NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, MAY 2, 2019
2:00 P.M.

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

BOARD OF DIRECTORS

Paul Yost, M.D., Chair
Dr. Nikan Khatibi, Vice Chair
Ria Berger
Ron DiLuigi
Supervisor Andrew Do
Alexander Nguyen, M.D.
Lee Penrose
Richard Sanchez
J. Scott Schoeffel
Supervisor Michelle Steel
Supervisor Doug Chaffee, 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. Homeless Health Initiatives
   b. Knox-Keene Licensure Regulation
   c. California Children's Services Advisory Group Meeting
   d. Medi-Cal Expansion Rate Reduction
   e. Executive Director, Human Resources

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. Consider Approving Minutes of the April 4, 2019 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the March 14, 2019 Meeting of the CalOptima Board of Directors' Provider Advisory Committee

REPORTS

3. Consider Amending the Contract with Veyo, LLC to Include Maintenance and Transportation Services for Whole-Child Model Members

4. Consider Authorizing a Contract for Pre-Payment of Services Provided to CalOptima Medi-Cal Members at the Be Well OC Wellness Hub Using Intergovernmental Transfer (IGT) 5 Funds in an Amount Not to Exceed $11.4 Million

5. Consider Approval of Modifications to CalOptima's Policy and Procedure Related to CalOptima's Whole-Child Model Program

6. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to Agreement 16-93274 with the California Department of Health Care Services in Order to Continue Operation of the OneCare and OneCare Connect Programs

7. Consider Appointment to the CalOptima Board of Directors' Provider Advisory Committee

8. Consider Authorizing Further Action Related to the Regulatory Requirement for Medi-Cal Provider Enrollment by the California Department of Health Care Services

9. Consider Approval of Modification of CalOptima Policy and Procedure Related to CalOptima's Whole-Child Model Family Advisory Committee

10. Consider Appointment to the CalOptima Board of Directors' Member Advisory Committee

11. Consider Actions Related to the Provision of Behavioral Health Services for CalOptima OneCare Connect (Medicare-Medicaid) and OneCare Programs (HMO-SNP) Members

12. Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2020 and Execute Contract with the Centers for Medicare & Medicaid Services; Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement *(to follow Closed Session)*

13. Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Connect Bid for Calendar Year 2020 and Execute Three-way contract with the Centers for Medicare & Medicaid Services and the Department of Health Care Services; Authorize the CEO to Amend/Execute OneCare Connect Health Network Contracts and Take Other Actions as Necessary to Implement *(to follow Closed Session)*

ADVISORY COMMITTEE UPDATES

14. Provider Advisory Committee Update

INFORMATION ITEMS

15. Strategic Plan Update

16. Introduction to the FY 2019-20 CalOptima Budget: Part 2

17. March 2019 Financial Summary

18. Compliance Report

19. Federal and State Legislative Advocates Reports

20. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

CS 1 Government Code Section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. Two Cases: Fountain Valley Regional Hospital and Medical Center v. CalOptima; Healthcare Insight, a division of Verisk Health, Inc. Orange County Superior Court Case No. 30-2017-00909571-CU-BC-CJC; Fountain Valley Regional Hospital and Medical Center v. CalOptima. Orange County Superior Court Case No. 30-2017-00951569-CU-BC-CJC

CS 2 Pursuant to Government Code section 54956.87, subdivision (b), Health Plan Trade Secrets – OneCare and OneCare Connect

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, June 6, 2019 at 2:00 p.m.

MEMORANDUM

DATE:	May 2, 2019
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; and Whole-Child Model Family Advisory Committee

Homeless Health Initiatives Underway; Clinical Field Teams Launched in April
CalOptima moved our $100 million commitment to homeless health from concept into action this past month in several ways, most notably with the launch of clinical field teams. Guided by your Board's ad hoc committee, which is meeting weekly to spearhead the effort, selected initiatives are summarized below.

- Clinical Field Teams: Launched on time on April 10, CalOptima's first clinical field team conducted its first medical visit with a member at a Santa Ana park. Following a newly established process, the Orange County Health Care Agency's Outreach and Engagement team contacted our internal Homeless Response Team, which then dispatched a Central City Community Health Center (CCCHC) field team, consisting of a physician assistant and medical assistant. The field team treated a member needing care for a sizable open wound. CalOptima and CCCHC agree the initial experience was successful and instructive. Since that time, three other Federally Qualified Health Center (FQHC) partners have begun their programs, including Korean Community Services on April 17, Hurtt Family Health Clinic on April 18 and Serve the People on April 23. We are communicating with other FQHCs, directly and through the Coalition of Orange County Community Health Centers, about their potential participation in the clinical field team program. As we develop a better understanding of the population, its needs and the best methods for serving them, we will continue expanding our coverage.
- Anaheim Encampment: Reflecting our commitment to meeting the healthcare needs of members experiencing homelessness, CalOptima recently participated in a collaborative effort to clear a homeless encampment of approximately 70 people in 40 tents along a stretch of railroad tracks located in Anaheim. The group included the County's Outreach and Engagement team, the City of Anaheim, public health nurses, and other service providers. CalOptima arranged FQHC mobile clinics to work alongside the group to address any medical needs of the homeless. In addition, CalOptima had a case manager on site to make referrals.
- Use of Funds: Approximately $60 million of CalOptima's homeless health commitment is for new initiatives not yet identified. CalOptima is obligated to follow statutory, regulatory, and contractual requirements in determining the type of initiatives that are permissible. To that end, CalOptima has publicly shared the "Use of CalOptima Funds" document that follows this report. The information about the agency's framework and

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allowable use of funds will ensure the community is aware of the principles guiding your Board's decision making regarding homeless health.

- Stakeholder Input: The Board ad hoc committee will be seeking additional input to our homeless health initiatives through meetings with stakeholders. CalOptima is in the process of identifying people and/or organizations to engage and will begin setting up those meetings. Recently, the ad hoc committee met with Former Santa Ana City Councilwoman Michele Martinez, Illumination Foundation CEO Paul Leon and Pastor Donald Dermit, from The Rock Church in Anaheim.
- State Programs and Legislation: Efforts to end the homeless crisis are ongoing statewide, and CalOptima is tracking a variety of bills and programs that have potential to positively impact Orange County. One example is the Housing for a Healthy California Program, which is a new source of funds for supportive housing through the Department of Housing and Community Development (DHCD). The program provides supportive housing for Medi-Cal members to reduce financial burdens related to medical and public services overutilization. DHCD is expected to open applications to supportive housing owners and developers for grants that total $36 million statewide. Orange County Health Care Agency intends to work with owners and developers to explore this funding opportunity. Separately, Assembly Bill 563 is state legislation that would grant the North Orange County Public Safety Task Force $16 million in funding to set up comprehensive crisis intervention infrastructure. The aim is to mitigate the local mental health and homeless crisis by expanding and coordinating the many available services, potentially through the Be Well OC Regional Mental Health and Wellness Campus. The bill is currently in the early stages of the legislative process.

Impact of New Knox-Keene Licensure Regulation Will Be Mitigated by Exemptions

With an effective date of July 1, 2019, a new Department of Managed Health Care (DMHC) global risk regulation will substantially expand the number of health care organizations required to have a Knox-Keene license. Fortunately, CalOptima was able to mitigate local concerns that the rule applied to our delegated health networks, which operate under three models — Health Maintenance Organizations (HMOs), Physician-Hospital Consortia (PHCs) and Shared-Risk Groups (SRGs). DHMC has now confirmed that CalOptima's limited Knox-Keene licensed HMO health networks may continue their current contractual arrangements with CalOptima, and the regulator has reached out to our partners to update their licenses. With regard to PHCs and SRGs, the DMHC has reviewed CalOptima's template contracts and believes that these limited risk-sharing arrangements will qualify for exemptions from the new licensure requirement. Contracts that renew or are amended after July 1, 2019, will need to be submitted to the DMHC for a review and exemption process that is anticipated to take no longer than 30 days. CalOptima staff has informed our health network partners about this latest positive development.

