973.0%	Non Operating Income (Loss)	2,709,910	252,544	2,457,366	973.0%
644,841	**809,550**	**(164,709)**	**(20.3%)**	**Change in Net Assets**	**644,841**	**809,550**	**(164,709)**	**(20.3%)**
97.6%	95.4%	(2.2%)		Medical Loss Ratio	97.6%	95.4%	(2.2%)	
3.2%	4.4%	1.3%		Administrative Loss Ratio	3.2%	4.4%	1.3%	
(0.7%)	0.2%	(0.9%)		Operating Margin Ratio	(0.7%)	0.2%	(0.9%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

CalOptima
Financial Dashboard
For the One Month Ended July 31, 2017

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	770,739	784,697	(13,958)	(1.8%)
OneCare Connect	15,365	15,488	(123)	(0.8%)
OneCare	1,367	1,315	52	4.0%
PACE	215	216	(1)	(0.5%)
Total	787,686	801,716	(14,030)	(1.7%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (1,907)	$ 1,443	$ (3,350)	(232.2%)
OneCare Connect	(453)	(594)	141	23.7%
OneCare	(45)	(220)	175	79.7%
PACE	337	(72)	410	565.7%
505 Bldg.	3	3	1	24.6%
Investment Income & Other	2,710	253	2,457	973.0%
Total	$ 645	$ 812	$ (167)	(20.5%)

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.9%	95.4%	(2.5)
OneCare Connect	96.1%	94.9%	(1.2)
OneCare	97.6%	109.1%	11.5

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 7,122	$ 9,895	$ 2,772	28.0%
OneCare Connect	1,445	1,944	499	25.7%
OneCare	77	104	28	26.5%
PACE	88	145	57	39.2%
Total	$ 8,732	$ 12,088	$ 3,356	27.8%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	876	900	25
OneCare Connect	233	237	4
OneCare	3	3	(0)
PACE	49	61	12
Total	1,162	1,202	40

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	880	871	9
OneCare Connect	66	65	0
OneCare	391	438	(47)
PACE	4	4	1
Total	1,341	1,379	(37)

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	770,739	784,697	(13,958)	(1.8%)
OneCare Connect	15,365	15,488	(123)	(0.8%)
OneCare	1,367	1,315	52	4.0%
PACE	215	216	(1)	(0.5%)
Total	787,686	801,716	(14,030)	(1.7%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (1,907)	$ 1,443	$ (3,350)	(232.2%)
OneCare Connect	(453)	(594)	141	23.7%
OneCare	(45)	(220)	175	79.7%
PACE	337	(72)	410	565.7%
505 Bldg.	3	3	1	24.6%
Investment Income & Other	2,710	253	2,457	973.0%
Total	$ 645	$ 812	$ (167)	(20.5%)

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.9%	95.4%	(2.5)
OneCare Connect	96.1%	94.9%	(1.2)
OneCare	97.6%	109.1%	11.5

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 7,122	$ 9,895	$ 2,772	28.0%
OneCare Connect	1,445	1,944	499	25.7%
OneCare	77	104	28	26.5%
PACE	88	145	57	39.2%
Total	$ 8,732	$ 12,088	$ 3,356	27.8%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	876	900	25
OneCare Connect	233	237	4
OneCare	3	3	(0)
PACE	49	61	12
Total	1,162	1,202	40

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	880	871	9
OneCare Connect	66	65	0
OneCare	391	438	(47)
PACE	4	4	1
Total	1,341	1,379	(37)

Back to Agenda

CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended July 31, 2017

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	787,686		801,716		(14,030)	
Revenues						
Medi-Cal	$ 248,460,055	$ 322.37	$ 244,788,286	$ 311.95	$ 3,671,769	$ 10.41
OneCare Connect	25,492,870	1,659.15	26,271,966	1,696.28	(779,096)	(37.13)
OneCare	1,348,574	986.52	1,258,717	957.20	89,857	29.32
PACE	1,502,158	6,986.78	1,419,576	6,572.11	82,582	414.67
Total Operating Revenue	276,803,657	351.41	273,738,545	341.44	3,065,112	9.97
Medical Expenses						
Medi-Cal	243,242,414	315.60	233,450,348	297.50	(9,792,066)	(18.09)
OneCare Connect	24,501,572	1,594.64	24,921,999	1,609.12	420,427	14.48
OneCare	1,316,306	962.92	1,373,880	1,044.78	57,574	81.86
PACE	1,076,672	5,007.78	1,347,207	6,237.07	270,535	1,229.29
Total Medical Expenses	270,136,964	342.95	261,093,434	325.67	(9,043,530)	(17.28)
Gross Margin	6,666,693	8.46	12,645,111	15.77	(5,978,418)	(7.31)
Administrative Expenses						
Salaries and Benefits	5,803,270	7.37	6,909,986	8.62	1,106,716	1.25
Professional fees	173,902	0.22	428,438	0.53	254,536	0.31
Purchased services	714,461	0.91	1,851,279	2.31	1,136,818	1.40
Printing and Postage	187,054	0.24	534,871	0.67	347,817	0.43
Depreciation and Amortization	378,092	0.48	463,298	0.58	85,206	0.10
Other	1,134,941	1.44	1,559,816	1.95	424,875	0.50
Indirect cost allocation, Occupancy expense	340,043	0.43	340,417	0.42	374	(0.01)
Total Administrative Expenses	8,731,762	11.09	12,088,105	15.08	3,356,343	3.99
Income (Loss) From Operations	(2,065,069)	(2.62)	557,006	0.69	(2,622,075)	(3.32)
Investment income						
Interest income	1,929,887	2.45	250,000	0.31	1,679,887	2.14
Realized gain/(loss) on investments	(40,179)	(0.05)	-	-	(40,179)	(0.05)
Unrealized gain/(loss) on investments	819,624	1.04	-	-	819,624	1.04
Total Investment Income	2,709,333	3.44	250,000	0.31	2,459,333	3.13
Net Rental Income	3,170	0.00	2,544	0.00	626	0.00
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(2,666)	(0.00)	-	-	(2,666)	(0.00)
QAF/IGT	-	-	-	-	-	-
Other Income	73	0.00	-	-	73	0.00
Change In Net Assets	**644,841**	**0.82**	**809,550**	**1.01**	**(164,709)**	**(0.19)**
Medical Loss Ratio	**97.6%**		**95.4%**		**(2.2%)**	
Administrative Loss Ratio	**3.2%**		**4.4%**		**1.3%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

Back to Agenda

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended July 31, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	532,249	238,490	770,739	15,365	1,367	215	787,686
REVENUES							
Capitation Revenue	$ 147,148,251	$ 101,311,804	$ 248,460,055	$ 25,492,870	$ 1,348,574	$ 1,502,158	$ 276,803,657
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	147,148,251	101,311,804	248,460,055	25,492,870	1,348,574	1,502,158	276,803,657
MEDICAL EXPENSES							
Provider Capitation	38,252,454	49,812,008	88,064,462	9,846,523	400,462	-	98,311,447
Facilities	24,090,011	20,888,338	44,978,348	2,480,464	394,962	202,365	48,056,139
Ancillary	-	-	-	584,735	31,515	-	616,250
Skilled Nursing	-	-	-	-	27,268	-	27,268
Professional Claims	7,184,543	8,072,631	15,257,174	-	-	243,696	15,500,870
Prescription Drugs	17,693,301	18,439,029	36,132,330	5,033,741	425,143	93,462	41,684,675
Long-term Care Facility Payments	53,169,264	2,490,933	55,660,197	5,231,479	-	(11,203)	60,880,473
Medical Management	2,810,261	-	2,810,261	1,064,319	28,294	424,452	4,327,325
Reinsurance & Other	73,685	265,957	339,642	260,312	8,663	123,900	732,517
Total Medical Expenses	143,273,518	99,968,896	243,242,414	24,501,572	1,316,306	1,076,672	270,136,964
Medical Loss Ratio	**97.4%**	**98.7%**	**97.9%**	**96.1%**	**97.6%**	**71.7%**	**97.6%**
GROSS MARGIN	**3,874,733**	**1,342,908**	**5,217,641**	**991,298**	**32,268**	**425,485**	**6,666,693**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			4,975,290	728,583	27,705	71,692	5,803,270
Professional fees			172,345	-	0	1,557	173,902
Purchased services			608,528	89,340	10,735	5,858	714,461
Printing and Postage			167,600	12,798	6,442	215	187,054
Depreciation and Amortization			375,995	-	-	2,096	378,092
Other expenses			1,101,679	29,387	0	3,874	1,134,941
Indirect cost allocation, Occupancy expense			(279,013)	584,428	31,910	2,718	340,043
Total Administrative Expenses			7,122,425	1,444,536	76,791	88,009	8,731,762
Admin Loss Ratio			**2.9%**	**5.7%**	**5.7%**	**5.9%**	**3.2%**
INCOME (LOSS) FROM OPERATIONS			(1,904,784)	(453,238)	(44,523)	337,476	(2,065,069)
INVESTMENT INCOME			-	-	-	-	2,709,333
NET RENTAL INCOME			-	-	-	-	3,170
NET GRANT INCOME			(2,666)	-	-	-	(2,666)
OTHER INCOME			73	-	-	-	73
CHANGE IN NET ASSETS			**$ (1,907,377)**	**$ (453,238)**	**$ (44,523)**	**$ 337,476**	**$ 644,841**
BUDGETED CHANGE IN ASSETS			1,443,045	(594,005)	(219,575)	(72,459)	809,550
VARIANCE TO BUDGET - FAV (UNFAV)			(3,350,421)	140,767	175,051	409,935	(164,709)

Back to Agenda

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $0.6 million, $0.2 million unfavorable to budget
- Operating deficit is $2.1 million with a surplus in non-operating of $2.7 million

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE			
Actual	Budget	Variance	
(1.9)	1.4	(3.4)	Medi-Cal
(0.5)	(0.6)	0.1	OCC
0.0	(0.2)	0.2	OneCare
0.3	(0.1)	0.4	PACE
(2.1)	**0.6**	**(2.6)**	**Operating**
2.7	0.3	2.5	Inv./Rental Inc, MCO tax
2.7	**0.3**	**2.5**	**Non-Operating**
0.6	**0.8**	**(0.2)**	**TOTAL**

Back to Agenda

CalOptima

Enrollment Summary

For the One Month Ended July 31, 2017

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
60,963	61,853	(890)	(1.4%)	Aged	60,963	61,853	(890)	(1.4%)
627	618	9	1.5%	BCCTP	627	618	9	1.5%
46,984	48,744	(1,760)	(3.6%)	Disabled	46,984	48,744	(1,760)	(3.6%)
324,532	330,072	(5,540)	(1.7%)	TANF Child	324,532	330,072	(5,540)	(1.7%)
95,766	104,110	(8,344)	(8.0%)	TANF Adult	95,766	104,110	(8,344)	(8.0%)
3,377	3,268	109	3.3%	LTC	3,377	3,268	109	3.3%
238,490	236,032	2,458	1.0%	MCE	238,490	236,032	2,458	1.0%
770,739	**784,697**	**(13,958)**	**(1.8%)**	**Medi-Cal**	**770,739**	**784,697**	**(13,958)**	**(1.8%)**
15,365	**15,488**	**(123)**	**(0.8%)**	**OneCare Connect**	**15,365**	**15,488**	**(123)**	**(0.8%)**
215	**216**	**(1)**	**(0.5%)**	**PACE**	**215**	**216**	**(1)**	**(0.5%)**
1,367	**1,315**	**52**	**4.0%**	**OneCare**	**1,367**	**1,315**	**52**	**4.0%**
787,686	**801,716**	**(14,030)**	**(1.7%)**	**CalOptima Total**	**787,686**	**801,716**	**(14,030)**	**(1.7%)**

Enrollment (By Network)

170,752	173,966	(3,214)	(1.8%)	HMO	170,752	173,966	(3,214)	(1.8%)
222,601	227,238	(4,637)	(2.0%)	PHC	222,601	227,238	(4,637)	(2.0%)
203,214	210,648	(7,434)	(3.5%)	Shared Risk Group	203,214	210,648	(7,434)	(3.5%)
174,172	172,847	1,325	0.8%	Fee for Service	174,172	172,847	1,325	0.8%
770,739	**784,697**	**(13,960)**	**(1.8%)**	**Medi-Cal**	**770,739**	**784,697**	**(13,958)**	**(1.8%)**
15,365	**15,488**	**(123)**	**(0.8%)**	**OneCare Connect**	**15,365**	**15,488**	**(123)**	**(0.8%)**
215	**216**	**(1)**	**(0.5%)**	**PACE**	**215**	**216**	**(1)**	**(0.5%)**
1,367	**1,315**	**52**	**4.0%**	**OneCare**	**1,367**	**1,315**	**52**	**4.0%**
787,686	**801,716**	**(14,030)**	**(1.7%)**	**CalOptima Total**	**787,686**	**801,716**	**(14,030)**	**(1.7%)**