California Children's Services (CCS) Advisory Group Meeting Focuses on CalOptima Readiness for Transition

Implementation of the Whole-Child Model (WCM) for CCS in Orange County is now only two months away. Given our impending transition, CalOptima was the focus of an April 10 meeting of the CCS Advisory Group, a highly engaged Department of Health Care Services (DHCS)-appointed panel of medical experts and member advocates who are dedicated to ensuring the WCM effectively serves children with complex CCS conditions. CalOptima Chief Medical Officer David Ramirez, M.D., Executive Director of Clinical Operations Tracy Hitzeman and

Thanh-Tam Nguyen, M.D., our medical director for WCM, shared detailed information about our authorization process, provider panel, delegated delivery system and more, all from the member's perspective. Our WCM Family Advisory Committee Representative Kristen Rogers also spoke. The meeting was an important opportunity to instill confidence about our ability to effectively integrate the CCS program, and we successfully demonstrated CalOptima's careful preparations for WCM. Feedback from the advisory group and DHCS leaders was supportive.

Future Medi-Cal Expansion (MCE) Rates Face Likely Reduction as State Regulator Examines CalOptima Reimbursement

Following a trend established across the past few years, DHCS is signaling a likely reduction in CalOptima's MCE capitation rates for FY 2019–20. Staff was notified in April that a significant adjustment may be ahead, based on the fact that CalOptima's reimbursement for the MCE population is a noticeable outlier. Specifically, DHCS identified that CalOptima's provider capitation and risk pool incentive payouts are significantly higher than those paid by other managed care plans in California. Staff has been in close communication with state officials who will soon share our draft rates. Importantly, we are continuing to communicate with our provider partners so they can plan ahead for a possible reduction. As more information becomes available, staff will look to your Board's Finance and Audit Committee for guidance on any adjustments to provider reimbursement.

CalOptima Welcomes New Executive Director, Human Resources

This past month, Brigette Gibb joined CalOptima as Executive Director, Human Resources. She has more than 35 years of public-sector experience. Most recently, Ms. Gibb worked as the human resources director for the Orange County Fire Authority (OFCA), where she led and directed the administration, coordination and evaluation of all human resources and risk management functions. She has established and maintained effective working relationships with the OCFA Board of Directors, city managers, executive team members and labor group representatives. She holds a master's degree in public administration, with a concentration in human resources, from California State University, Fullerton.

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Use of CalOptima Funds

- ***CalOptima's Structure, Purpose, and Revenue.*** CalOptima is a County Organized Health System (COHS) established by the Orange County Board of Supervisors. It must comply with the COHS enabling statute [1] and with the County's authorizing ordinance. [2]
    - Most of CalOptima's revenues relate to its operations as a Medicaid managed care plan. As such, it receives funding from:
        - the federal government through the Centers for Medicare & Medicaid Services (CMS) which funds the State Medicaid program by proving Federal Financial Participation (FFP). FFP funds more than 50% of Medicaid expenditures in California. [3];
        - the state government through Medi-Cal and as a Medi-Cal managed care plan, through a contract with the California Department of Health Care Services (DHCS); and
        - intergovernmental transfers (IGTs), as pertinent here, from public entities in Orange County, with the largest contributor being the University of California at Irvine.
    - CalOptima must comply with the requirements placed on the use of funds imposed by these sources.
- ***Federal and State Law, State Contract, Orange County Parameters.***
    - ***Beneficiary of expenditure.*** CalOptima is precluded under State law from using its Medi-Cal reserves to pay for items or services for individuals who are not eligible for Medicaid or Medicare.
        - State law mandates that [CalOptima] "shall not use any payments or reserves from the Medi-Cal program" for the purpose of providing health care delivery systems to public agencies, private businesses, as well as uninsured or indigent persons who are the responsibility of the County or for the purpose of contracting for "the provision of health care services to persons who are eligible to receive medical benefits under any publicly supported program." [4]
        - CalOptima may, however, use Medi-Cal payments and reserves for: negotiating the exclusive Medicaid managed care contract for the county and arranging for the provision of covered Medi-Cal services; or providing

[1] Welf. & Inst. Code § 14087.54.
[2] O.C.C.O. § 4-11-1.
[3] CalOptima also receives federal revenue for its Medicare Advantage, Cal MediConnect and PACE programs.
[4] Welf. & Inst. Code § 14087.54(b)(3); *see also* O.C.C.O. § 4-11-2(a).

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"health care delivery systems" to individuals eligible for Medicare or both Medicare and Medicaid.[5]

- ***Service.*** CalOptima is subject to regulation by both the federal and state government (as well as Orange County's authorizing ordinance).
  - CalOptima's State Medi-Cal contract requires that specific (but not all) Medi-Cal covered services must be provided by it and CalOptima cannot use Medi-Cal payments or reserves to provide services that are not covered by the Medi-Cal program.
  - Housing (room and board) is not a traditional Medicaid benefit, and is not reflected in the list of covered health care services in the Medi-Cal Act. CMS historically has taken the position that payments for "room and board are not eligible for Federal financial participation [FFP]."[6] CMS takes the position that "room and board" includes capital funds used for new construction or rehabilitation of housing, but can assist states with the coverage of certain housing related activities and services.[7]
  - Federal Medicaid law affirmatively offers flexibility for managed care plans to cover "services or settings that are in lieu of services or settings covered under the State plan." Such services may be covered when "the State makes certain determinations and, if and when approved, can be included in rate development. CalOptima could seek proactive approval from DHCS under its COHS contract to fund housing or enhanced housing support services as an "in lieu of" service (*i.e.,* a cost-effective substitute for other services).
  - Medicaid does not pay for services that are duplicated by other programs under Federal or State law.[8]
  - Orange County participates in a pilot program under the State Medicaid's "Whole Person Care" that targets Medi-Cal beneficiaries who are seriously homeless. CalOptima is currently a participating entity in this pilot program for specific functions. CalOptima could work with Orange County to seek DHCS' approval of amendments to Orange County's approved application to make CalOptima's role in providing housing-related services and supports more explicit.

[5] O.C.C.O. § 4-11-2(a).
[6] June 26, 2016 Center for Medicaid & CHIP Services Informational Bulletin from Director Vikki Wachino re "Coverage of Housing-Related Activities and Services for Individuals with Disabilities."
[7] *Id.*
[8] 42 U.S.C. § 1396a(a)(25); Cal. Welf. & Inst. Code §§ 100020(a), 14000(b).

- CalOptima is expected to participate in a new Medicaid health homes program which includes housing navigator services for eligible beneficiaries.

- ***Collateral consequences of expenditures, including***:
  - **Potential impact on future rates.** Medicaid managed care plan capitation rates are required to be actuarially sound, which means that they: (i) "must be based only upon services covered under the State plan" or required to meet mental health parity requirements; and (ii) must "represent a payment amount that is adequate to allow the [managed care plan] to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements." [9] Based on CMS' position on housing (room and board), as discussed above, costs, associated with housing expenditures likely would not be incorporated into capitation rate development.
    - Additionally, the expenditures would not count toward the adult expansion medical loss ratio (MLR) and risk corridor incorporated into CalOptima's contract. The MLR requires CalOptima to expend at least 85 percent of net capitation payments received on allowed medical expenses for adult expansion members. Given CMS' view on housing (room and board), expenditures on housing would not be "allowed medical expenses" for purposes of the MLR calculation.
  - **Enforcement risks of noncompliance, potentially including expenditures that are not proactively authorized.** If CalOptima does not meet the terms of its contract with DHCS (including meeting applicable Federal requirements), and is determined to have made inappropriate expenditures, it risks sanctions and civil money penalties, as well as recoupment of capitation payments. [10] CalOptima could also face actions from CalOptima members, providers, or other interested parties who contest the expenditures. In addition, programs offering non-covered services to Medicaid or Medicare eligible beneficiaries must be carefully structured to avoid fraud and abuse risks, *e.g.,* patient inducement restrictions.
  - **Public agency considerations**. CalOptima is a public agency and as such must comply with generally applicable limitations. Governmental entities have only the powers expressly granted to them in law and those implied powers necessary to effectuate what has been granted. Furthermore, courts

[9] 42 C.F.R. § 438.3(c)(1)(ii).
[10] See e.g. ,Welf. & Inst. Code § 14304(a); CalOptima contract, Exh. B, ¶ 12.

have interpreted a provision in the California Constitution prohibiting any gift of any public money or thing of value to invalidate legislation would contribute funds that were not in furtherance of the general purpose for which the governmental entity was formed. [11]

- ***CalOptima's IGT Agreements, pre-2017-2018.*** Some of CalOptima's Medi-Cal payments have been funded by intergovernmental transfers (IGTs) from UCI or other public entities. CalOptima has often been required to pay designated providers with these IGT-funded payments, and to expend remaining amounts for defined purposes, such as "community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the social safety net, and improve children's health."
    - CalOptima retained IGT funds must be used for Medi-Cal beneficiaries.
    - Use of CalOptima retained IGT funds are governed by the defined purposes in state and federal-approved IGT agreements and use for other purposes may contravene the terms of the IGT Agreements.
    - Additional federal, state and local law restrictions apply in addition to any IGT contractual limitations.

[11] *Golden Gate Bridge & Highway Dist. V. Luehring,* 4 Cal. App. 3d 204, 210 (Cal. Ct. App. 1970).

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

April 4, 2019

A Regular Meeting of the CalOptima Board of Directors was held on April 4, 2019, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:00 p.m. Supervisor Steel led the Pledge of Allegiance.

ROLL CALL

Members Present: Paul Yost, M.D., Chair; Dr. Nikan Khatibi, Vice Chair; Ria Berger, Ron DiLuigi, Supervisor Andrew Do, Alexander Nguyen, M.D., Lee Penrose, Richard Sanchez (non-voting), Scott Schoeffel, Supervisor Michelle Steel

Members Absent: All Members present

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

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader reported that the Department of Health Care Services (DHCS) certified that CalOptima's 12 delegated health networks and our direct network, CalOptima Community Network, meet the requirements for Whole-Child Model (WCM) program participation. CalOptima continues to engage with stakeholder groups at the local and state levels to ensure awareness and work toward a smooth transition effective July 1, 2019.

PUBLIC COMMENT

1. Sharon Quirk-Silva, Assemblymember, 65th District, California State Assembly; Mike Robbins, Anaheim Homeless Policy Working Group; Angel VanStark; David Duran, Housing is a Human Right OC, Peoples Homeless Task Force OC; and Mark Richard Daniels, HHROC/Los Amigos de Orange County – Oral re: Agenda Item 4, Consider Actions Related to Delivery of Care for Homeless CalOptima Members.
2. Abe Marouf, Innovative Integrated Health, dba Fresno PACE; Josef Holper, Office of Assemblymember Sharon Quirk-Silva, 65th District; Ryan Yamamoto, Coalition of Orange County Community Health Centers; Dr. Marie S. Torres, AltaMed Health Services Corporation; Gloria Colazo, Vice Chair, St. Jude Health Center Board of Directors; Bobby McDonald, Black Chamber of Orange County – Oral re: Agenda Item 24, Consider Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima.

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CONSENT CALENDAR

2. Minutes
   a. Consider Approving Minutes of the March 7, 2019 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the January 10, 2019 Meeting of the CalOptima Board of Directors' Member Advisory Committee, the August 23, 2018 Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee, and the February 14, 2019 Meeting of the CalOptima Board of Directors' Provider Advisory Committee

3. Consider Appointment of CalOptima Treasurer

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

CLOSED SESSION

CS 1 CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
The Board of Directors adjourned to closed session at 2:05 p.m. pursuant to: 1) Significant exposure to litigation pursuant to Government Code section 54956.9, subdivision (d)(2): Three Cases; and 2) Initiation of litigation pursuant to Government Code section 54956.9, subdivision (d)(4): One Case. It was noted that Director Schoeffel did not participate in closed session due to potential conflicts of interest.

The Board of Directors reconvened to open session at 3:23 p.m. with no reportable actions taken.

REPORTS

4. Consider Actions Related to Delivery of Care for Homeless CalOptima Members
Mr. Schrader presented an overview of the Orange County Coroner's report on homeless deaths during the period 2014-18 and possible interventions. It was noted that the Board of Directors' Quality Assurance Committee will conduct deeper analysis into the causes of homeless deaths and interventions, case studies for each cause of homeless death, benchmarks and comparison with interventions and resources in other counties, and presentations from partnering organizations. A review of the Clinical Field Team and Homeless Response Team structure, the proposed homeless coordination at hospitals, and medical respite program was provided to the Board for discussion.

An ad hoc comprised of Chair Yost, and Directors DiLuigi and Penrose held several meetings to examine the issues related to homeless health and to develop recommendations for Board consideration. The ad hoc recommended that the Board commit $100 million to a Homeless Health Reserve, stipulating that the funds can only be used for homeless health. As proposed, the total amount of $100 million includes $25.2 million previously approved by the Board for the BeWell OC initiative, recuperative care, and startup costs related to the Clinical Field Team and the Homeless Response Team. An additional $76 million was recommended to fund the Homeless Response Team, homeless coordination at hospitals, and other new initiatives involving medically necessary covered Medi-Cal services for homeless CalOptima members to be funded through IGT 8 and Fiscal Year 2018-19 operating funds.

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David Ramirez, M.D., Chief Medical Officer, reviewed possible initiatives and interventions that may be considered in the community, at shelters, and in the recuperative care setting, including: advanced wound care, psychiatry, telepsychiatry, screening members at risk for depression and referring for treatment as appropriate, training and incentives for providers to prescribe Narcan to reverse overdose symptoms in the field; medication assisted therapy services to treat substance use disorders and prevent opioid overdose; training and incentives for outpatient providers to identify and address homelessness and housing insecurity during office visits; predictive analytics to identify those at risk of becoming homeless who would benefit from outreach and intensive management, and creating dedicated CalOptima homeless health team including a dedicated medical director and director to help coordinate this work.

After considerable discussion of the matter, Board members commented that the recommended funding commitment to a Homeless Health Reserve is not capped at $100 million, and additional funding could be allocated later, if needed, for the delivery of medically necessary Medi-Cal covered services for homeless Medi-Cal members to improve their health status and reduce the number of homeless deaths. Chair Yost appointed Directors Nguyen and Sanchez to the Homeless Health Ad Hoc.

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors: 1) Approved the creation of a restricted Homeless Health Reserve in the amount of $100 million: $24 million in previously approved initiatives using Intergovernmental Transfer (IGT) 1-7 funds, and $76 million in IGT 8 funds (approximately $43 million) with the balance from Fiscal Year 2018-19 operating funds; and 2) Stipulated that funds can only be used for homeless health. (Motion carried 8-0-0; Director Schoeffel absent)***

5. Consider Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program

Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors: 1) Ratified the implementation plan for the Board authorized Clinical Field Team Pilot Program (CFTPP); 2) Ratified contracts with the following Federally Qualified Health Centers to participate in the CFTPP: Central City Community Health Center, Hurtt Family Health Clinic, Inc., Korean Community Services, Inc., dba Korean Community Services Health Center, and Serve the People Community Health Center; and 3) Authorized expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service basis through June 30, 2019. (Motion carried 8-0-0; Director Schoeffel absent)***

6. Consider Authorizing Establishment of a Post Whole Person Care Pilot Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program

Director Sanchez did not participate in this item due to his position with the Orange County Health Care Agency and left the room during the discussion and vote. Vice Chair Khatibi did not participate in the discussion and vote on this item due to potential conflicts of interest.