Back to Agenda

CalOptima
Enrollment Trend by Network Type
Fiscal Year 2017

Network Type	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	MMs
HMO													
Aged	4,058	-	-	-	-	-	-	-	-	-	-	-	4,058
BCCTP	1	-	-	-	-	-	-	-	-	-	-	-	1
Disabled	6,749	-	-	-	-	-	-	-	-	-	-	-	6,749
TANF Child	61,492	-	-	-	-	-	-	-	-	-	-	-	61,492
TANF Adult	30,429	-	-	-	-	-	-	-	-	-	-	-	30,429
LTC	3	-	-	-	-	-	-	-	-	-	-	-	3
MCE	68,020	-	-	-	-	-	-	-	-	-	-	-	68,020
	170,752	-	-	-	-	-	-	-	-	-	-	-	170,752
PHC													
Aged	1,480	-	-	-	-	-	-	-	-	-	-	-	1,480
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	7,318	-	-	-	-	-	-	-	-	-	-	-	7,318
TANF Child	162,801	-	-	-	-	-	-	-	-	-	-	-	162,801
TANF Adult	12,604	-	-	-	-	-	-	-	-	-	-	-	12,604
LTC	-	-	-	-	-	-	-	-	-	-	-	-	-
MCE	38,398	-	-	-	-	-	-	-	-	-	-	-	38,398
	222,601	-	-	-	-	-	-	-	-	-	-	-	222,601
Shared Risk Group													
Aged	3,809	-	-	-	-	-	-	-	-	-	-	-	3,809
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	8,108	-	-	-	-	-	-	-	-	-	-	-	8,108
TANF Child	72,723	-	-	-	-	-	-	-	-	-	-	-	72,723
TANF Adult	32,775	-	-	-	-	-	-	-	-	-	-	-	32,775
LTC	-	-	-	-	-	-	-	-	-	-	-	-	-
MCE	85,799	-	-	-	-	-	-	-	-	-	-	-	85,799
	203,214	-	-	-	-	-	-	-	-	-	-	-	203,214
Fee for Service (Dual)													
Aged	48,036	-	-	-	-	-	-	-	-	-	-	-	48,036
BCCTP	25	-	-	-	-	-	-	-	-	-	-	-	25
Disabled	20,343	-	-	-	-	-	-	-	-	-	-	-	20,343
TANF Child	3	-	-	-	-	-	-	-	-	-	-	-	3
TANF Adult	1,205	-	-	-	-	-	-	-	-	-	-	-	1,205
LTC	3,002	-	-	-	-	-	-	-	-	-	-	-	3,002
MCE	2,816	-	-	-	-	-	-	-	-	-	-	-	2,816
	75,430	-	-	-	-	-	-	-	-	-	-	-	75,430
Fee for Service (Non-Dual)													
Aged	3,580	-	-	-	-	-	-	-	-	-	-	-	3,580
BCCTP	601	-	-	-	-	-	-	-	-	-	-	-	601
Disabled	4,466	-	-	-	-	-	-	-	-	-	-	-	4,466
TANF Child	27,513	-	-	-	-	-	-	-	-	-	-	-	27,513
TANF Adult	18,753	-	-	-	-	-	-	-	-	-	-	-	18,753
LTC	372	-	-	-	-	-	-	-	-	-	-	-	372
MCE	43,457	-	-	-	-	-	-	-	-	-	-	-	43,457
	98,742	-	-	-	-	-	-	-	-	-	-	-	98,742
MEDI-CAL TOTAL													
Aged	60,963	-	-	-	-	-	-	-	-	-	-	-	60,963
BCCTP	627	-	-	-	-	-	-	-	-	-	-	-	627
Disabled	46,984	-	-	-	-	-	-	-	-	-	-	-	46,984
TANF Child	324,532	-	-	-	-	-	-	-	-	-	-	-	324,532
TANF Adult	95,766	-	-	-	-	-	-	-	-	-	-	-	95,766
LTC	3,377	-	-	-	-	-	-	-	-	-	-	-	3,377
MCE	238,490	-	-	-	-	-	-	-	-	-	-	-	238,490
	770,739	-	-	-	-	-	-	-	-	-	-	-	770,739
PACE	215	-	-	-	-	-	-	-	-	-	-	-	215
OneCare	1,367	-	-	-	-	-	-	-	-	-	-	-	1,367
OneCare Connect	15,365	-	-	-	-	-	-	-	-	-	-	-	15,365
TOTAL	787,686	-	-	-	-	-	-	-	-	-	-	-	787,686

Back to Agenda

ENROLLMENT:

Overall MTD enrollment was 787,686

- Unfavorable to budget by 14,030 or 1.7%
- Decreased 1,380 or 0.2% from prior month
- Decreased 11,397 or 1.4% from prior year (July 2016)

Medi-Cal enrollment was 770,739

- Unfavorable to budget by 13,958
    - TANF unfavorable by 13,884
    - Expansion favorable by 2,458
    - SPD unfavorable by 2,641
    - LTC favorable by 109
- Decreased 1,489 from prior month

OneCare Connect enrollment was 15,365

- Unfavorable to budget by 123
- Decreased 140 from prior month

OneCare enrollment was 1,367

- Favorable to budget by 52
- Increased 246 from prior month

PACE enrollment was 215

- Unfavorable to budget by 1
- Increased 3 from prior month

CalOptima - Medi-Cal Total
Statement of Revenues and Expenses
For the One Month Ended July 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
770,739	784,697	(13,958)	(1.8%)	Member Months	770,739	784,697	(13,958)	(1.8%)
				Revenues				
248,460,055	244,788,286	3,671,769	1.5%	Capitation revenue	248,460,055	244,788,286	3,671,769	1.5%
248,460,055	244,788,286	3,671,769	1.5%	Total Operating Revenues	248,460,055	244,788,286	3,671,769	1.5%
				Medical Expenses				
88,064,462	87,120,002	(944,460)	(1.1%)	Provider capitation	88,064,462	87,120,002	(944,460)	(1.1%)
44,978,348	43,882,873	(1,095,476)	(2.5%)	Facilities	44,978,348	43,882,873	(1,095,476)	(2.5%)
15,257,174	13,866,229	(1,390,945)	(10.0%)	Professional Claims	15,257,174	13,866,229	(1,390,945)	(10.0%)
36,132,330	35,568,155	(564,175)	(1.6%)	Prescription drugs	36,132,330	35,568,155	(564,175)	(1.6%)
55,660,197	49,570,383	(6,089,814)	(12.3%)	MLTSS	55,660,197	49,570,383	(6,089,814)	(12.3%)
2,810,261	3,127,688	317,428	10.1%	Medical Management	2,810,261	3,127,688	317,428	10.1%
339,642	315,017	(24,625)	(7.8%)	Reinsurance & other	339,642	315,017	(24,625)	(7.8%)
243,242,414	233,450,348	(9,792,066)	(4.2%)	Total Medical Expenses	243,242,414	233,450,348	(9,792,066)	(4.2%)
5,217,641	11,337,938	(6,120,297)	(54.0%)	Gross Margin	5,217,641	11,337,938	(6,120,297)	(54.0%)
				Administrative Expenses				
4,975,290	5,873,696	898,406	15.3%	Salaries, wages & employee benefits	4,975,290	5,873,696	898,406	15.3%
172,345	371,772	199,426	53.6%	Professional fees	172,345	371,772	199,426	53.6%
608,528	1,578,285	969,757	61.4%	Purchased services	608,528	1,578,285	969,757	61.4%
167,600	398,736	231,136	58.0%	Printing and postage	167,600	398,736	231,136	58.0%
375,995	461,246	85,251	18.5%	Depreciation & amortization	375,995	461,246	85,251	18.5%
1,101,679	1,489,944	388,265	26.1%	Other operating expenses	1,101,679	1,489,944	388,265	26.1%
(279,013)	(278,785)	228	0.1%	Indirect cost allocation	(279,013)	(278,785)	228	0.1%
7,122,425	9,894,894	2,772,468	28.0%	Total Administrative Expenses	7,122,425	9,894,894	2,772,468	28.0%
				Operating Tax				
10,135,218	10,900,346	765,128	7.0%	Tax Revenue	10,135,218	10,900,346	765,128	7.0%
10,135,218	0	(10,135,218)	0.0%	Premium tax expense	10,135,218	0	(10,135,218)	0.0%
0	10,900,346	10,900,346	100.0%	Sales tax expense	0	10,900,346	10,900,346	100.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
				Grant Income				
69,250	291,249	(221,999)	(76.2%)	Grant Revenue	69,250	291,249	(221,999)	(76.2%)
58,863	258,276	199,414	77.2%	Grant expense - Service Partner	58,863	258,276	199,414	77.2%
13,053	32,973	19,920	60.4%	Grant expense - Administrative	13,053	32,973	19,920	60.4%
(2,666)	0	(2,666)	0.0%	Total Net Grant Income	(2,666)	0	(2,666)	0.0%
73	0	73	0.0%	Other income	73	0	73	0.0%
(1,907,377)	1,443,045	(3,350,421)	(232.2%)	Change in Net Assets	(1,907,377)	1,443,045	(3,350,421)	(232.2%)
97.9%	95.4%	-2 5%	-2.7%	Medical Loss Ratio	97.9%	95.4%	-2 5%	-2.7%
2.9%	4.0%	1 2%	29.1%	Admin Loss Ratio	2.9%	4.0%	1 2%	29.1%

Back to Agenda

MEDI-CAL INCOME STATEMENT – JULY MONTH:

REVENUES of $248.5 million are favorable to budget by $3.7 million, driven by:

- Unfavorable volume related variance of: $4.4 million
- Favorable price related variance of $8.0 million due to:
  - $4.5 million for Coordinated Care Initiative (CCI) revenue and In-Home Supportive Services (IHSS)
  - $1.9 million of fiscal year 2017 LTC related revenue recognized for members with Non-LTC aid codes
  - $1.5 million of fiscal year 2017 BHT Revenue

MEDICAL EXPENSES: Overall $243.2 million, unfavorable to budget by $9.8 million due to:

- **Long term care claim payments (MLTSS)** are unfavorable to budget $6.1 million due to:
  - LTC unfavorable variance of $3.5 million adjustment of IHSS expense corresponding with the favorable CCI revenue variance above
  - Nursing facility unfavorable variance of $2.0 million
- **Provider Capitation** is unfavorable $0.9 million due to BHT Capitation
- **Facilities** expenses are unfavorable to budget $1.1 million due to Hospital Shared Risk Pool

ADMINISTRATIVE EXPENSES are $7.1 million, favorable to budget $2.8 million, driven by:

- Purchased Services: $1.0 million favorable to budget
- Salary & Benefits: $0.9 million favorable to budget due to open positions
- Other Non-Salary: $0.9 million unfavorable to budget

CHANGE IN NET ASSETS is ($1.9) million for the month, unfavorable to budget by $3.4 million

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the One Month Ended July 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
15,365	15,488	(123)	(0.8%)	Member Months	15,365	15,488	(123)	(0.8%)
				Revenues				
7,368,561	7,522,125	(153,564)	(2.0%)	Medi-Cal Capitation revenue	7,368,561	7,522,125	(153,564)	(2.0%)
18,124,309	18,749,841	(625,532)	(3.3%)	Medicare Capitation revenue	18,124,309	18,749,841	(625,532)	(3.3%)
25,492,870	26,271,966	(779,096)	(3.0%)	Total Operating Revenue	25,492,870	26,271,966	(779,096)	(3.0%)
				Medical Expenses				
9,846,523	7,723,110	(2,123,413)	(27.5%)	Provider capitation	9,846,523	7,723,110	(2,123,413)	(27.5%)
2,480,464	5,094,250	2,613,786	51.3%	Facilities	2,480,464	5,094,250	2,613,786	51.3%
584,735	626,246	41,511	6.6%	Ancillary	584,735	626,246	41,511	6.6%
5,231,479	4,254,619	(976,860)	(23.0%)	Long Term Care	5,231,479	4,254,619	(976,860)	(23.0%)
5,033,741	5,827,270	793,529	13.6%	Prescription drugs	5,033,741	5,827,270	793,529	13.6%
1,064,319	1,279,330	215,011	16.8%	Medical management	1,064,319	1,279,330	215,011	16.8%
260,312	117,174	(143,138)	(122.2%)	Other medical expenses	260,312	117,174	(143,138)	(122.2%)
24,501,572	24,921,999	420,427	1.7%	Total Medical Expenses	24,501,572	24,921,999	420,427	1.7%
991,298	1,349,967	(358,669)	(26.6%)	Gross Margin	991,298	1,349,967	(358,669)	(26.6%)
				Administrative Expenses				
728,583	926,395	197,811	21.4%	Salaries, wages & employee benefits	728,583	926,395	197,811	21.4%
0	38,333	38,333	100.0%	Professional fees	0	38,333	38,333	100.0%
89,340	239,868	150,528	62.8%	Purchased services	89,340	239,868	150,528	62.8%
12,798	103,801	91,003	87.7%	Printing and postage	12,798	103,801	91,003	87.7%
29,387	51,148	21,761	42.5%	Other operating expenses	29,387	51,148	21,761	42.5%
584,428	584,428	(0)	(0.0%)	Indirect cost allocation, Occupancy Expense	584,428	584,428	(0)	(0.0%)
1,444,536	1,943,972	499,436	25.7%	Total Administrative Expenses	1,444,536	1,943,972	499,436	25.7%
				Operating Tax				
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
(453,238)	(594,005)	140,767	23.7%	Change in Net Assets	(453,238)	(594,005)	140,767	23.7%
96.1%	94.9%	-1.2%	-1.3%	Medical Loss Ratio	96.1%	94.9%	-1.2%	-1.3%
5.7%	7.4%	1.7%	23.4%	Admin Loss Ratio	5.7%	7.4%	1.7%	23.4%

Back to Agenda

ONECARE CONNECT INCOME STATEMENT – JULY MONTH:

REVENUES of $25.5 million are unfavorable to budget by $0.8 million driven by:

- Unfavorable volume related variance of $0.2 million due to lower enrollment
- Unfavorable price related variance of $0.6 million due to Part D

MEDICAL EXPENSES are favorable to budget $0.4 million due to:

- Favorable volume related variance of $0.2 million due to lower enrollment
- Favorable price related variance of $0.2 million from Rx rebates