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Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors: 1) Authorized the establishment of a Medical Respite Program for CalOptima members meeting clinical criteria who have exhausted available recuperative care days under the Orange County Health Care Agency (OCHCA) Whole Person Care Pilot (WPC) program; staff to return to the Board for approval of implementing policies, and obtaining state approval, as appropriate; 2) Authorized reallocation of $250,000 to fund the Medical Respite Program from the $10 million previously allocated IGT 6/7 funds for recuperative care in support of the OCHCA WPC program; and 3) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima's agreement with the County of Orange to allow for reallocation of funds away from the WPC program for medically justified medical respite services for qualifying homeless CalOptima members who have exhausted available recuperative care days under the WPC program. (Motion carried 7-0-0; Vice Chair Khatibi recused; Director Schoeffel absent)***

7. Consider Approval of Modifications of CalOptima Policies and Procedures Related to CalOptima's Whole-Child Model (WCM) Program

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors approved modifications to the following policies and procedures in connection with Whole-Child Model program: DD.2006: Enrollment In/Eligibility with CalOptima [Medi-Cal]; DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process [Medi-Cal]; GG.1125: Cancer Clinical Trials [Medi-Cal, OneCare, OneCare Connect]; and GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices [Medi-Cal]. (Motion carried 8-0-0; Director Schoeffel absent)***

8. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Except Those Associated with the University of California, Irvine or St. Joseph Healthcare and its Affiliates

Supervisor Steel did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts through June 30, 2020, except those associated with the University of California, Irvine, or St. Joseph Healthcare and its affiliates, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State, and amend these contract terms to reflect requirements associated with the Whole-Child Model program and make applicable regulatory changes and other requirements. (Motion carried 7-0-0; Supervisor Steel recused; Director Schoeffel absent)***

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9. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service (FFS) Primary Care Physician (PCP) Contracts, Except Those Associated with the University of California, Irvine or St. Joseph Healthcare and its Affiliates

Supervisors Do and Steel did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act.

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service primary care physician contracts through June 30, 2020, except those associated with the University of California-Irvine or St. Joseph Healthcare and its Affiliates with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State, and amend these contract terms to reflect requirements associated with the Whole-Child Model program and make applicable regulatory changes and other requirements. (Motion carried 6-0-0; Supervisors Do and Steel recused; Director Schoeffel absent)***

10. Consider Authorizing Extensions of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Except Those Associated with Children's Hospital of Orange County, the University of California, Irvine and St. Joseph Health and its Affiliates

Supervisors Do and Steel did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act.

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service specialist physician contracts through June 30, 2020, except those associated with Children's Hospital of Orange County, the University of California-Irvine or St. Joseph Health and its Affiliates with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State. (Motion carried 6-0-0; Supervisors Do and Steel recused; Director Schoeffel absent)***

11. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated with St. Joseph Health and its Affiliates

Due to his provider affiliations, Director Penrose did not participate in this item and left the room during the discussion and vote. Director DiLuigi did not participate in the discussion and vote on this item due to his affiliation with St. Jude Clinic.

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts through June 30, 2020, associated with St. Joseph Health and its affiliates, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State, and amend these contract terms to reflect***

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requirements associated with the Whole-Child Model program and make applicable regulatory changes and other requirements. (Motion carried 6-0-0; Director DiLuigi recused; Directors Penrose and Schoeffel absent)

12. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service (FFS) Primary Care Physician (PCP) Contracts Associated with St. Joseph Health and its Affiliates

Due to his provider affiliations, Director Penrose did not participate in this item and left the room during the discussion and vote. Supervisor Do did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service primary care physician contracts through June 30, 2020, associated with St. Joseph Health and its Affiliates with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State, and amend these contract terms to reflect requirements associated with the Whole-Child Model program and make applicable regulatory changes and other requirements. (Motion carried 6-0-0; Supervisor Do recused; Directors Penrose and Schoeffel absent)***

13. Consider Authorizing Extensions of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with St. Joseph Health and its Affiliates

Chair Yost did not participate in the discussion and vote on this item due to his affiliation with Providence St. Joseph Healthcare as an anesthesiologist physician, and he passed the gavel to Vice Chair Khatibi. Supervisor Do did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act. Due to his provider affiliations, Director Penrose did not participate in this item and left the room during the discussion and vote.

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service specialist physician contracts through June 30, 2020, associated with St. Joseph Health and its Affiliates with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State. (Motion carried 5-0-0; Chair Yost and Supervisor Do recused; Directors Penrose and Schoeffel absent)***

14. Consider Authorizing Extensions of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with the University of California, Irvine

Director Nguyen did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisor Do did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act.

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Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service specialist physician contracts through June 30, 2020, associated with the University of California-Irvine with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State. (Motion carried 6-0-0; Supervisor Do recused; Directors Nguyen and Schoeffel absent)***

15. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service (FFS) Primary Care Physician (PCP) Contracts, Associated with the University of California, Irvine

Director Nguyen did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisor Do did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service primary care physician contracts through June 30, 2020, associated with the University of California, Irvine with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State, and amend these contract terms to reflect requirements associated with the Whole-Child Model program and make applicable regulatory changes and other requirements. (Motion carried 6-0-0; Supervisor Do recused; Directors Nguyen and Schoeffel absent)***

16. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Associated with the University of California, Irvine

Director Nguyen 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 Khatibi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts through June 30, 2020, associated with the University of California, Irvine with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State, and amend these contract terms to reflect requirements associated with the Whole-Child Model program and make applicable regulatory changes and other requirements. (Motion carried 7-0-0; Directors Nguyen and Schoeffel absent)***

17. Consider Authorizing Extensions of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with Children's Hospital of Orange County

Chair Yost did not participate in the discussion and vote on this item due to his affiliation with Children's Hospital of Orange County as an anesthesiologist physician, and he passed the gavel to

Vice Chair Khatibi. Supervisor Do did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act.

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service specialist physician contracts through June 30, 2020, associated with Children's Hospital of Orange County with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State. (Motion 6-0-0; Chair Yost and Supervisor Do recused; Director Schoeffel absent)***

18. Consider Authorizing New Contracts with the Direct Contracted, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service Hospitals to Increase Rates in Support of Hospital Discharge Obligations and to Incorporate Changes Related to the Department Health Care Services (DHCS) Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children's Hospital of Orange County

Due to his provider affiliations, Director Penrose did not participate in this item and left the room during the discussion and vote.

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors: 1) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into new hospital fee-for-service contracts with a July 1, 2019, effective date that are substantially similar to the current contracts, but that also address the following: have an initial term through June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward based on rate changes implemented by the State; modify the Medi-Cal Classic rates with Orange County acute care hospitals contracted for full-scope Medi-Cal services to support hospital discharge coordination, including the utilization by hospitals of data sharing technology to help facilitate coordination of services for homeless individuals with other providers and community partners; provide for payments under the DHCS Hospital Directed Payments programs, including all necessary language changes to meet the program's requirements, as set forth in DHCS's All Plan Letter 19-001; include provisions to reflect requirements associated with the Whole-Child Model (WCM) program and make any other required regulatory changes; and 2) Ratified the contract amendment with Children's Hospital of Orange County reflecting requirements associated with the WCM program, regulatory changes and other requirements for the period prior to the effective date of the new contract. (Motion carried 7-0-0; Directors Penrose and Schoeffel absent)***

19. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts that Expire During Fiscal Year 2019-20

Supervisors Do and Steel did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act.