ADMINISTRATIVE EXPENSES are favorable to budget by $0.5 million

CHANGE IN NET ASSETS is ($0.5) million, $0.1 million favorable to budget

CalOptima - OneCare
Statement of Revenues and Expenses
For the One Month Ended July 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,367	1,315	52	4 0%	Member Months	1,367	1,315	52	4.0%
				Revenues				
1,348,574	1,258,717	89,857	7.1%	Capitation revenue	1,348,574	1,258,717	89,857	7.1%
1,348,574	1,258,717	89,857	7.1%	Total Operating Revenue	1,348,574	1,258,717	89,857	7.1%
				Medical Expenses				
400,462	333,072	(67,390)	(20.2%)	Provider capitation	400,462	333,072	(67,390)	(20.2%)
394,962	443,130	48,168	10 9%	Inpa ient	394,962	443,130	48,168	10.9%
31,515	47,625	16,110	33 8%	Ancillary	31,515	47,625	16,110	33.8%
27,268	41,048	13,780	33.6%	Skilled nursing facilities	27,268	41,048	13,780	33.6%
425,143	475,900	50,757	10.7%	Prescription drugs	425,143	475,900	50,757	10.7%
28,294	25,320	(2,974)	(11.7%)	Medical management	28,294	25,320	(2,974)	(11.7%)
8,663	7,785	(878)	(11.3%)	Other medical expenses	8,663	7,785	(878)	(11.3%)
1,316,306	1,373,880	57,574	4 2%	Total Medical Expenses	1,316,306	1,373,880	57,574	4.2%
32,268	(115,163)	147,431	128 0%	Gross Margin	32,268	(115,163)	147,431	128.0%
				Administrative Expenses				
27,705	20,170	(7,535)	(37.4%)	Salaries, wages & employee benefits	27,705	20,170	(7,535)	(37.4%)
0	13,333	13,333	100 0%	Professional fees	0	13,333	13,333	100.0%
10,735	11,990	1,255	10 5%	Purchased services	10,735	11,990	1,255	10.5%
6,442	26,788	20,346	76 0%	Prin ing and postage	6,442	26,788	20,346	76.0%
0	221	221	100 0%	Other operating expenses	0	221	221	100.0%
31,910	31,910	(0)	(0.0%)	Indirect cost allocation, Occupancy Expense	31,910	31,910	(0)	(0 0%)
76,791	104,412	27,620	26 5%	Total Administrative Expenses	76,791	104,412	27,620	26.5%
(44,523)	(219,575)	175,051	79.7%	Change in Net Assets	(44,523)	(219,575)	175,051	79.7%
97.6%	109.1%	11.5%	10.6%	Medical Loss Ra io	97.6%	109.1%	11.5%	10.6%
5.7%	8.3%	2.6%	31.4%	Admin Loss Ra io	5.7%	8.3%	2.6%	31.4%

Back to Agenda

CalOptima - PACE
Statement of Revenues and Expenses
For the One Month Ended July 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
215	216	(1)	(0.5%)	Member Months	215	216	(1)	(0.5%)
				Revenues				
1,056,968	1,092,996	(36,029)	(3.3%)	Medi-Cal capitation revenue	1,056,968	1,092,996	(36,029)	(3.3%)
445,190	326,579	118,611	36 3%	Medicare capitation revenue	445,190	326,579	118,611	36.3%
1,502,158	1,419,576	82,582	5 8%	Total Operating Revenues	1,502,158	1,419,576	82,582	5.8%
				Medical Expenses				
333,542	409,447	75,905	18 5%	Clinical salaries & benefits	333,542	409,447	75,905	18.5%
202,365	311,869	109,505	35.1%	Claims payments to hospitals	202,365	311,869	109,505	35.1%
243,696	257,680	13,984	5.4%	Professional Claims	243,696	257,680	13,984	5.4%
93,462	108,451	14,989	13 8%	Prescription drugs	93,462	108,451	14,989	13.8%
(11,203)	11,902	23,104	194.1%	Long-term care facility payments	(11,203)	11,902	23,104	194.1%
90,910	89,233	(1,677)	(1.9%)	Patient Transportation	90,910	89,233	(1,677)	(1.9%)
0	0	0	0 0%	Reinsurance	0	0	0	0.0%
123,900	158,625	34,725	21 9%	Other Expenses	123,900	158,625	34,725	21.9%
1,076,672	1,347,207	270,535	20.1%	Total Medical Expenses	1,076,672	1,347,207	270,535	20.1%
425,485	72,369	353,117	487 9%	Gross Margin	425,485	72,369	353,117	487.9%
				Administrative Expenses				
71,692	89,725	18,034	20.1%	Salaries, wages & employee benefits	71,692	89,725	18,034	20.1%
1,557	5,000	3,443	68 9%	Professional fees	1,557	5,000	3,443	68.9%
5,858	21,136	15,278	72 3%	Purchased services	5,858	21,136	15,278	72.3%
215	5,547	5,332	96.1%	Printing and postage	215	5,547	5,332	96.1%
2,096	2,052	(44)	(2.2%)	Depreciation & amortization	2,096	2,052	(44)	(2.2%)
3,874	18,503	14,629	79.1%	Other operating expenses	3,874	18,503	14,629	79.1%
2,718	2,864	146	5.1%	Indirect cost allocation, Occupancy Expense	2,718	2,864	146	5.1%
88,009	144,827	56,818	39 2%	Total Administrative Expenses	88,009	144,827	56,818	39.2%
				Operating Tax				
0	0	0	0 0%	Total Net Operating Tax	0	0	0	0.0%
337,476	(72,459)	409,935	565.7%	Change in Net Assets	337,476	(72,459)	409,935	565.7%
71.7%	94.9%	23.2%	24 5%	Medical Loss Ratio	71.7%	94.9%	23 2%	24.5%
5 9%	10.2%	4.3%	42 6%	Admin Loss Ratio	5.9%	10.2%	4 3%	42.6%

CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the One Month Ended July 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
24,056	21,387	2,669	12.5%	Rental income	24,056	21,387	2,669	12.5%
24,056	21,387	2,669	12.5%	Total Operating Revenue	24,056	21,387	2,669	12.5%
				Administrative Expenses				
29,508	23,186	(6,322)	(27.3%)	Purchase services	29,508	23,186	(6,322)	(27.3%)
159,482	161,474	1,991	1.2%	Depreciation & amortization	159,482	161,474	1,991	1.2%
14,913	9,117	(5,797)	(63.6%)	Insurance expense	14,913	9,117	(5,797)	(63.6%)
107,149	158,122	50,972	32.2%	Repair and maintenance	107,149	158,122	50,972	32.2%
69,306	0	(69,306)	0.0%	Other Operating Expense	69,306	0	(69,306)	0.0%
(359,472)	(333,055)	26,417	7.9%	Indirect allocation, Occupancy Expense	(359,472)	(333,055)	26,417	7.9%
20,887	18,843	(2,044)	(10.8%)	Total Administrative Expenses	20,887	18,843	(2,044)	(10.8%)
3,170	2,544	626	24.6%	Change in Net Assets	3,170	2,544	626	24.6%

Back to Agenda

OTHER STATEMENTS – JULY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($44.5) thousand, $175.1 thousand favorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $0.3 million, $0.4 million favorable to budget

505 CITY PARKWAY BUILDING INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $3.2 thousand; $0.1 thousand favorable to budget

CalOptima
BALANCE SHEET
July 31, 2017

ASSETS			**LIABILITIES & FUND BALANCES**		
Current Assets			Current Liabilities		
	Operating Cash	$520,629,891		Accounts payable	$19,191,148
	Investments	1,042,089,960		Medical claims liability	1,256,027,205
	Capitation receivable	555,427,127		Accrued payroll liabilities	9,641,084
	Receivables - Other	20,691,018		Deferred revenue	110,962,533
	Prepaid Expenses	5,183,841		Deferred lease obligations	190,764
				Capitation and withholds	589,500,324
	Total Current Assets	**2,144,021,837**		**Total Current Liabilities**	**1,985,513,058**
Capital Assets	Furniture and equipment	33,437,912	Other employment benefits liability		28,767,486
	Leasehold improvements	5,884,660			
	505 City Parkway West	49,422,364	Net Pension Liabilities		16,144,973
		88,744,936	Long Term Liabilities		100,000
	Less: accumulated depreciation	(35,029,816)			
	Capital assets, net	**53,715,120**	**TOTAL LIABILITIES**		**2,030,525,517**
Other Assets	Restricted deposit & Other	300,000	Deferred inflows of Resources - Excess Earnings		-
			Deferred inflows of Resources - Changes in Assumptions		1,340,010
	Board-designated assets				
	Cash and cash equivalents	29,002,485	Tangible net equity (TNE)		89,980,450
	Long term investments	507,352,179	Funds in excess of TNE		624,122,783
	Total Board-designated Assets	536,354,664			
	Total Other Assets	**536,654,664**	**Net Assets**		**714,103,233**
	Deferred outflows of Resources - Pension Contributions	5,234,198			
	Deferred outflows of Resources - Difference in Experience	1,072,771			
	Deferred outflows of Resources - Excess Earnings	5,270,171			
TOTAL ASSETS & OUTFLOWS		**2,745,968,760**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**		**2,745,968,760**

Back to Agenda

BALANCE SHEET:

ASSETS increased $5.9 million from June

- **Net Capitation Receivables** increased $33.0 million based upon payment receipt timing and receivables
- **Short-term Investments** decreased $40.3 million due to payment receipt timing and cash funding requirements
- **Cash and Cash Equivalents** increased by $24.2 million based upon payment receipt timing and receivables

LIABILITIES increased $5.2 million from June

- **Medical Claims Liability** by line of business increased $9.6 million due to increase medical liability relating to Coordinated Care Initiative (CCI)
- **Capitation Payable** increased $8.7 driven by timing of Capitation payments
- **Accrued Expenses** decreased $20.7 million based on the timing of sales tax payments and an earlier fiscal year-end processing cut-off

NET ASSETS are $714.1 million

CalOptima
Statement of Cash Flows
July 31, 2017

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	644,841	644,841
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	537,574	537,574
Changes in assets and liabilities:		
Prepaid expenses and other	470,806	470,806
Catastrophic reserves		
Capitation receivable	(32,569,410)	(32,569,410)
Medical claims liability	9,601,185	9,601,185
Deferred revenue	6,989,408	6,989,408
Payable to providers	8,660,614	8,660,614
Accounts payable	(20,932,143)	(20,932,143)
Other accrued liabilities	889,337	889,337
Net cash provided by/(used in) operating activities	(25,707,788)	(25,707,788)
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Investments	40,335,792	40,335,792
Purchase of property and equipment	48,332	48,332
Change in Board designated reserves	(1,216,290)	(1,216,290)
Net cash provided by/(used in) investing activities	39,167,834	39,167,834
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	13,460,046	13,460,046
CASH AND CASH EQUIVALENTS, beginning of period	$507,169,844	507,169,844
CASH AND CASH EQUIVALENTS, end of period	**$ 520,629,891**	**$ 520,629,891**

Back to Agenda

CalOptima
Board Designated Reserve and TNE Analysis
as of July 31, 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,551,672				
	Tier 1 - Logan Circle	146,259,887				
	Tier 1 - Wells Capital	146,315,362				
Board-designated Reserve		439,126,921	310,823,204	482,596,199	128,303,717	(43,469,278)
TNE Requirement	Tier 2 - Logan Circle	97,227,743	89,980,450	89,980,450	7,247,293	7,247,293
	Consolidated:	536,354,664	400,803,654	572,576,648	135,551,010	(36,221,985)
	Current reserve level	*1.87*	*1.40*	*2.00*		

Back to Agenda

CalOptima Foundation
Statement of Revenues and Expenses
For the One Month Ended July 31, 2017
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	0	0	0.0%	Total Operating Revenue	0	0	0	0.0%
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	0	6,184	6,184	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	2,985	2,985	100.0%
0	0	0	0.0%	Travel	0	0	0	0.0%
0	0	0	0.0%	Supplies	0	0	0	0.0%
0	0	0	0.0%	Contractual	0	0	0	0.0%
2,083	231,923	229,840	99.1%	Other	2,083	231,923	229,840	99.1%
2,083	241,092	239,009	99.1%	Total Operating Expenditures	2,083	241,092	239,009	99.1%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
(2,083)	(241,092)	(239,009)	(99.1%)	Program Income	(2,083)	(241,092)	(239,009)	(99.1%)

Back to Agenda

CalOptima Foundation
Balance Sheet
July 31, 2017

ASSETS		LIABILITIES & NET ASSETS	
Operating cash	2,868,139	Accounts payable-Current	0
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**2,868,139**	Grants-Foundation	0
		Total Current Liabilities	0
		Total Liabilities	**2,083**
		Net Assets	**2,866,056**
TOTAL ASSETS	**2,868,139**	**TOTAL LIABILITIES & NET ASSETS**	**2,868,139**

Back to Agenda

CALOPTIMA FOUNDATION – JULY MONTH

INCOME STATEMENT:

Income Statement:

Operating Revenue

No activity.

Operating Expenses

CalOptima Foundation operating expenses were $2K for audit fees YTD.

* Expense categories includes: professional fees, staff services, travel and miscellaneous supplies.

* Major Actual to Budget variance was in "Other" category - $239K favorable variance YTD.

  - FY18 budget was allocated monthly based on the remaining $2.8M fund balance.
  - Actual recognized expenses were much lower than budgeted anticipated CalOptima support activities.

Balance Sheet:

Assets

* Cash - $2.86M remains from the FY14 $3.0M transferred by CalOptima for grants and programs in support of providers and community.

Liabilities

Payable to CalOptima - $2K for audit fees - Foundation.

Budget Allocation Changes

Reporting Changes for July 2017

Transfer Month	Line of Business	From:	To:	Amount	Expense Description	Fiscal Year
July	Medi-Cal	IS - Infrastructure - Professional Fee (Virtualization Architecture Assessment)	IS - Infrastructure - Professional Fee (On-Site Staff for the Phone System)	$48,600	Re-Purpose $48,600 from Professional Fees (Virtualiza ion Architecture Assessment) to pay for an on-site staff for the phone system	2018
July	Medi-Cal	Facilities - Purchased Services (Restacking Services)	Facilities - Purchased Services (Reconfiguration Services)	$15,000	Re-Purpose $15,000 from Purchased Services (Restacking Services) to reconfiguration and breakdown of furniture for the mail room and the Rover Rock Offices and other related expenses	2018

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.

This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Back to Agenda

Board of Directors' Meeting
September 7, 2017

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare Connect

- 2017 Performance Measure Validation (PMV) Activity: On July 7, 2017, CalOptima received an engagement letter from CMS' contractor, Health Services Advisory Group, Inc. (HSAG), for a performance measure validation (PMV) activity of select core and state-specific reporting measures for Medicare-Medicaid Plans (MMPs). HSAG will validate the data collection and reporting processes used by the MMPs to calculate the performance measure rates required by CMS to ensure that data reported by MMPs are accurate and valid. On July 11, 2017, HSAG conducted a kick off webinar with MMPs to prepare for the PMV activity. HSAG has scheduled the PMV activity for September 18, 2017.

- CMS Universe Integrity Testing (*applicable to OneCare Connect and OneCare*): In August 2017, CalOptima's Office of Compliance began conducting Universe Integrity Testing to validate the completeness and accuracy of all universes required for submission during a CMS full-scope program audit for OneCare and OneCare Connect to ensure audit readiness. Specifically, CalOptima's Office of Compliance began validating the completeness and accuracy of all universes in accordance with the final 2017 CMS Medicare Parts C and D Program Audit Protocols and the 2017 CMS Program Audit Pilot Protocols for Medicare-Medicaid Plans (MMPs).

2. Medi-Cal

- DMHC 1115 Waiver Seniors and Persons with Disabilities (SPDs) Audit: The DMHC conducted its tri-annual audit of CalOptima's Medi-Cal SPDs from February 6-10, 2017. The DMHC conducted the audit on behalf of the DHCS as part of an inter-agency agreement. The audit covered the period from November 1, 2014 through October 31, 2016. On July 27, 2017, DHCS sent CalOptima a report regarding the audit, which identified ten (10) deficiencies in the areas of utilization management, continuity of care, availability and accessibility, member rights, and quality management. CalOptima has forty five (45) calendar days to submit a corrective action plan (CAP) to DHCS regarding the deficiencies.

Back to Agenda

B. Regulatory Compliance Notices

1. CalOptima did not receive any notices of non-compliance from its regulators for the month of July 2017.

C. Updates on Internal and Health Network Audits

1. Internal Audits: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
March 2017	30%	N/A	N/A	0%	80%	67%	89%	60%	73%	87%	Nothing to Report	Nothing to Report	Nothing to Report
April 2017	50%	N/A	N/A	0%	60%	67%	83%	80%	67%	88%	Nothing to Report	Nothing to Report	Nothing to Report
May 2017	10%	N/A	N/A	0%	10%	70%	89%	60%	73%	92%	Nothing to Report	Nothing to Report	Nothing to Report

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent – 72 hours, Routine – 5 business days)
  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for initial notification to the requesting provider (24 hours)
  - Failure to meet timeframe for written notification to the requesting provider (24 hours)

- The lower scores for clinical decision making were due to the following reason:
  - Failure to cite criteria for decision

- The lower letter scores were due to the following reasons:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide alternative direction in referral back to primary care physician (PCP) on denial

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- Medi-Cal Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2017	100%	90%	100%	100%
April 2017	90%	100%	100%	100%
May 2017	100%	100%	100%	100%

  - No significant trends to report.

- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Letter Accuracy	Determination Timeliness	Acknowledgement Timeliness
March 2017	100%	95%	100%
April 2017	100%	90%	95%
May 2017	95%	95%	95%

  - The compliance rate for letter accuracy has decreased from 100% in April 2017 to 95% in May 2017 due to acknowledgement letters not being sent timely.

- Medi-Cal Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	Medi-Cal Call Center	Member Liaison Call Center
March 2017	100%	100%
April 2017	100%	100%
May 2017	100%	100%

  - No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

2. Internal Audits: OneCare

- OneCare Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
March 2017	0%
April 2017	0%
May 2017	0%

  - No claims were rejected in error due to formulary restrictions from March through May 2017.

- OneCare Pharmacy: Coverage determination timeliness is reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
March 2017	100%
April 2017	100%
May 2017	100%

  - The compliance rate for coverage determination timeliness remains consistent at 100% from March through May 2017.

- OneCare Utilization Management

  - Due to low membership for the months of March 2017 through May 2017, there were no standard organization determinations, denials, or expedited organization determinations reported.

- OneCare Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2017	100%	100%	100%	70%
April 2017	100%	100%	100%	80%
May 2017	100%	100%	100%	100%

  - No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
March 2017	100%	100%	100%	100%
April 2017	100%	100%	100%	100%
May 2017	100%	100%	100%	100%

  - No significant trends to report.

- OneCare Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Customer Service
March 2017	100%
April 2017	100%
May 2017	100%

  - No significant trends to report.

3. Internal Audits: OneCare Connect [a\]

- OneCare Connect Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
March 2017	0%
April 2017	0%
May 2017	0%

  - No claims were rejected in error due to formulary restrictions from March through May 2017.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- OneCare Connect Pharmacy: Coverage determination timeliness is reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
March 2017	100%
April 2017	100%
May 2017	99%

  - ➢ No significant trends to report.

- OneCare Connect Utilization Management: Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM For Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
March 2017	90%	N/A	45%	44%	28%	70%	50%	88%	Nothing to Report	Nothing o Repor	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
April 2017	80%	N/A	20%	70%	35%	100%	70%	90%	Nothing to Report	Nothing o Repor	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
May 2017	40%	N/A	40%	90%	35%	70%	73%	89%	Nothing to Report	Nothing o Repor	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

  - ➢ The lower scores for timeliness were due to the following reasons:
    - Failure to meet timeframe for decision (Urgent – 72 hours, Routine – 5 business days)
    - Failure to meet timeframe for initial notification to the requesting provider (24 hours)
    - Failure to meet timeframe for written notification to the requesting provider (24 hours)

  - ➢ The lower scores for letter review were due to the following reason:
    - Failure to provide letter with description of services in lay language

- OneCare Connect Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2017	100%	100%	100%	70%
April 2017	50%	100%	100%	80%
May 2017	100%	100%	100%	90%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- No significant trends to report.

- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
March 2017	100%	93%	100%	100%
April 2017	95%	100%	100%	100%
May 2017	100%	86%	86%	100%

- The compliance rate for payment accuracy has decreased from 100% in April 2017 to 86% in May 2017 due to failure to pay all modifiers on claim.

- The compliance rate for letter accuracy has decreased from 100% in April 2017 to 86% in May 2017 due to letter being sent prior to claim being processed.

- OneCare Connect Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Connect Customer Service
March 2017	100%
April 2017	100%
May 2017	100%

- No significant trends to report.

4. Internal Audits: PACE

- PACE Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2017	100%	100%	100%	90%
April 2017	100%	100%	100%	60%
May 2017	100%	90%	100%	90%

- No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check LAG
March 2017	100%	100%	100%	100%
April 2017	100%	100%	100%	100%
May 2017	100%	100%	100%	100%

  - ➢ No significant trends to report.

5. Health Network Audits: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
March 2017	88%	89%	92%	83%	65%	92%	94%	74%	78%	89%	Nothing to Report	Nothing to Report	Nothing to Report
April 2017	68%	97%	99%	94%	74%	88%	90%	80%	100%	97%	46%	81%	58%
May 2017	77%	83%	82%	89%	79%	84%	91%	75%	89%	98%	67%	39%	66%

  - ➢ The lower scores for timeliness were due to the following reasons:
    - Failure to meet timeframe for decision (Urgent – 72 Hours, Routine – 5 business days)
    - Failure to meet timeframe for provider written notification (2 business days)
    - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)
    - Failure to meet timeframe for member delay notification (2 business days)

  - ➢ The lower scores for clinical decision making (CDM) were due to the following reasons:
    - Failure to obtain adequate clinical information
    - Failure to have appropriate professional make decision
    - Failure to use criteria for decision

  - ➢ The lower letter scores were due to the following reasons:

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- Failure to provide information on how to file a grievance
- Failure to provide letter in member preferred language
- Failure to provide language assistance program (LAP) insert with approved threshold languages
- Failure to describe why the request did not meet criteria in lay language
- Failure to provide description of services in lay language
- Failure to provide alternative direction in referral back to PCP on denial
- Failure to provide name and contact information for health care professional responsible for decision to requesting provider
- Failure to provide notification to enrollee of delayed decision and anticipated decision date
- Failure to provide notification to provider of delayed decision and anticipated decision date
- Failure to provide peer-to-peer discussion with medical reviewer

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2017	94%	92%	92%	98%
April 2017	100%	99%	99%	97%
May 2017	100%	99%	96%	91%

➢ The compliance rate for denied claims timeliness decreased from 99% in April 2017 to 96% in May 2017 due to incorrect received date utilized to process the claim.

➢ The compliance rate for denied claims accuracy decreased from 97% in April 2017 to 91% in May 2017 due to interest on claim being paid inappropriately and denying claims incorrectly.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- Medi-Cal Claims: Misclassified Hospital Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
March 2017	100%	100%
April 2017	100%	100%
May 2017	97%	100%

  - The compliance rate for misclassified paid claims decreased from 100% in April 2017 to 97% in May 2017 due to claim being misclassified in the universe.

- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2017	95%	100%	100%	100%
April 2017	100%	100%	100%	100%
May 2017	100%	100%	100%	100%

  - No significant trends to report.

6. Health Network Audits: OneCare [a\]

- OneCare Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making (CDM) for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timeliness for Denials	CDM for Denials	Letter Score for Denials
March 2017	79%	Nothing to Report	65%	89%	59%	80%	70%	92%
April 2017	82%	Nothing to Report	57%	88%	67%	80%	73%	94%
May 2017	100%	Nothing to Report	76%	88%	72%	75%	61%	92%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- The lower scores for timeliness were due to the following reason:
  - Failure to meet timeframe for decision making (Expedited – 24 hours)

- The lower scores for clinical decision making (CDM) were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision
  - Failure to obtain adequate clinical information to deny
  - No indication that the medical reviewer was involved in the denial determination

- The lower letter scores were due to the following reasons:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide description of requested services in lay language
  - Failure to offer to discuss decision with reviewer

- OneCare Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
March 2017	100%	89%
April 2017	100%	97%
May 2017	100%	100%

- No significant trends to report.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2017	100%	100%	96%	81%
April 2017	99%	100%	100%	94%
May 2017	100%	100%	100%	89%

- The compliance rate for denied claims accuracy decreased from 94% in April 2017 to 89% in May 2017 due to services being rendered and billed when member is no long eligible during the date of service.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

7. Health Network Audits: OneCare Connect [a\]

- OneCare Connect Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
March 2017	87%	100%	72%	85%	63%	67%	68%	83%	25%	74%	85%	Nothing to Report	Nothing to Report	Nothing to Report
April 2017	77%	100%	77%	82%	82%	43%	78%	80%	56%	87%	96%	100	Nothing to Report	60%
May 2017	88%	100%	80%	87%	86%	50%	76%	77%	100%	100%	89%	0%	Nothing to Report	75%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for provider initial notification (24 hours)
  - Failure to provide proof of successful written notification to requesting provider (2 business days)

- The lower scores for clinical decision making (CDM) were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision
  - Failure to obtain adequate clinical information to deny
  - Failure to have appropriate professional make decision

- The lower letter scores were due to the following reasons:
  - Failure to provide information on how to file a grievance
  - Failure to provide letter in member preferred language
  - Failure to provide language assistance program (LAP) insert with approved threshold languages
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide description of services in lay language
  - Failure to provide alternative direction in referral back to PCP on denial
  - Failure to provide name and contact information for health care professional responsible for decision to requesting provider
  - Failure to provide notification to enrollee of delayed decision and anticipated decision date
  - Failure to provide notification to provider of delayed decision and anticipated decision date
  - Failure to provide peer-to-peer discussion with medical reviewer

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- OneCare Connect Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
March 2017	94%	93%
April 2017	100%	97%
May 2017	100%	100%

  - No significant trends to report.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2017	97%	90%	100%	95%
April 2017	96%	95%	98%	100%
May 2017	91%	96%	96%	96%

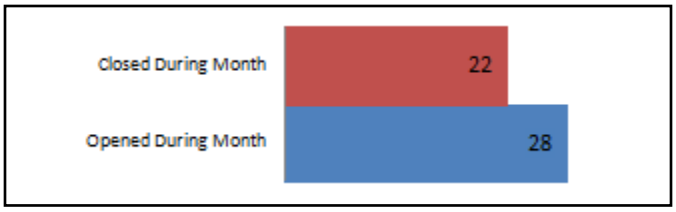
  - The compliance rate for paid claims timeliness decreased from 96% in April to 91% in May 2017 due to untimely processing.
  - The compliance rate for denied claims timeliness decreased from 98% in April 2017 to 96% in May 2017 due to incorrect received date being used for processing.
  - The compliance rate for denied claims accuracy decreased from 100% in April 2017 to 96% in May 2017 due to interest incorrectly being applied.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

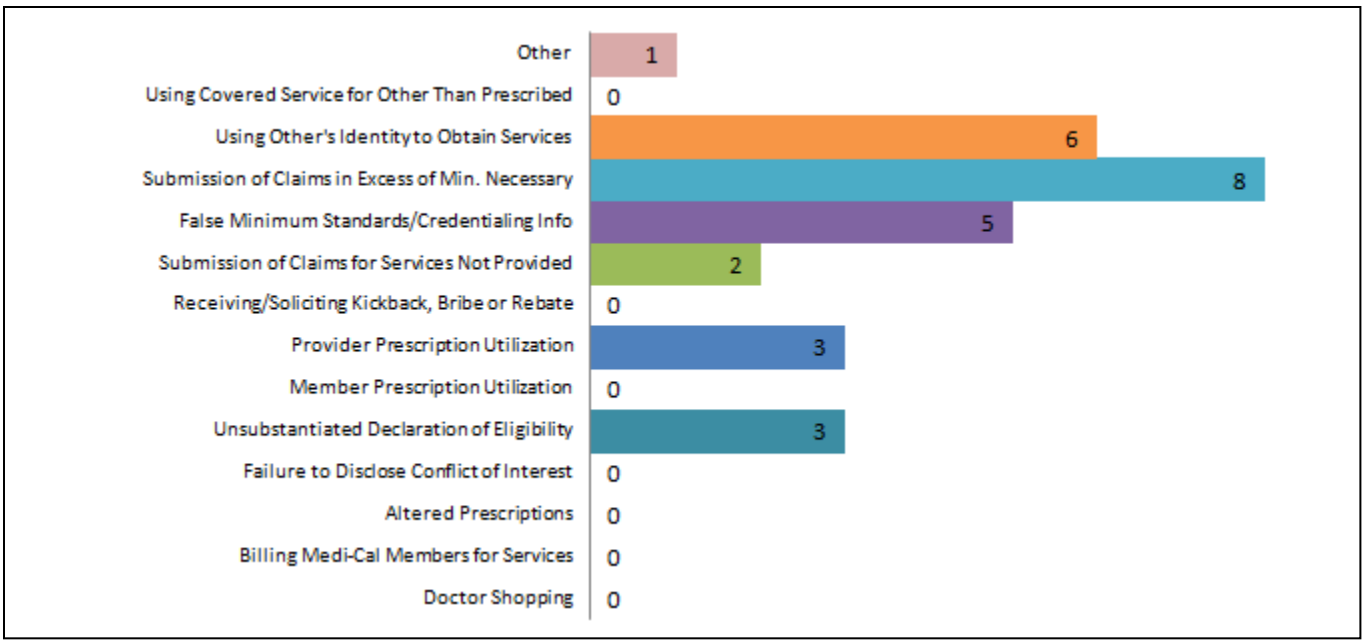
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations (July 2017)

Case Status
Case status at the end of July 2017



Note: Cases that are referred to DHCS or the MEDIC are not "closed" until CalOptima receives notification of case closure from the applicable government agency.