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Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE ancillary services provider contracts through June 30, 2020, retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State, and amend these contract terms to reflect requirements associated with the Whole-Child Model program and make applicable regulatory changes and other requirements. (Motion carried 6-0-0; Supervisors Do and Steel recused; Director Schoeffel absent)***

20. Consider Approval of Proposed Changes to CalOptima Contracting Policy EE.1135: Long Term Care Facility Contracting

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer to modify existing CalOptima Contracting Policy EE.1135: Long Term Care Facility Contracting. (Motion carried 8-0-0; Director Schoeffel absent)***

21. Consider Approval of Proposed Changes to CalOptima Contracting Policy EE.1141: CalOptima Provider Contracts

Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors authorized the Chief Executive Officer to modify existing CalOptima Contracting Policy EE.1141: CalOptima Provider Contracts. (Motion carried 8-0-0; Director Schoeffel absent)***

22. Consider Approval of Proposed Revisions to CalOptima Information Services Policy IS.1306: Shared Drives Authorization and Classification

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors authorized and approved updates to CalOptima Policy IS.1306: Shared Drives Authorization and Classification, subject to regulatory approval, as necessary. (Motion carried 7-0-0; Directors Nguyen and Schoeffel absent)***

23. Consider Authorizing and Directing Execution of Amendments 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 Supervisor Do, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute Amendment A07 to the PACE Agreement between the Department of Health Care Services and CalOptima regarding Calendar Year 2018 capitation rates and other language updates. (Motion carried 7-0-0; Directors Nguyen and Schoeffel absent)***

24. Consider Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima

Candice Gomez, Executive Director, Program Implementation, presented the recommended actions to consider requests for letters of support from organizations seeking to offer PACE services in Orange

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County independent of CalOptima, and if requests for letters of support are approved, authorize the Chief Executive Officer, with the assistance of Legal Counsel, to submit CalOptima letter(s) of support to the Department of Health Care Services (DHCS).

After discussion of the matter, the Board took the following actions.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer to submit to DHCS a Letter of Support in response to the request from Fresno PACE to become an independent PACE Organization in Orange County. (Motion carried 6-1-0; Director Penrose voting no; Directors Nguyen and Schoeffel absent)***

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors authorized the Chief Executive Officer to submit to DHCS a Letter of Support in response to the request from AltaMed to become an independent PACE Organization in Orange County. (Motion carried 5-1-0; Director Penrose voting no; Supervisor Steel recused; Directors Nguyen and Schoeffel absent)***

25. Consider Authorizing Contract with Vendor for Consulting Services Related to CalOptima's Strategic Plan 2020-2022

Action: ***On motion of Supervisor Steel, seconded and carried, the Board of Directors: 1) Approved the recommended consultant, Chapman Consulting, for consulting services for CalOptima Strategic Plan 2020-2022 activities; 2) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into an agreement with the recommended consulting organization; and 3) In the event CalOptima and Chapman Consulting are unable to reach agreeable contract terms within thirty (30) days, authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into an agreement with the next qualified bidder, Pacific Health Consulting Group, for consulting services for CalOptima Strategic Plan 2020-2022 activities. (Motion carried 6-0-0; Supervisor Do and Directors Nguyen and Schoeffel absent)***

26. Consider Appointment to the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors appointed Cathleen Collins as a Family Member Representative on the Board of Directors' Whole-Child Model Family Advisory Committee for the remainder of a two-year term ending June 30, 2020. (Motion carried 6-0-0; Supervisor Do and Directors Nguyen and Schoeffel absent)***

27. Consider Authorizing Expenditures in Support of CalOptima's Participation in a Community Event

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors authorized up to $10,000 and staff participation at Age Well Senior Services 12th Annual South County Senior Summit in Aliso Viejo on May 17, 2019, made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and***

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statutory purpose, and authorized the Chief Executive Officer to execute agreements as necessary for the event and expenditures. (Motion carried 6-0-0; Supervisor Do and Directors Nguyen and Schoeffel absent)

ADVISORY COMMITTEE UPDATES

28. Provider Advisory Committee (PAC) Update

John Nishimoto, O.D., PAC Chair, reported that an ad hoc will be meeting to review the applications received for open positions on the PAC and present recommendations for consideration. The Committee will also review the current Goals and Objectives at the April 11, 2019 meeting.

29. Member Advisory Committee (MAC) Update

MAC Chair Sally Molnar reported that the Nominations Ad Hoc reviewed applicants for the Children Representative, and the recommended candidate will be presented to the Board for consideration at a future meeting. It was noted that recruitment will continue for the Long-Term Services and Supports Representative.

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

Patty Mouton, OCC MAC Vice Chair, reported that ad hoc committees were formed to review applications received for the Member Advocate Representative and the recruitment for seats whose terms are set to expire on June 30, 2019.

INFORMATION ITEMS

31. Introduction to the FY 2019-20 CalOptima Budget: Part 1

As Chair of the Board of Directors' Finance and Audit Committee (FAC), Director Penrose reported that at the May 16, 2019 meeting, the FAC will conduct a thorough review of the proposed Fiscal Year 2019-20 CalOptima Budget, which will include elements of the Quarterly Budget Actual Review (QBAR) process.

The following Information Items were accepted as presented:
32. February 2019 Financial Summary
33. Compliance Report
34. Federal and State Legislative Advocates Reports
35. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Chair Yost appointed Director Berger to serve on the Board of Directors' Finance and Audit Committee (FAC) to fill the seat previously occupied by Director DiLuigi who stepped down from the FAC in early March. Dr. Yost commented on the prior Board action approving up to $11.4 million in IGT funding to support Be Well OC Wellness Hub initiative being implemented in conjunction with the County and other stakeholders, and directed staff to place this item on the May 2, 2019 Board meeting agenda to consider the contract with the County detailing the agreed upon enhanced services that CalOptima members will receive at this new facility. Dr. Yost noted that from time to time, Board members are making special requests of staff. To ensure that the entire Board has visibility on Board member special requests and that best practices are followed, Dr. Yost directed that special requests either be coordinated through the Chair or through the full Board. Dr. Yost also directed staff to

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confirm available funding to enable the Homeless Health Ad Hoc to travel to Sacramento to meet with the legislative delegation and to agendize for Board consideration if needed. As previously indicated, Directors Nguyen and Sanchez were appointed to the Homeless Health Ad Hoc.

ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 6:45 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: May 2, 2019

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MINUTES

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

March 14, 2019

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, March 14, 2019, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Teri Miranti, PAC Vice Chair, called the meeting to order at 8:09 am. Dr. Caliendo led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Teri Miranti, Vice Chair; Anjan Batra, M.D; Donald Bruhns; Theodore Caliendo, M.D.; Stephen Flood; Jena Jensen; Junie Lazo-Pearson, Ph.D.; Craig Myers; Mary Pham, Pharm.D., CHC; Jacob Sweidan, M.D.
Members Absent:	John Nishimoto, O.D., Chair; Brian Lee, Ph.D.
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Nancy Huang, Interim Chief Financial Officer; Michelle Laughlin, Executive Director, Network Operations; Arif Shaikh, Director, Government Affairs; Cheryl Simmons, Staff to the Advisory Committees, Customer Service; Samantha Fontenot, Program Specialist, Customer Service

MINUTES

Approve the Minutes of the February 14, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Dr. Sweidan, seconded and carried, the Committee approved the minutes of the February 14, 2019 meeting. (Motion carried 10-0-0; Members Lee and Nishimoto absent)***

PUBLIC COMMENTS

There were no requests for public comment.

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REPORTS

Consider Recommendations of Provider Advisory Committee Hospital Representative Candidate

At the February 14, 2019 PAC meeting, a Nominations Ad Hoc Committee (Ad Hoc), comprised of Vice Chair Miranti and Members Myers and Sweidan, was formed to review and recommend a candidate for the open Hospital seat. The members of the Ad Hoc Committee met via conference call on March 6, 2019 to discuss and review the application received.

The Nominations Ad Hoc Committee recommended Harold Patton, RN. MSN, Chief Nursing Officer at the University of California Irvine Medical Center as a candidate for the open Hospital seat for a term expiring on June 30, 2020. The recommendation will be presented to the Board of Directors for consideration at their May 2, 2019 meeting.

Action: ***On motion of Dr. Sweidan, seconded and carried, the Committee recommended that the Board of Directors consider the appointment of Harold Patton, RN, MSN, as the Hospital Representative for a term expiring on June 30, 2020. (Motion carried 10-0-0; Members Lee and Nishimoto absent)***

After approval of the recommendation, Member Myers, suggested the formation of an Ad Hoc Committee to review the candidate application process prior to the next annual recruitment in 2020.

CEO AND MANAGEMENT REPORTS

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer (COO), provided an update to the Committee on the open nomination process for MAC and PAC. In addition, she provided an update on CalOptima's annual Qualified Medical Beneficiaries (QMB) project. She also noted that the Health Homes Program launch was deferred from July 1, 2019 to January 1, 2020 at the request of CalOptima.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer (CMO), provided an update on CalOptima's approach to Clinical Quality metrics.

Vice Chair Miranti reordered the agenda to hear Item VII.C., Proposed Health Network Quality Performance Rating Methodology.

Proposed Health Network Quality Performance Rating Methodology Presentation

Kelly Rex-Kimmet, Director, Quality Analytics, provided a comprehensive presentation on CalOptima's Health Networks Quality Ranking Proposal and the next steps. A discussion among the members and management ensued regarding standards of excellence and the issue that not all

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National Committee for Quality Assurance (NCQA) metrics align with Medi-Cal covered services. Ms. Rex-Kimmet advised the Committee that CalOptima continues to work with a consultant and the metrics will be shared with the health networks, Quality Improvement Committee (QIC) and Board prior to implementation.

Chief Financial Officer

Nancy Huang, Interim Chief Financial Officer, provided an update on the Department of Health Care Services (DHCS) 2017/18 rates for the Proposition 56, Supplemental Payments and noted that rates would be increasing for 2018/19. Ms. Huang noted that for July 1, 2019, the fee-for-service networks would be accountable for paying this rate increase. CalOptima will use the current reconciliation process upon receipt of the payment in March 2019. Ms. Huang advised the committee that the Centers for Medicare & Medicaid Services (CMS) would be auditing all plans on Medical Loss Ratio (MLR) covering the last 30 months.

Network Operations Update

Michelle Laughlin, Executive Director, Network Operations, provided an update on the submission of signed contracts to DHCS for the Network Adequacy for CalOptima's health networks. Ms. Laughlin was pleased to report that CalOptima completed the filing, and the DHCS is currently reviewing the file and CalOptima is expected to hear back on March 15, 2019. Member Sweidan asked whether CalOptima could speak to DHCS about the possibility of carving out the new hemophilia drugs that are needed by some of the children transferring from California Children's Services (CCS) to the Whole-Child Model. After discussion among several PAC members, Dr. Ramirez agreed to investigate it and would provide an update to the committee.

Federal & State Budget Update

Arif Shaikh, Director, Government Affairs, provided an update on the Department of Managed Health Care (DMHC) new regulation on global risk. He noted that CalOptima is exempt from having to hold a Knox Keene license, but that there is a possibility that this new Knox Keene licensing requirements may impact some of CalOptima's health networks.

INFORMATION ITEMS

Homeless Health Update

Michael Schrader, Chief Executive Officer, a detailed summary CalOptima's Homeless Health Imitative and the steps that CalOptima will be taking to address them. He noted that CalOptima is working closely with Federally Qualified Health Centers (FQHCs) to support clinical field teams. CalOptima is also seeking legal opinions on the use of Intergovernmental Transfer (IGT) Funds for non-Medi-Cal services. He also mentioned there are two paths to support housing initiatives: 1) build housing and rent assistance. CalOptima is waiting for guidance from the DHCS on this initiative and 2) offer case management to help coordinate and refer homeless people to housing services.

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PAC Member Updates

Vice Chair Miranti announced that the PAC will continue their recruitment for the nurse position and noted that several applications have been received for this seat and will be reviewed in April with the 2019 annual recruitment applicants. Vice Chair Miranti announced the 2019 annual recruitment is under way and applications are being accepted for the following seats: Long-Term Services and Supports (2 seats), Non-Physician Medical Practitioner, Pharmacy, and Physician (2 seats) Representatives. She also noted that nominations for the Chair and Vice Chair positions were also being accepted.

Vice Chair Miranti formed a 2019 Nominations Ad Hoc committee to review applications and make recommendations. Members Myers, Pham and Sweidan agreed to serve on the ad hoc.

ADJOURNMENT

There being no further business, Vice Chair Miranti adjourned the meeting at 10:04 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the Advisory Committees

Approved: April 11, 2019

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Amending the Contract with Veyo, LLC to Include Maintenance and Transportation Services for Whole-Child Model Members

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the contract with CalOptima's Non-Medical Transportation (NMT) provider, Veyo LLC (Veyo), to include Maintenance and Transportation (M&T) services for Whole-Child Model (WCM) Members.

Background/Discussion

The Department of Health Care Services (DHCS) Numbered Letter 03-0810 establishes requirements for delivery of M&T for members with CCS eligible conditions. On occasion, members with California Children's Services (CCS) conditions need to access services not available in Orange or the surrounding counties. As part of the program, CalOptima Community Network (CCN) and health network members will be offered medically necessary services provided by out-of-network, out-of-area, and/or out-of-state providers, if CalOptima or health network case management determines that there are no other resources available in-network. In general, it is the responsibility of the member or parent(s)/legal guardian(s) to provide M&T services which include travel, food and lodging. However, the WCM program will approve M&T services when the costs to the member or family present a barrier to the WCM member's access to CCS authorized care. All M&T service requests will be submitted to CalOptima for review and approval to determine the level of M&T that the member and family will receive and then forward the request to the M&T vendor to coordinate and book the M&T services.

At the August 2, 2018 meeting, the Board authorized staff to contract with Veyo to provide Non-Medical Transportation services to members effective January 1, 2019. Staff has confirmed through a reference check and determined, based upon information provided by Veyo, that Veyo has the necessary experience to coordinate M&T services for CalOptima WCM members. Under the WCM program, CalOptima will be responsible for authorizing and paying for CCN and health network members M&T services. If approved by the Board, Veyo will work with the member and/or their family to arrange and book air transportation, ground transportation and lodging as authorized by CalOptima. Veyo will also reimburse member for meals, mileage, parking, and other expenses in accordance with DHCS guidance and CalOptima Policy GG.1547 Maintenance and Transportation.

In support of providing M&T services to WCM members, staff requests approval of the recommended action to amend the contract with Veyo to include M&T services, effective June 1, 2019. CalOptima will begin coordinating M&T services on and after July 1, 2019.

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Fiscal Impact

The recommended action to amend the contract for NMT services with Veyo to include M&T services to WCM Members is forecasted to be budget neutral to CalOptima. Given the very low numbers of members requiring M&T services, annual costs for the benefit can be volatile and difficult to predict. However, medical and administrative costs for the M&T benefit are likely to be small relative to the overall costs for the WCM program. Management will include projected medical expenses associated with the WCM program, including M&T, in CalOptima's Fiscal Year 2019-20 Operating Budget. CalOptima will closely monitor expenses and continue to work with DHCS to ensure that WCM revenue will be sufficient to support all benefit costs.