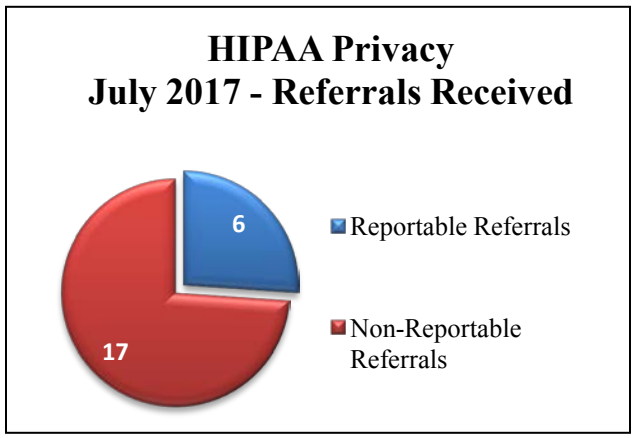
Types of FWA Cases: (Received in July 2017)

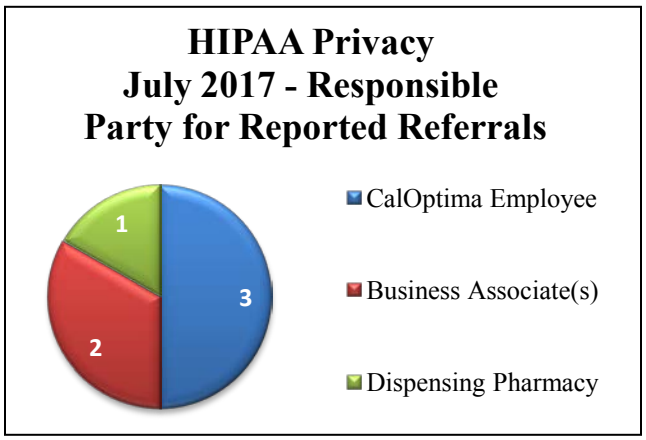


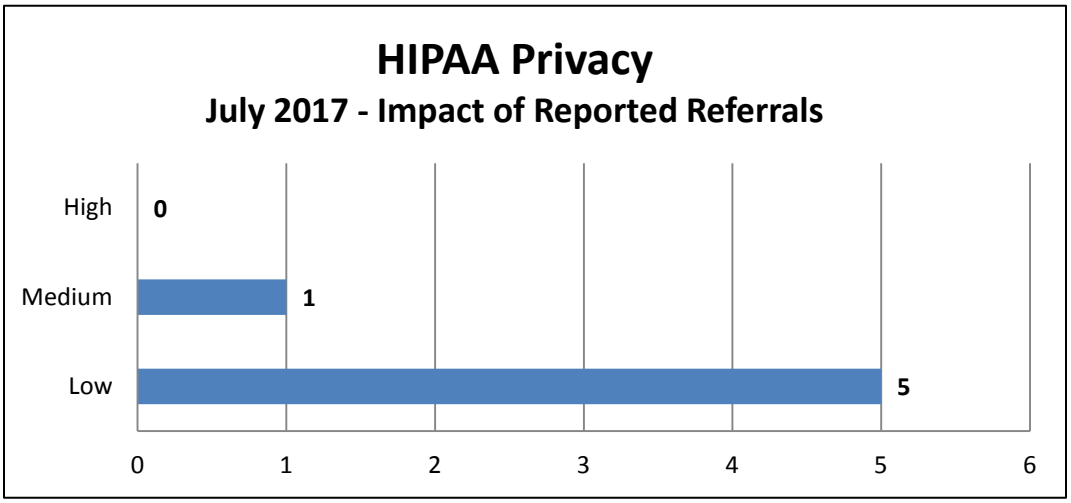
a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

E. Privacy Update (July 2017)







PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	5
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights	1
Total Number of Referrals Reported	**6**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting
September 7, 2017

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

Back to Agenda

Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

August 9, 2017

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: August Report

The final three weeks of the month of July saw the dramatic conclusion of the debate in the Senate on its efforts to repeal and replace the Affordable Care Act with nearly all other legislative activity on health care issues on hold until this high priority for both parties was resolved. The following summary covers the second half of the month of July through August 9.

The End of 'Repeal and Replace'
Prior to adjourning for the Fourth of July recess, Senate Majority Leader Mitch McConnell (R-KY) postponed a planned procedural vote on the Better Health Care Act (BCRA), the legislative product of Senate Republican deliberations that would have phased out the Medicaid expansion more slowly than the House-passed American Health Care Act (AHCA), but implemented a more drastic long-term cut to the program as it phased in per capita caps. This bill did not satisfy conservative Republican Senators who sought greater reforms to the insurance plans in the Affordable Care Act's individual marketplaces nor did it satisfy moderate Republican Senators who were concerned about the impact of the Medicaid changes, among other provisions.

Leader McConnell committed to holding a vote upon return from the Fourth of July recess regardless of whether it was likely to pass or not. Corralling 50 votes out of his 52 member conference became even more difficult July 15 – the weekend prior to the planned beginning of votes – when Senator John McCain (R-AZ) was diagnosed with a glioblastoma above his left eye. Treatment for this deadly brain cancer had to begin immediately and uncertainty reigned for until Senator McCain announced the following week that he would travel to Washington for the health care votes. Without Senator McCain, Republicans could only afford to lose 1 vote. Senator Susan Collins (R-ME) had previously made clear that she would be voting against the bill while several others like Senators Lisa Murkowski (R-AK), Rob Portman (R-OH), Dean Heller (R-NV), and Shelley Moore Capito (R-WV) had long been considered weak in their support. With Senator McCain announcing he would return to the Capitol for the vote, optimism increased among Republicans that he would not risk his health to vote against his party's greatest legislative priority. In the meantime, Senate Republicans continued to negotiate behind closed doors about the content of the BCRA that they would vote on and await a final CBO score of an amendment supported by Senators Ted Cruz (R-TX) and Mike Lee (R-UT), that would have allowed insurance companies to offer plans on the individual market that did not comply with the ACA's coverage mandates as long as they also offered a plan that did.

Back to Agenda

On Monday evening, July 17, Senate Republican optimism was temporarily laid low when Senators Mike Lee (R-UT) and Jerry Moran (R-KS) announced that they could not support the BCRA, the Senate Republican attempt at repealing and replacing the ACA. This announcement meant that Senate Republicans did not have the majority necessary to pass their bill. Soon thereafter, Senators Murkowski, Collins, and Capito also announced their opposition. Before the Senate had a chance to start voting, it appeared as if it was clear that it did not have the votes to move forward to even begin debate.

On Wednesday, July 19, Leader McConnell announced (partially at the urging of the President who would have lunch later that day with all 52 GOP Senators) that he planned to hold the vote on the motion to proceed to the House-passed AHCA "early next week". But it was not clear at that time exactly what Leader McConnell would be asking his members to vote for since by this point it had become clear that the House-passed AHCA, the Senate-developed BCRA, and the 2015 'partial repeal only' bills did not have sufficient support among Senate Republicans.

Nonetheless, following their party lunches on the afternoon of Tuesday, July 25, Leader McConnell began the floor process to repeal and replace the Affordable Care Act in the Senate. Technically, he would hold a vote on the motion to proceed to the House-passed AHCA, but with the expectation that they would vote on a series of amendments striking the entire AHCA and replacing it with other GOP proposals like a revised BCRA (i.e., a version of 'repeal and replace') and the Obamacare Repeal Reconciliation Act (i.e., an updated version of the 'repeal only' bill that nearly all Senate Republicans supported in 2015. Leader McConnell did not necessarily urge Senate Republicans to vote for a particular bill, but merely to vote for the motion to proceed in order to keep the process alive so that new amendments could be offered to address Senators' concerns. And, despite not knowing what the final bill would be, the vote on the motion to proceed was tied 50-50 and passed with the support of Vice President Mike Pence, whose constitutional role is also to serve as President of the Senate and cast any tie-breaking votes. Senators Collins and Murkwoski were the only two Republican Senators to vote against the motion to proceed.

Following the vote on Tuesday afternoon, Senator McCain took the floor to deliver a speech just days after being diagnosed with brain cancer. His speech castigated the both parties in the Senate for failing to act in a bipartisan fashion on a number of issues, including health care. For the remainder of the week, Democrats would urge Republican Senators from the floor to heed the words of their former Presidential nominee and start over.

With debate now open, the Majority Leader began to put forward several amendments for votes while Democrats engaged in a number of delay tactics, such as requiring the clerk to read the bill

three times before actual debate can begin. (Typically, the reading of the bill is dispensed with by unanimous agreement). With each amendment, however, an insufficient number of GOP Senators voted for passage. An amendment that included the BCRA plus a version of the Cruz amendment and $100 billion for Medicaid expansion enrollees to purchase private coverage requested by Senator Rob Portman (R-OH) failed 43-57 with 9 Republican Senators voting against it. The following day on Wednesday, July 26, an amendment offered by Senator Rand Paul (R-KY) failed 45-55. What was known to be true according to GOP Senators' pre-vote statements was now made clear by their actual votes: none of the proposals could garner a majority. Yet, Republicans still controlled the floor and had several hours of debate remaining.

Rumors of a so-called 'skinny bill' circulated all week as a possible end-game scenario. In this scenario, Leader McConnell would put forward a bill representing the 'lowest common denominator' of what he thought Senate Republicans could agree to: provisions zeroing out the individual and employer mandates and a repeal of the medical device tax. This bill would not feature a full repeal nor a full replace. And, like the vote on the motion to proceed earlier in the week, Leader McConnell would urge his members to vote for it not necessarily because he thought it would become law but so that they could keep the process alive and enter into a conference committee with the House. In a conference committee, House and Senate legislators meet to reach an agreement on bills on the same topic with different provisions. Once an agreement is reached, the bill is returned to each body for a final up-or-down vote without any changes allowed.

Once it became clear Thursday afternoon that this was in fact Republican Senate leadership's plan, a number of GOP Senators – Ron Johnson (WI), John McCain (AZ), and Lindsey Graham (SC) – held a press conference vehemently stating their opposition to the bill but also saying they would vote for it if they had a guarantee from the House that it would not simply take up and pass it. Shortly thereafter, House Speaker Paul Ryan issued a statement at roughly 7:45pm that he would be "willing" to enter into a conference, but that any product would have to pass the Senate first. Two and a half hours later, Senate Republican leaders released the text of the bill, which included provisions to:

- zero out the individual and employer mandates;
- repeal the medical device tax;
- cut Medicaid funding for Planned Parenthood;
- increase the allowed contributions to Health Savings Accounts;
- give states the ability to allow insurers to offer plans that do not comply with the existing ACA coverage mandates; and
- cut funding for the Prevention and Public Health Fund.

With the 20 hours of allotted debate set to end at roughly 1:00am, the Senate prepared for a vote on the skinny bill. Reporters watched the action on the floor closely, interpreting the various ongoing conversations and gestures. It soon became clear that Sen. McCain was prepared to vote against the bill, which would sink it assuming that Senators Collins and Murkowski held onto their position. First, Senator Flake (R-AZ), his fellow Senator from Arizona was asked to speak with him. Then, Vice President Pence, on hand to cast a tie-breaking vote, was tasked with trying to persuade him. Next, both the Vice President and Senator McCain left the Senate floor where the Senator took a call from the President, who urged him to vote for the bill. After several minutes outside the Senate chamber and nearly 45 minutes after the vote began, Senator McCain walked in, waived for the attention of the clerk, and delivered a thumbs down, signaling his vote against the bill. Democratic Leader Chuck Schumer (NY) quieted gasps and cheers from the Democratic Senators and supporters in the gallery. The vote was soon called: Republicans lost 49-51 with three GOP Senators – Collins, Murkowski, and McCain – all voting against. Leader McConnell pulled the bill from the floor and returned it to the Senate calendar, where it still sits ready to be taken up if necessary. In the days that followed, Senate Republican leaders effectively declared that the 7 year effort to repeal and replace the Affordable Care Act was over and that a bipartisan effort to stabilize the individual marketplaces would begin immediately.