Rationale for Recommendation

The Department of Health Care Services (DHCS) Numbered Letter 03-0810 establishes requirements for delivery of M&T for members with CCS eligible conditions. Amending the contract with CalOptima's NMT vendor fulfills the requirements to provides access to M&T for CalOptima WCM members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated August 2, 2018, Consider Actions Related to CalOptima's Medi-Cal Whole-Child Model Program Provider Payment Methodology
4. Board Action August 2, 2018, Consider Authorizing Contract with Non-Medical Transportation (NMT) Vendor Effective January 1, 2019
5. Board Action dated September 6, 2018, Consider Modifications and Development of CalOptima Policies and Procedures Related to Whole-Child Model, Medicaid and CHIP Managed Care Final rule (Finale Rule), and Annual Policy Review
6. DHCS Numbered Letter 03-0810
7. Policy GG.1547: Maintenance and Transportation (Draft)

/s/ Michael Schrader — *4/24/2019*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Veyo LLC	4875 Eastgate Mall	San Diego	CA	92121

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact
Candice Gomez, Executive, Program Implementation, 714-246-8400

Recommended Actions
1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

Rev. 6/7/2018

        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background
The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

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integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

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Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

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While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

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To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

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Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

~~1. Michael Arnot for a two-year term ending June 30, 2020;~~
~~2. Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
~~3. Gabriela Huerta for a two-year term ending June 30, 2020; and~~
~~4. Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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Background

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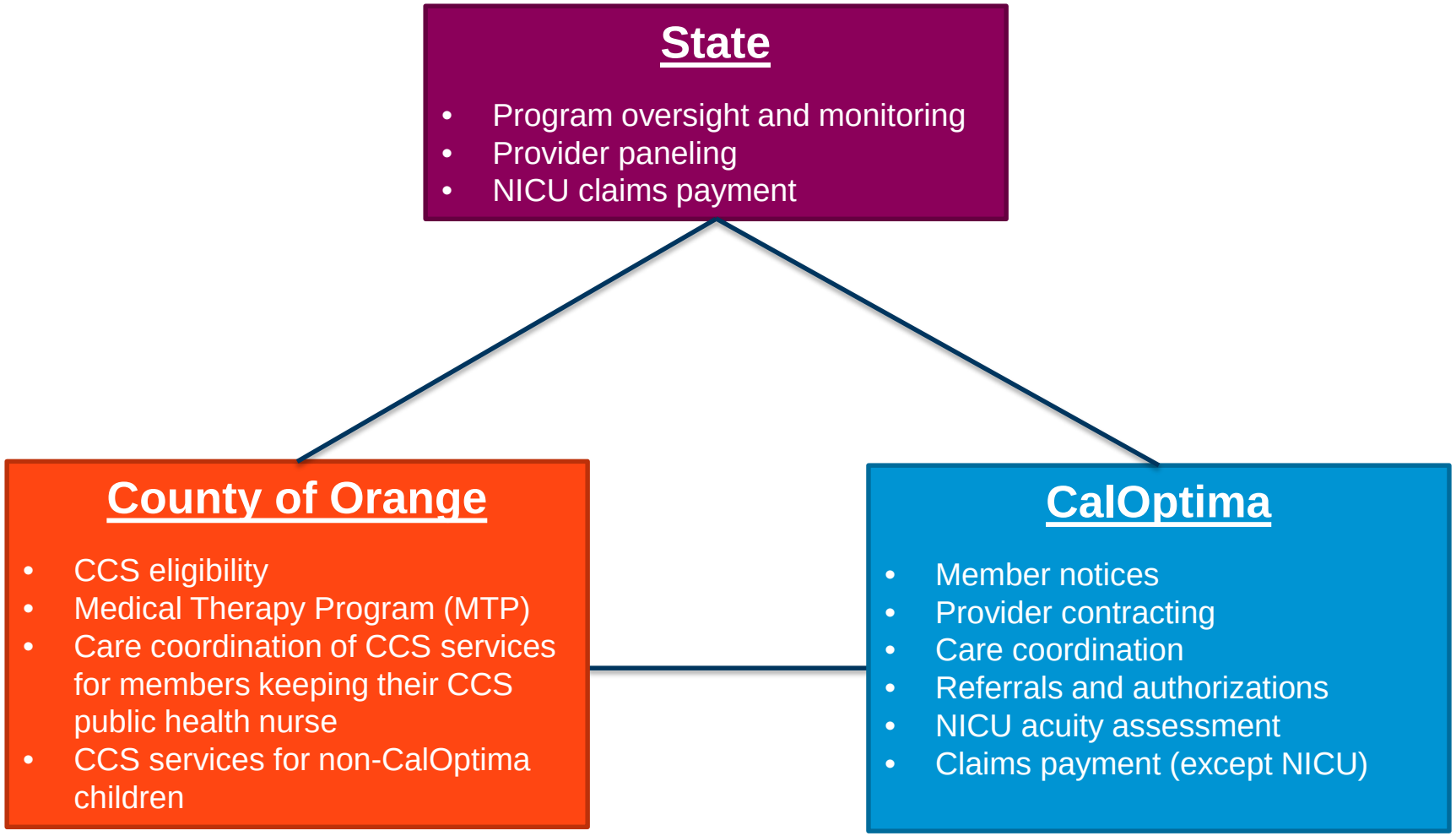
Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



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WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages	City of Residence (Top 5)
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent	• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

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WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

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2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

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Implementation Plan Elements

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Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

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Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

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Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

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Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

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Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

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WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

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WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

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Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

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Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

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- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev. 11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

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The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

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Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

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RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

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The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

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

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Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

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1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

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2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

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1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

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a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

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None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

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IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

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Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

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Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

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Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

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3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

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Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
3. Consider Actions Related to CalOptima's Medi-Cal Whole-Child Model Program Provider Payment Methodology

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions
Approve provider payment methodology for the CalOptima Medi-Cal Whole-Child Model (WCM) program.

Background
The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS will implement the WCM program on a phased-in basis, with implementation for Orange County scheduled to begin no sooner than January 1, 2019. CalOptima will assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorization activities, claims management (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for Neonatal Intensive Care Unit (NICU) services. The Orange County Health Care Agency (OC HCA) will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members, including individuals who exceed the Medi-Cal income thresholds and undocumented children who transition out of CalOptima when they turn 18 years old. OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

In order to ensure compliance with regulatory requirements, CalOptima will refer to SB 586, guidance issued by DHCS through All Plan Letters (APL), plan contract amendments and readiness requirements, and CCS requirements published in the CCS Numbered Letters. Previously, CCS was carved-out of CalOptima's Medi-Cal MCP contract. As such, CalOptima CCS services were not included in the existing delivery model or health network contracts. CalOptima members receiving

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CCS services were enrolled with CalOptima Direct (COD), CalOptima's Community Network (CCN), or other contracted health networks.

To meet the goals of the WCM, beginning January 1, 2019, CalOptima plans to allow members receiving CCS services to remain enrolled with either CalOptima's Community Network or other contracted CalOptima health networks. CalOptima will delegate CCS services to health networks according to the current health network models. The three health network models include Health Maintenance Organization (HMO), Physician-Hospital Consortium (PHC), or Shared-Risk Group (SRG).

Discussion

DHCS Capitation Rates

CalOptima received draft Fiscal Year (FY) 2018-19 (effective January 2019 – June 2019) capitation rates from DHCS on April 27, 2018. The rates reflect reimbursement for both CCS and non-CCS services. CalOptima will continue to monitor the sufficiency of the WCM rates, and work closely with DHCS to ensure adequate Medi-Cal revenue to support the new program.

Projected Medical Costs

Staff has analyzed high-level data on the transitioning CCS-eligible group provided by the State. Generally, the transitioning group appears to incur extensive medical costs that are highly variable and volatile. In addition, the WCM population is relatively small, which reduces the ability to spread high cost cases across a larger enrollment. CalOptima has limited experience data available to forecast medical expenses and to make definitive assessments of potential financial risks.