Senator Lamar Alexander (R-TN), chairman of the Senate Health, Education, Labor, and Pensions (HELP) Committee embraced the responsibility and opportunity to work with the ranking member of that Committee, Senator Patty Murray (D-WA), on such legislation. In a hearing the following week, Senator Alexander said that he wanted to pass a bill by the end of September that was "small, balanced, and bipartisan." In other words, it would be narrowly focused on the individual marketplaces only (no Medicaid changes), it would fund the cost-sharing reduction payments for insurance companies long-sought by Democrats and in exchange Republicans would get flexibility in the coverage mandates to bring down premiums, and both parties had to support it. He plans to hold hearings in the HELP Committee the first week of September once Congress returns from its August recess.

Throughout the Senate debate, Akin Gump shared real-time updates on the amendments being offered and final vote tallies.

In addition, the Congress faces an overwhelming series of must-pass bills with difficult deadlines that have been put off while it debated changes to the ACA. These include:

- funding the government by September 31 or facing a government shutdown;
- raising the debt ceiling by roughly October or facing a government default; and, among other items,

- reauthorizing the Children's Health Insurance Program or allowing millions of children to lose health insurance.

House Committee Action on D-SNP Reauthorization
While the Senate struggled with the ACA, the House took action in two committees in reauthorize Special Needs Plans (SNPs), which are set to expire in 2018.

On July 13, the House Ways & Means Health Subcommittee voted in support of H.R. 3168 to reauthorize SNPs for five years. The bill, which would reauthorize SNPs for 5 years, had the bipartisan support of the Chairman, Pat Tiberi (R-OH-12), and Ranking Member, Sandy Levin (D-MI-9). Since the House Energy and Commerce Committee has primary jurisdiction over Medicaid, the next stop for the bill is the E&C Committee, which soon took action. On July 26, the E&C Health Subcommittee held a hearing on entitled "Examining the Extension of Special Needs Plans" featuring testimony from the President of the National MLTSS Health Plan Association, a former director of the Federal Coordinated Health Care office in CMS, and the CEO of SCAN Health Plan. Reauthorization of SNPs received the bipartisan support of the subcommittee's leaders in their opening statements. It is expected that this legislation continues to move forward in the fall as a series of bills in the House that mirrors the myriad issues addressed by the Senate's CHRONIC Care Act, which provides for a permanent reauthorization of SNPs.

Akin participated in conference calls with and submitted comments to House Ways & Means Committee staff on behalf of CalOptima regarding H.R. 3168 and provided a summary of the House Energy & Commerce Committee hearing for CalOptima.

Back to Agenda

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Donald B. Gilbert Michael R. Robson Trent E. Smith Alan L. Edelstein OF COUNSEL

CALOPTIMA LEGISLATIVE REPORT

By Don Gilbert and Trent Smith
August 9, 2017

The Legislature has left Sacramento on their month-long summer recess. They will return August 21 to conclude their work for the year. Before adjourning on September 15, the Legislature will dispense with nearly a thousand bills that remain on calendar. For the most part, policy committees have concluded their work. The Appropriations Committees in both the Assembly and the Senate still need to conclude their work of reviewing bills for potential fiscal impacts on the state.

The final couple weeks of the legislative calendar will require the Senate and Assembly to meet in marathon floor sessions where the final votes on bills will take place. Bills that pass these final votes will move to the Governor.

Earlier this year, the Legislature and Governor tackled some significant policy issues surrounded in political intrigue. First, the Legislature passed a major gas and vehicle license fee increase. The 12 cents per gallon increase in gasoline is earmarked for road and highway improvements. However, to reach the two-thirds vote requirement to pass tax increases, a newly elected moderate Democrat from Orange County, Josh Newman, had to vote for the bill package. As a result, Republican activists have launched an effort to recall Senator Newman. Many political insiders believe the recall could be successful considering Senator Newman won his November election by a narrow margin. Republican strategists are also banking on the fact that tax increases are traditionally unpopular and gas tax and vehicle license fee increases are even more unpopular. However, Senator Newman's district is not a "traditional" Orange County district as changing demographics makes it less conservative compared to other legislative districts in the county. The recall effort will certainly be worth watching, both in Orange County and throughout California.

Before the Legislature adjourned for their summer break they passed a package of bills to continue California's Greenhouse Gas Reduction Program. Known as Cap-and-Trade, businesses that create air pollution and greenhouse gases are able to buy and sell pollution credits in a commodity market system. The program annually generates hundreds of millions of dollars in revenue for the state, which is then spent on programs intended to reduce air pollution and greenhouse gases. One of the projects that will continue to receive funding from the Cap-and-Trade program is the controversial High-Speed Rail System.

Renewing the expiring Cap-and-Trade program was a priority for the Governor. However, again a two-thirds vote of the Legislature was required. With the support of the California Chamber of Commerce and other business interests, some Republicans, including the Assembly Republican Leader, voted to extend the program. Many Republican activists and party officials are upset that the Cap-and-Trade program was extended with support from Republican legislators. The Capitol community is waiting to see if there will be any political fallout from the Cap-and-Trade vote.

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The Legislature is not done tackling major politically charged policy issues. When they return in late August, the Governor has committed to work with them to address the California housing crisis. Creating more affordable housing is a priority of the Legislature's Democrat leadership. Because they helped the Governor pass his legislative priority, Cap-and-Trade, he has agreed to work on their priority issue. We do not yet know what proposals will be included in the affordable housing package.

There are several bills of interest to CalOptima that are still pending in the Legislature. SB 4 by Senator Mendoza is one of those bills. CalOptima has no position on SB 4 but we continue to monitor the bill's progress. As it left the Senate, SB 4 dealt with environmental issues associated with goods movement. However, the amendments placed in the bill when it reached the Assembly propose to codify in state statue the composition of CalOptima's Board of Directors. The bill essentially locks into state law the current designated board slots. The bill also allows the addition of more public member positions to the board with a two-thirds vote of the CalOptima Board and ratification by the Orange County Board of Supervisors. The statue would expire January 1, 2023 unless renewed by the State Legislature.

SB 4 passed out of two policy committees on unanimous votes and now awaits a vote on the Assembly Floor. We understand that an urgency clause will be amended into the bill when the Legislature returns August 21. An urgency clause allows the bill to become law upon the signature of the Governor rather than January 1, 2018.

We have also been very closely watching SB 538 by Senator Monning. This bill prohibits various contract provisions between a hospital and health plan. According to the author, his bill seeks to prohibit anti-competitive contract provisions that dominant hospital systems impose on health plans to maintain market power and to inflate prices charged to consumers, workers, and employers. SB 538 was introduced in response to media stories highlighting some recent contract provisions Sutter Health imposed on certain health plans. The bill was supported by a unique coalition of health plans, businesses, and labor unions. Obviously, hospitals opposed the bill. SB 538 passed out of the Senate and was scheduled for a hearing in the Assembly Health Committee in early July. However, the author decided not to bring the bill up for a vote, which likely indicates that he was not sure he had the votes necessary to pass the bill. SB 538 can be pursued further in 2018.

We continue to monitor negotiations between health plans and public hospitals on a new financing mechanism required under federal regulations. At issue is who will carry more financial risk – the health plans or the public hospitals. Under the current law, there is more ability to base rates on past encounter data. Originally, the Department of Health Care Services (DHCS) believed that the federal government would prohibit any "lookback" process to accurately determine rates and instead require the health plans and public hospitals to assume more risk. However, it now appears that the federal government will not be as stringent on this point. As a result, we are told a conceptual agreement has been reached between health plans and public hospitals. The agreement will be amended into either AB 180 by Assemblyman Wood or SB 152 by Senator Hernandez.

Back to Agenda

Negotiations continue between health plans and DHCS on timely access standards that are also being required by the federal government. We believe language will emerge soon after the Legislature returns from their summer break. The timely access language will likely be amended into AB 180 or SB 152, whichever bill is not used for the hospital payment language.

We previously reported that DHCS would like to see some major changes in the 340B Drug Billing Program, which allows Federally Qualified Health Clinics (FQHC) and public hospitals to purchase prescription drugs at significantly discounted prices. The clinics and hospitals can sell the drugs at an increased price and keep the profits to use in the care of their patients. DHCS proposed budget trailer bill language to correct problems regarding the use of contract pharmacies in the 340B Drug Billing Program. They pointed to instances where a 340B covered clinic or hospital does not directly dispense medications to a beneficiary, instead they contract with a different pharmacy, typically a non-340B entity, who dispenses the drug at a non-340B price that is then billed to the department or health plan. The trailer bill language proposed to prohibit the use of contract pharmacies in the 340B program in Medi-Cal to avoid inappropriate duplicate discounts and prevent unnecessary overpayment in Medi-Cal. However, this proposal was not adopted as part of the final budget agreement. There is some speculation that this proposal could again be part of the Governor's proposed budget next year.

Back to Agenda

Congressional Health Care Reform Efforts
Chronology of Events

U.S. SENATE

Date	Senate Action	Analysis
7/28/17	**Senate Rejects "Skinny Repeal" Amendment** Vote: 49-51	• Eliminates penalties for individual mandate • Eliminates penalties for all employer mandates through 2024 • Through the state waiver process, allows states to provide health plans without the ACA's 10 essential health benefits • Repeals medical device tax: 2018-2020 • Allows individuals to contribute more to health savings accounts for three years No reference to Medicaid reform Sens. Murkowski (R), McCain (R), and Collins (R) voted no
7/26/17	**Senate Rejects "Repeal Now, Replace Later" Amendment** (Sen. Paul) Vote: 45–55	
7/25/17	**Senate Rejects BCRA With Amendments** (Sens. Cruz and Portman) Vote: 43–57	Sen. Cruz: • Allows health insurers to sell plans with limited benefits if they also offer at least one plan that complies with ACA requirements Sen. Portman: • Provides $100 billion for individuals who lose Medicaid to purchase commercial health coverage
7/25/17	**Senate Approves "Motion to Proceed" on H.R. 1628** Vote: 51–50	Sens. Murkowski (R) and Collins (R) vote no. VP Pence casts tie-breaking vote.
7/21/17	**Senate Parliamentarian Determines Certain BCRA Provisions Violate Budget Reconciliation Requirements (Byrd Rule)**	Certain BCRA provisions are found to violate the Byrd rule, including: • Cutting federal funding for Planned Parenthood • Prohibiting the use of federal subsidies to buy insurance that covers abortion services • Requiring individuals who have a lapse in insurance coverage to wait six months before obtaining coverage through a health care exchange • Ending the requirement that state's alternative benefit Medicaid plans cover the ACA's 10 essential health benefits

Congressional Health Care Reform Efforts: *Chronology of Events*

Date	Senate Action	Analysis
7/20/17	**CBO Scores BCRA** (Includes Sen. McConnell Amendment)	Beginning in 2021, the first year of Medicaid impact, a reduction of $55 billion (approximately 10%) in Medicaid spending, which may result in 10 million fewer enrollees (approximately 14%) through 2021. In 2026, a reduction of $87 billion (approximately 14%) in Medicaid spending, which may result in 15 million fewer enrollees (approximately 18%) through 2026.
7/20/17	**BCRA Amendment Offered** (Sen. McConnell)	Preserves three ACA-related taxes: • Payroll tax on individuals with annual income over $200,000 ($250,000 for couples) • Investment income tax • Provision that prevents insurance companies from writing off executive compensation Medicaid provisions remain unchanged.
7/19/17	**CBO Scores** **"Repeal Now, Replace Later" Bill**	Beginning in 2020, the first year of Medicaid impact, a reduction of $75 billion (approximately 13%) in Medicaid spending, which may result in 15 million fewer enrollees (approximately 20%) through 2020. In 2026, a reduction of $144 billion (approximately 23%) in Medicaid spending, which may result in 19 million fewer enrollees (approximately 23%) through 2026.
7/19/17	**Three Republican Senators Publicly Oppose "Repeal Now, Replace Later"** (Sens. Murkowski, Moore Capito and Collins)	
7/19/17	**Leader McConnell Calls for "Repeal Now, Replace Later" Vote**	This bill would eliminate the ACA's Medicaid Expansion (MCE) in 2020. No changes to Medicaid Classic.
7/18/17	**Two More Republican Senators Publicly Oppose BCRA** (Sens. Lee and Moran)	Total number of public "no" votes is four.
7/13/17	**BCRA Amendment Offered** (Sens. Cruz and Lee)	Allows health insurers to sell plans with limited benefits if they also offer at least one plan that complies with ACA requirements. Medicaid provisions remain unchanged.
7/02/17	**Leader McConnell Postpones BCRA Vote**	
6/28/17	**DHCS Releases Fiscal Analysis of BCRA**	Beginning in 2020, a reduction of $3 billion (approximately 3%) to Medi-Cal. Classic would not see any reductions in 2020, and MCE would see a $2.6 billion reduction. In 2026, a reduction of $29.3 billion to Medi-Cal: $11.3 billion in reductions for Classic and $18 billion for MCE.
6/26/17	**Two Republican Senators Publicly Oppose BCRA** (Sens. Collins and Paul)	• Susan Collins (ME) opposes due to Medicaid reductions • Rand Paul (KY) opposes due to continuation of several ACA policies

Back to Agenda

Congressional Health Care Reform Efforts: *Chronology of Events*

Date	Senate Action	Analysis
6/26/17	**CBO Scores BCRA**	Beginning in 2021, the first year of Medicaid impact, a reduction of $70 billion (approximately 13%) in Medicaid spending, which may result in 10 million fewer enrollees (approximately 14%) through 2021. In 2026, a reduction of $158 billion (approximately 25%) in Medicaid spending, which may result in 15 million fewer enrollees (approximately 18%) through 2026. In 2036, a 35% reduction in Medicaid spending.
6/22/17	**Senate Releases Better Care Reconciliation Act (BCRA) Discussion Draft**	Medicaid Classic: • Transitions Classic 50/50 FMAP formula to per capita caps beginning in FY 2021 (AHCA: FY 2020). Establishes new per-enrollee baseline amount based on a state's Medicaid spending over eight consecutive quarters from FY 14–17 (AHCA: based on 2016 Medicaid spending). These amounts would increase by the CPI-M from FY 2021–24. In FY 2025, the growth rate would drop from CPI-M to the CPI-U. MCE: • Maintains the MCE 90/10 FMAP formula until 2021 (AHCA: 2020). Three year phase-down of MCE FMAP (85/15 in 2021, 80/20 in 2022, 75/25 in 2023. 50/50 FMAP in 2024).
6/21/17	**CalOptima Sends Letter of Concern Regarding Senate Consideration of AHCA to Sens. Feinstein and Harris**	Opposes reduced federal funding from: • Proposed per capita cap formula • MCE reductions
6/20/17	**CalOptima Signs Part of Coalition Letter (including Blue Shield, L.A. Care, Molina, and IEHP) to Senate Leaders Regarding Medicaid Reform**	• Expresses the importance of Medicaid • Opposes Medicaid provisions being debated • Offers to work with the Senate on meaningful reforms

U.S. HOUSE OF REPRESENTATIVES

Date	House Action	Analysis
5/04/17	**AHCA Passes House** Vote: 217–213	Orange County House Delegation CD 38 – Sanchez: NO CD 39 – Royce: AYE CD 45 – Walters: AYE CD 46 – Correa: NO CD 47 – Lowenthal: NO CD 48 – Rohrabacher: AYE CD 49 – Issa: AYE
5/03/17	**AHCA Amended** (Reps. MacArthur and Palmer)	Rep. MacArthur: • Through the state waiver process, allows states to set their own essential health benefits and allows commercial health insurers to charge individuals with pre-existing conditions up to five times more than healthy individuals (ACA: 3:1) Rep. Palmer: • Allocates $15 billion for high-risk pool to reduce premiums for individuals with pre-existing conditions

Back to Agenda

Congressional Health Care Reform Efforts: *Chronology of Events*

Date	House Action	Analysis
3/24/17	**Speaker Ryan Postpones Vote on AHCA**	
3/24/17	**CalOptima Letter Regarding AHCA to Orange County Congressional Delegation**	Shares concerns with reduced federal funding through: • Proposed per capita caps formula • MCE reductions
3/21/17	**AHCA Amended** (Rep. Walden)	Changes to Medicaid: • Through state waiver process, allows states to add Medicaid work requirements and choose block grant formula vs. per capita cap formula • Increases per capita cap annual growth rate for elderly and disabled from CPI-M to CPI-M + 1%
3/21/17	**DHCS Releases Analysis of AHCA**	Beginning in 2020, the first year of Medi-Cal impact, a reduction of nearly $6 billion to Medi-Cal (approximately 5%): $680 million in reductions for Classic and $4.8 billion for MCE. In 2027, a reduction of $24 billion to Medi-Cal: $5.3 billion in reductions for Classic and $18.6 billion for MCE.
3/13/17	**CBO Scores AHCA**	Beginning in 2020, the first year of Medicaid impact, a reduction of $68 billion (approximately 12%) in Medicaid spending, which may result in 9 million fewer enrollees (approximately 12%) through 2020. In 2026, a reduction of $155 billion (approximately 25%) in Medicaid spending, which may result in 14 million fewer enrollees (approximately 17%) through 2026.
3/08/17	**AHCA Amended by Two House Committees (E&C and W&M)**	Technical, non-substantive changes. Medicaid provisions remain unchanged.
3/06/17	**American Health Care Act (AHCA)** **H.R. 1628** **Introduced in the House**	Medicaid Classic: • Transitions Classic 50/50 FMAP formula to per capita caps beginning in FY 2020. Establishes new per-enrollee baseline amount based on a state's 2016 Medicaid spending levels. These amounts would increase by the consumer price index medical (CPI-M) MCE: • Transitions MCE FMAP formula from 90/10 to 50/50 beginning January 1, 2020 • Current MCE enrollees who experience a 30-day break in coverage after January 1, 2020, funded at 50/50 FMAP

Back to Agenda

2017–18 Legislative Tracking Matrix

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Position
HR 1628 (Black)	The American Health Care Act (AHCA) would make sweeping changes to the national health care system. For CalOptima, the most significant changes would be 1) Changes to the Medicaid financing structure from the federal medical assistance percentage (FMAP) to a per capita cap system, 2) Decreased federal dollars for Medicaid expansion members who leave and return to the program, 3) Additional state authority to set "essential health benefit" requirements for Medicaid plans, and 4) Potentially decreased funding and additional restrictions for state waiver programs. *Senate Amendment 270:* "Better Care Reconciliation Act" would replace Medicaid FMAP with per capita caps and phase-down federal funding for Medicaid expansion beginning in 2021. *Senate Amendment 271:* "Repeal Now, Replace Later" would repeal Medicaid expansion beginning in 2020.	**05/04/2017** Passed House, referred to Senate **07/25/2017** Failed Senate **07/26/2017** Failed Senate	Sent letter of concern
HR 3168 (Tiberi)	This bill would make a number of reforms to the Medicare program, and most importantly for CalOptima, it would re-authorize dual eligible special needs plans (D-SNPs) for five years, including CalOptima's OneCare program. Historically, D-SNPs have been temporarily re-authorized by Congress, and are currently set to expire on December 31, 2018.	**07/13/2017** Passed House Ways and Means Subcommittee on Health	Sent letter of support for D-SNP re-authoriza-tion
S 191 (Cassidy)	The Patient Freedom Act would repeal several mandates in the Affordable Care Act (ACA), such as the individual and employer mandates, as well as the essential health benefit requirements. The bill retains most of the ACA consumer protections, such as prohibiting discrimination, pre-existing conditions exclusions, and annual/lifetime limits. Once the ACA provisions are repealed, the bill would provide greater state flexibility for their Medicaid and exchange programs. Specifically, states would be given three options after the ACA provisions are repealed: 1) A state-specific health system (excluding the repealed ACA provisions) with 95 percent of current federal funding available to states prior to implementation of this bill, 2) A state-based health care system with no federal financial assistance, or 3) Continue under current system at funding no more than option 1 (state legislatures would be required to reinstate the ACA requirements and mandates repealed by S. 191).	**01/23/2017** Referred to Senate Finance Committee	Watch
S 870 (Hatch)	This bill would make a number of reforms to the Medicare program, and most importantly for CalOptima, it would permanently re-authorize dual eligible special needs plans (D-SNPs), including CalOptima's OneCare program. Historically, D-SNPs have been temporarily re-authorized by Congress, and are currently set to expire on December 31, 2018. According to the bill author, this bill aims to improve care for individuals with multiple chronic conditions and who are enrolled in Medicare and/or Medicaid.	**05/18/2017** Passed Senate Finance Committee	Support

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Position
AB 15 (Maienschein)	This bill would require DHCS to increase the Denti-Cal provider reimbursement rates to the regional commercial rates for the 15 most common dental services. While the bill does not specify a dollar amount for the increase, it does note Denti-Cal's low utilization and funding levels, citing the need for increased reimbursement rates to attract additional providers. CalOptima members who receive Denti-Cal benefits outside of CalOptima may be affected by this proposed increase in funding. This bill would take effect on January 1, 2018.	**05/26/2017** Held under submission	Watch
AB 97 (Ting)	Thill bill enacts California's Budget for FY 17-18. The bill funds state departments, projects, and programs for the upcoming fiscal year.	**06/27/2017** Signed into law	Watch
AB 120 (Ting)	This "junior budget bill" contains specific state Medi-Cal appropriations and instructions for allocating those funds. Section 3(1)1-5 of the bill requires Proposition 56 revenue to include $325 million for increased Medi-Cal physician payments and $140 million for increased Denti-Cal provider payments. Most of the remaining Proposition 56 funds will be used for general Medi-Cal expenditures. Additionally, section 1(16) of the bill requires DHCS to provide Medicare Part A recoupment amounts to plans by July 31, 2017. This is a result of a state enrollment error, where some Medi-Cal members with Medicare Part A were incorrectly enrolled as Medi-Cal expansion members and were funded at a higher federal match. DHCS must return $365 million to the federal government and will collect payments from Medi-Cal health plans, including CalOptima.	**06/27/2017** Signed into law	Watch
AB 340 (Arambula)	This bill would require the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) to include screenings for incidents of trauma that affect a child's mental or physical health. The EPSDT program is a comprehensive, preventive Medi-Cal benefit for children under the age of 21. CalOptima provides most EPSDT services, while the Orange County Health Care Agency (HCA) covers services not covered by CalOptima. Further clarification is needed in the bill to define whether trauma screening is considered a specialty mental health service offered by county mental health plans, or if Medi-Cal managed care plans would be responsible for providing these services.	**06/28/2017** Passed Senate Committee on Health, referred to Senate Committee on Appropriations	Watch
AB 675 (Ridley-Thomas)	This bill would appropriate $650 million of state General Fund dollars to DHCS in order to allow In-Home Supportive Services (IHSS) to continue as a Medi-Cal managed care benefit. The Coordinated Care Initiative (CCI) contained a "poison pill" that went into effect in January, meaning IHSS will no longer be a Medi-Cal managed care benefit beginning January 1, 2018. This bill aims to retain the IHSS provision of CCI by shifting dollars from the state General Fund to DHCS.	**05/26/2017** Held under submission	Watch
SB 4 (Mendoza)	This bill would codify the current seat designations on the CalOptima Board of Directors, and modify the Board member removal process.	**07/13/2017** Passed Assembly Committee on Local Government	Watch
SB 97 (Committee on Budget and Fiscal Review)	This bill enacts the health care trailer bill language related to the state FY 17-18 budget bill. Most importantly for CalOptima, it extends the Cal MediConnect (CMC) program, including CalOptima's OneCare Connect program, until December 31, 2019. IHSS administration will be transferred back to the counties but will still remain available to OneCare Connect members. The bill also includes language that restores certain dental benefits on January 1, 2018 and certain optical benefits on January 1, 2020.	**07/10/2017** Signed into law	Watch

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Position
SB 152 (Hernandez)	Based on the most recent guidance from DHCS, CalOptima will implement the Whole Child Model (WCM) no sooner than January 1, 2019. However, under current law, DHCS is required to submit a report to the Legislature no later than January 1, 2021 (two years after plan implementation). Since the WCM implementation date has been delayed, this bill has been introduced to allow plans the full three years to implement the WCM before DHCS submits its report to the Legislature. This bill would also allow DHCS to make this report available to the public with 90 days instead of the original 30 days.	**07/06/2017** Passed Assembly, re-referred to Senate	Watch
SB 171/ AB 205 (Hernandez/ Wood)	This bill would implement certain provisions of the CMS Medicaid managed care rules, making changes at the state level regarding Medi-Cal managed care plans and state fair hearings, time and distance requirements for providers, medical loss ratios, and public hospital financing.	**07/11/2017** Passed Committees on Health, referred to Committees on Appropriations	Watch
SB 223 (Atkins)	This bill would require Medi-Cal managed care plans to notify members of their nondiscriminatory protections, and translate its member materials into the top 15 languages as identified by the U.S. Census. Plans are currently required to translate materials into threshold languages based on regional population. It would also require interpreters to be deemed qualified by the state and receive additional ethics, conduct, and proficiency training.	**06/28/2017** Passed Senate Committee on Health, referred to Senate Committee on Appropriations	Watch

The CalOptima Legislative Tracking Matrix includes information regarding legislation that directly impacts CalOptima and our members. These bills are closely tracked and analyzed by CalOptima's Government Affairs Department throughout the legislative session. All official "Support" and "Oppose" positions are approved by the CalOptima Board of Directors. Bills with a "Watch" position are monitored by staff to determine the level of impact.

2017 Federal Legislative Dates

January 3	115th Congress convenes
January 20	Presidential Inauguration
April 10–21	Spring recess
July 28–September 1	Summer recess
September 30	Spending expires for federal fiscal year 2016–17
September 30	CHIP funding expires under current law, pending Congressional action
September 30	2017 budget resolution expires
November 20–24	Fall recess

2017 State Legislative Dates

January 4	Legislature reconvenes
February 17	Last day for legislation to be introduced
April 28	Last day for policy committees to hear and report bills to fiscal committees
May 12	Last day for policy committees to hear and report non-fiscal bills to the floor
May 26	Last day for fiscal committees to report fiscal bills to the floor
May 30–June2	Floor session only
June 2	Last day to pass bills out of their house of origin
June 15	Budget bill must be passed by midnight
July 21–August 21	Summer recess
September 1	Last day for fiscal committees to report bills to the floor
September 5–15	Floor session only
September 15	Last day for bills to be passed. Interim recess begins
October 15	Last day for Governor to sign or veto bills passed by the Legislature

Sources: 2017 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

Board of Directors Meeting
September 7, 2017

CalOptima Community Outreach Summary – August 2017

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors as indicated pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in a number of community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Events Update

On July 29, 2017, CalOptima provided sponsorship and a resource table at the Back to School Outreach event hosted by the Collaboration to Assist Motel Families. The event provides information about programs and services available to serve children and their families who live in motels. More than 600 homeless (according to the McKinney-Vento definition) and underserved individuals attended the event, with more than 463 students attending. Participants included children and families living in motels, homeless shelters and multi-family homes.

The goal of the event was to ensure that each child starts the school year with needed resources and support. Participants had the opportunity to visit with over 50 community organizations to gather information about housing, financial stability, mental health services, after-school care and early intervention. Children received school supplies, haircuts, clothes, books and health screenings at no cost. Game booths, face painting and many other fun activities were also available for participants to enjoy.

The Collaboration to Assist Motel Families provides information and networking opportunities for health and human social services providers serving residents living in motels in Anaheim and the

Back to Agenda

surrounding cities. CalOptima has participated as a member of the collaborative for more than five years and continues to support this effort. Members meet monthly to share information and resources to assist motel families toward self-sufficiency.

For additional information or questions, please contact Tiffany Kaaiakamanu, manager of Community Relations at **657-235-6872**, or email tkaaiakamanu@caloptima.org.

Summary of Public Activities

During August, CalOptima participated in 41 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
8/01/17	• Collaborative to Assist Motel Families Meeting
8/02/17	• Orange County Aging Services Collaborative Meeting • Orange County Healthy Aging Initiative Meeting • Anaheim Human Services Network Meeting
8/03/17	• Homeless Provider Forum
8/04/17	• Covered Orange County General Meeting • Help Me Grow Advisory Meeting
8/07/17	• Orange County Mental Health Services Act Steering Committee Meeting • Orange County Communication Workgroup
8/08/17	• Orange County Strategic Plan for Aging — Social Engagement • Buena Clinton Neighborhood Coalition Meeting • Susan G. Komen Orange County — Unidos Contra el Cancer de Seno Meeting • San Clemente Youth Wellness & Prevention Coalition Meeting
8/09/17	• Buena Park Collaborative Meeting • Anaheim Homeless Collaborative Meeting
8/10/17	• FOCUS Collaborative Meeting • Orange County Women's Health Policy Project — Advisory Board Meeting
8/11/17	• Senior Citizens Advisory Council Meeting • Annual Senior Fair hosted by the Office of Congresswoman Linda Sanchez
8/14/17	• Orange County Veterans and Military Families Collaborative Meeting • Fullerton Collaborative
8/15/17	• Orange County Cancer Coalition Meeting • Placentia Community Collaborative Meeting

Back to Agenda

8/16/17	• Covered Orange County Steering Committee Meeting • Orange County Promotoras
8/16/17	• La Habra Move More Eat Health Plan Meeting • Minnie Street Family Resource Center Professional Roundtable • Vision Y Compromiso — Promotoras Meeting
8/17/17	• Orange County Children's Partnership Committee Meeting • Surf City Senior Providers Network and Luncheon
8/22/17	• OC Senior Roundtable • Santa Ana Building Healthy Communities Meeting
8/24/17	• Orange County Disability Coalition Meeting • Orange County Care Coordination for Kids Meeting
8/28/17	• Community Health Research and Exchange Meeting • Stanton Collaborative

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

8/11/17	• Annual Senior Fair hosted by the Office of Congresswoman Linda Sanchez
8/12/17	• Back to School Health Fair hosted by the Institute for Healthcare Advancement
8/19/17	• Annual Super Senior Saturday hosted by the City of Buena Park (Registration Fee: $150 included one table and two chairs for outreach)
8/26/17	• Health Fair hosted by River Church
8/29/17	• Mariposa Villa Health Fair hosted by MJ Housing and Services

CalOptima organized or convened the following 14 community stakeholder events, meeting and presentations:

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

8/01/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (Spanish)
8/02/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You
8/03/17	• CalOptima New Member Orientation for Medi-Cal Members (Vietnamese)
8/04/17	• County Community Service Center Health Education Seminar — Topic:

Back to Agenda

	Understanding Alzheimer's and How to Keep the Brain Healthy
8/08/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (Spanish) • CalOptima New Member Orientation for Medi-Cal Members (Spanish and English)
8/09/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You
8/15/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (Spanish)
8/16/17	• CalOptima New Member Orientation for Medi-Cal Members (Korean and Farsi) • CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You
8/18/17	• County Community Service Center Health Education Seminar — Topic: Understanding Alzheimer's and How to Keep the Brain Healthy
8/22/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (Spanish)
8/23/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You
8/24/17	• CalOptima New Member Orientation for Medi-Cal Members (Chinese, Arabic and Vietnamese)

CalOptima did not provide any endorsement for events during this reporting period (e.g., letters of support, program/public activity event with support, or use of name/logo).

Back to Agenda

CalOptima Board of Directors
Community Activities

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

September			
Friday, 9/1 9-10:30am	++Covered Orange County General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	The Village 1505 E. 17th St. Santa Ana
Monday, 9/4 1-4pm	++OCHCA Mental Health Services Act Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 9/5 9:30-11am	++Collaborative to Assist Motel Families	**Steering Committee Meeting: Open to Collaborative Members**	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Tuesday, 9/5 4:30-6pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public** ***Registration required***	CalOptima Room 150
Wednesday, 9/6 10-11am	*New Member Orientation Presentations in Farsi and Korean	**Community Presentation Open to the Public**	CalOptima
Wednesday, 9/6 4:30-6pm	*Health Education Weight Control Class	**Community Presentation Open to the Public** ***Registration required***	CalOptima Room 150
Thursday, 9/7 9-11am	++Homeless Provider Forum	**Steering Committee Meeting: Open to Collaborative Members**	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange

* *CalOptima Hosted*

\+ *Exhibitor/Attendee*
++ *Meeting Attendee*

Back to Agenda

Thursday, 9/7 9-10:30am	++Refugee Forum of Orange County	**Steering Committee Meeting: Open to Collaborative Members**	Access California Services 631 S. Brookhurst St. Anaheim
Thursday, 9/7 9:30-10:30am	*New Member Orientation Presentation in Vietnamese	**Community Presentation Open to the Public**	County Community Service Center 15496 Magnolia St. Westminster
Thursday, 9/7 10am-12pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public** ***Registration required***	Anaheim Mira Loma Park Resource Center 2600 E. Miraloma Way Anaheim
Friday, 9/8 9:30-11am	++Senior Citizen Advisory Council Meeting	**Steering Committee Meeting: Open to Collaborative Members**	Location varies
Saturday, 9/9 9am-2pm	+Huntington Beach Council on Aging 29th Annual Senior Saturday	**Health/Resource Fair Open to the Public**	Huntington Beach Pier
Monday, 9/11 1-2pm	++Orange County Veterans and Military Families Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 9/11 2:30-3:30pm	++Fullerton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 9/12 9-10:30am	++OC Strategic Plan for Aging-Social Engagement Committee	**Steering Committee Meeting: Open to Collaborative Members**	Alzheimer's OC 2515 McCabe Way Irvine
Tuesday, 9/12 11:30am-12:30pm	++Buena Clinton Neighborhood Coalition	**Steering Committee Meeting: Open to Collaborative Members**	Buena Clinton Youth and Family Center 12661 Sunswept Ave. Garden Grove
Thursday, 9/12 1-2pm	*New Member Orientation Presentations in English and Spanish	**Community Presentation Open to the Public**	CalOptima
Thursday, 9/12 2-4pm	++Susan G. Komen Unidos Contra el Cancer del Seno Coalition	**Steering Committee Meeting: Open to Collaborative Members**	Susan G. Komen OC 700 Newport Center Dr. Newport Beach

Tuesday, 9/12 4-5:30pm	++San Clemente Youth Wellness & Prevention Coalition	**Steering Committee Meeting: Open to Collaborative Members**	San Clemente High School 700 Avenida Pico San Clemente
Tuesday, 9/12 4:30-6pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public *Registration required***	CalOptima Rm 150
Wednesday, 9/13 9-11am	*CalOptima Community Alliances Forum	**Community Presentation Open to the Public *Registration requested***	Delhi Center 505 E. Central Ave. Santa Ana
Wednesday, 9/13 10-11am	*New Member Orientation Presentations in Farsi and Korean	**Community Presentation Open to the Public**	CalOptima
Wednesday, 9/13 12-1:30pm	++Anaheim Homeless Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Anaheim Central Library 500 W. Broadway Anaheim
Wednesday, 9/13 4:30-6pm	*Health Education Weight Control Class	**Community Presentation Open to the Public *Registration required***	CalOptima Rm 150
Thursday, 9/14 10am-12pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public *Registration required***	Anaheim Mira Loma Park Resource Center 2600 E. Miraloma Way Anaheim
Thursday, 9/14 10-11am	*New Member Orientation Presentations in Chinese and Arabic	**Community Presentation Open to the Public**	CalOptima
Thursday, 9/14 11:30am-12:30pm	++FOCUS Collaborative Meeting	**Steering Committee Meeting: Open to Collaborative Members**	Magnolia Park Family Resource Center 11402 Magnolia Street Garden Grove
Thursday, 9/14 3-5pm	++OC Women's Health Project	**Steering Committee Meeting: Open to Collaborative Members**	The Village 1505 E. 17th St. Santa Ana
Thursday, 9/14 6-8pm	++State Council on Developmental Disabilities Regional Advisory Committee Meeting	**Steering Committee Meeting: Open to Collaborative Members**	State Council on Developmental Disabilities 2000 E. Fourth St. Santa Ana

Saturday, 9/16 10am-1pm	+City of Anaheim Health Living Fall Resource Fair	**Health/Resource Fair Open to the Public**	Downtown Anaheim Community Ctr. 250 E. Center St. Anaheim
Tuesday, 9/19 8:30-10am	++North OC Senior Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	St. Jude Community Services 130 W. Bastanchury Rd. Fullerton
Tuesday, 9/19 10-11:30am	++Placentia Community Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Placentia Presbyterian Church 849 Bradford Ave. Placentia
Tuesday, 9/19 4:30-6pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public *Registration required***	CalOptima Rm 150
Wednesday, 9/20 9:15-11am	++Covered OC Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	The Village 1505 E. 17th St. Santa Ana
Wednesday, 9/20 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	Minnie Street Family Resource Center 1300 McFadden Ave. Santa Ana
Wednesday, 9/20 1-4pm	++Orange County Promotoras	**Steering Committee Meeting: Open to Collaborative Members**	Location varies
Wednesday, 9/20 1:30-3pm	++La Habra Move More Eat Health Plan	**Steering Committee Meeting: Open to Collaborative Members**	Friends of Family Community Clinic 501 S. Idaho St. La Habra
Wednesday, 9/20 4:30-6pm	*Health Education Weight Control Class	**Community Presentation Open to the Public *Registration required***	CalOptima Room 150
Thursday, 9/21 8:30-10am	++Orange County Children's Partnership Committee	**Steering Committee Meeting: Open to Collaborative Members**	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana
Thursday, 9/21 10am-12pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public *Registration required***	Anaheim Mira Loma Park Resource Center 2600 E. Miraloma Way Anaheim

Thursday, 9/21 10-11am	*New Member Orientation Presentations in English and Spanish	**Community Presentation Open to the Public**	CalOptima
Friday, 9/22 7:30am-4:30pm	+UCI Mind and Alzheimer's OC 28th Annual Southern California Alzheimer's Disease Research Conference	**Conference Health/Resource Fair *Registration required***	Irvine Marriott Hotel 18000 Von Karman Ave. Irvine
Monday, 9/25 12:30-1:30pm	++Stanton Collaborative Meeting	**Steering Committee Meeting: Open to Collaborative Members**	Stanton Civic Center 7800 Katella Ave. Stanton
Tuesday, 9/26 7:30-9am	++OC Senior Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	Orange Senior Center 170 S. Olive Orange
Tuesday, 9/26 3:30-4:30pm	++Santa Ana Building Healthy Communities	**Steering Committee Meeting: Open to Collaborative Members**	KidWorks 1902 W. Chestnut Ave. Santa Ana
Tuesday, 9/26 4:30-6pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public *Registration required***	CalOptima Room 150
Wednesday, 9/27 10:30-11:30am	++OC Human Trafficking Task Force General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	Community Service Program 1221 E. Dyer Rd. Santa Ana
Wednesday, 9/27 4:30-6pm	*Health Education Weight Control Class	**Community Presentation Open to the Public *Registration required***	CalOptima Room 150
Thursday, 9/28 8:30-10am	++Disability Coalition of Orange County	**Steering Committee Meeting: Open to Collaborative Members**	Dayle McIntosh Center 501 N. Brookhurst St. Anaheim
Thursday, 9/28 9:30-10:30am	*New Member Orientation Presentation in Vietnamese	**Community Presentation Open to the Public**	County Community Service Center 15496 Magnolia St. Westminster
Thursday, 9/28 10am-12pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public *Registration required***	Anaheim Mira Loma Park Resource Center 2600 E. Miraloma Way Anaheim

Thursday, 9/28 10-11am	*New Member Orientation Presentations in Chinese and Arabic	**Community Presentation Open to the Public**	CalOptima
Thursday, 9/28 1-3pm	++Orange County Care Coordination for Kids	**Steering Committee Meeting: Open to Collaborative Members**	Help Me Grow 2500 Redhill Ave. Santa Ana
Saturday, 9/30 11am-3pm	+Cal State Fullerton Center for Successful Aging Annual Conference and Expo	**Conference Health/Resource Fair *Registration required***	Cal State Fullerton 800 N. State College Fullerton
October			
Sunday, 10/1 8am-12pm	+OC Association for Vietnamese Mental Health Awareness and Support Walk to End Stigma Against Mental Illness	**Health/Resource Fair Open to the Public**	Mile Square Park 16801 Euclid St. Fountain Valley
Monday, 10/2 1-4pm	++OCHCA Mental Health Services Act Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 10/3 9:30-11am	++Collaborative to Assist Motel Families	**Steering Committee Meeting: Open to Collaborative Members**	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Tuesday, 10/3 4:30-6pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public *Registration required***	CalOptima Room 150
Wednesday, 10/4 9-10:30am	++OC Aging Services Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 10/4 10am-12pm	++Anaheim Human Services Network	**Steering Committee Meeting: Open to Collaborative Members**	Orange County Family Justice Center 150 W. Vermont Anaheim
Wednesday, 10/4 10:30am-12pm	++OC Healthy Aging Initiative	**Steering Committee Meeting: Open to Collaborative Members**	Alzheimer's OC 2515 McCabe Way Irvine

+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda

Wednesday, 10/4 4:30-6pm	*Health Education Weight Control Class	**Community Presentation Open to the Public** ***Registration required***	CalOptima Room 150
Thursday, 10/5 9:30-10:30am	*New Member Orientation Presentation in Vietnamese	**Community Presentation Open to the Public**	County Community Service Center 15496 Magnolia St. Westminster
Thursday, 10/5 4:30-6pm	*Health Education Weight Control Class	**Community Presentation** ***Registration required***	H.I.S. House 907 N. Bradford Ave. Placentia
Friday, 10/6 9-10:30am	++Covered Orange County General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	The Village 1505 E. 17th St. Santa Ana
Friday, 10/6 10-11am	++Help Me Grow Advisory Meeting	**Steering Committee Meeting: Open to Collaborative Members**	Help Me Grow 2500 Redhill Ave. Santa Ana