Provider Payment Model

In order to mitigate potential financial risks to the health networks resulting from the implementation of the WCM program, CalOptima recommends creating a new provider reimbursement methodology specific to the WCM population, as summarized below. The goal of the new reimbursement methodology is to reduce the likelihood of unreasonable financial burdens on health networks due to potentially high costs for the WCM population. The following sections describe CalOptima's proposed WCM provider reimbursement by network arrangement type.

CalOptima Direct Networks (COD/CCN)

For direct fee-for-service providers, reimbursement will depend on whether the providers are contracted with CalOptima and whether they are paneled to provide CCS services.

For non-professional services, including hospital and ancillary, CalOptima will pay contracted providers at the contracted rate for both CCS and non-CCS members. CalOptima will reimburse non-contracted providers at 100% of the designated Medi-Cal payment rates.

For professional specialist services, CalOptima will continue to reimburse providers under the current CCS payment policy. Providers who are CCS paneled, whether they are contracted or non-contracted, will be reimbursed at 140% of the Medi-Cal Fee Schedule for all services provided to members under 21.

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Service Type	Contracted Provider	Non-Contracted Provider
Hospital & Ancillary	Contracted Rates	100% of CalOptima Medi-Cal Fee Schedule
PCP	Contracted Rates	100% of CalOptima Medi-Cal Fee Schedule
CCS Paneled Specialist	140% of CalOptima Medi-Cal Fee Schedule	140% of CalOptima Medi-Cal Fee Schedule
Non-CCS Paneled Specialist	Contracted Rates	100% of CalOptima Medi-Cal Fee Schedule

Delegated Health Networks (HMO/PHC/SRG)
To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. To develop the initial capitation rate, CalOptima will employ the following methods:

- Establish estimated professional and hospital capitation rates that are consistent with DHCS' pricing methodology and include payments for CCS and non-CCS services;
- Align the service category pricing as closely as possible to the contracted division of financial responsibility associated with each health network and hospital;
- Carve out financial risk from the capitation rate for prescription drugs, managed long-term services and supports, and high cost conditions, including but not limited to members diagnosed with hemophilia, members in treatment for end stage renal disease (ESRD), members receiving an organ transplant, and maintenance and transportation costs for specific cases requiring special arrangements;
- Exclude projected expenses from the capitation rate for catastrophic cases. CalOptima will reimburse expenses to delegated health networks and hospitals through an interim catastrophic reimbursement process and risk corridor settlement;
- Apply blended capitation rates developed across all members and that are not separated into different age/gender bands. However, CalOptima will apply an age/gender factor by health network to adjust for cost variances due to the enrollment mix;
- Apply acuity risk factors to adjust for cost variances due to medical acuity; and
- Include an administration load to the both the professional and hospital capitation rates to address administrative expenses and medical management. The proposed 6.6% administration load is consistent the amount DHCS applies to CalOptima's WCM capitation rate. As proposed, CalOptima will keep this percentage fixed to ensure that health networks and hospitals are adequately compensated for the expenditures required to implement and manage the WCM program.

CalOptima recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, CalOptima will implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases and (2) Retrospective risk corridor.

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1) Interim Reimbursement for Catastrophic Cases: The purpose of providing interim catastrophic reimbursement payments is to mitigate potential cash flow shortfalls due to the occurrence of high cost cases. CalOptima proposes implementing the following process to reimburse delegated health networks and hospitals for catastrophic cases to supplement their monthly capitation payments:

   - Reimbursement will be determined by the total delegated medical costs incurred for a given member within a given reconciliation period. If the total delegated medical costs for a given member exceed a prescribed threshold, CalOptima will reimburse the provider for the costs in excess of the threshold;
   - CalOptima will evaluate professional expenses and hospital expenses for a given member separately and will apply CalOptima's existing reinsurance thresholds of $17,000 per member per year for professional expenses and $150,000 per member per year for hospital expenses. CalOptima will not apply a coinsurance level to members in the WCM program;
   - Networks will be required to submit complete and accurate payment data to substantiate all incurred expenses. Payment data will be validated and repriced, similar to CalOptima's existing reinsurance reimbursement process; and
   - Initially, CalOptima will process the interim catastrophic reimbursement on a quarterly basis to minimize cash flow issues for health networks and hospitals. However, CalOptima may adjust the frequency of the reimbursement process in the event a health network or hospital requires reimbursement on a more timely basis.

2) Retrospective Risk Corridor: CalOptima will implement a retrospective risk corridor to better align health network and hospital capitation to their incurred costs. Risk corridors can serve as a safety net for providers that incur a high level of expenses relative to the capitation that they receive. CalOptima will work with health networks and hospitals to construct risk corridor parameters that provide adequate compensation, while still maintaining a reasonable financial incentive to efficiently manage utilization and costs. The risk corridor will be based on the following parameters:

   - Risk corridors will only apply to the medical component (excludes medical management and administration expenses) of the WCM capitation rate;
   - The prospective capitation rate will be used as the basis for the risk corridor reconciliation. CalOptima will also account for funding previously paid through the interim catastrophic reimbursement payment process during the reconciliation process;
   - The number of risk corridors applied and the range of each will be determined from an evaluation of projected risk to the delegated health networks and hospitals. Risk corridors will be set at levels that were projected to achieve an optimal balance that provides sufficient risk mitigation and financial incentives for providers;
   - Each risk corridor will have an associated percentage that splits risk between CalOptima and the provider. Similarly, risk sharing will be set at levels that achieve an optimal balance that provides sufficient risk mitigation and financial incentives for providers. The following table gives the proposed risk corridor ranges and risk sharing percentages:

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Medical Loss Ratio Threshold	CalOptima's Risk/Surplus Share	Description
> 115%	95%	CalOptima will reimburse 95% of incurred medical expenses that are >115%
>105% to ≤ 115%	90%	CalOptima will reimburse 90% of incurred medical expenses that are >105% and ≤ 115%
>102% to ≤ 105%	75%	CalOptima will reimburse 75% of incurred medical expenses that are >102% and ≤ 105%
>100% to ≤ 102%	50%	CalOptima will reimburse 50% of incurred medical expenses that are >100% and ≤ 102%
100%	0%	No change in reimbursement
< 100% to ≥ 98%	50%	CalOptima will recoup 50% of capitation if medical expenses are <100% and ≥ 98%
< 98% to ≥ 95%	75%	CalOptima will recoup 75% of capitation if medical expenses are <98% and ≥ 95%
< 95% to ≥ 85%	90%	CalOptima will recoup 90% of capitation if medical expenses are <95% and ≥ 85%
< 85%	100%	CalOptima will recoup 100% of capitation if medical expenses are <85%

* Risk corridor will be evaluated from the medical component of the capitation rate.

- For SRG and PHC networks, risk corridor reconciliations will be evaluated separately for each capitation type (e.g. professional capitation and hospital capitation). For HMO health networks, risk corridor reconciliations will be evaluated against total capitation, which may include professional, hospital, pharmacy, or other delegated services, if applicable; and
- Risk corridor reconciliations will be performed on a calendar year basis, beginning with the period from January 1, 2019, to December 31, 2019. CalOptima may adjust the frequency as more experience becomes available. Each annual reconciliation report shall include refreshed reports from the previous two (2) annual settlement periods. After two (2) years, the refreshed report shall be considered final.

Fiscal Impact

Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Considering the limited data available on the CCS population, the volatility associated with the cost of providing their care, and the protections being proposed for the health networks, the underlying

assumption behind the staff recommendation is that the state will ensure that the program is adequately funded. If this assumption were to prove inaccurate, the program could potentially represent significant economic downside to CalOptima.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of CCS to the WCM, and to mitigate financial risks to our delegated health networks and hospitals.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *7/25/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Authorizing Contract with a Non-Medical Transportation (NMT) Vendor Effective January 1, 2019

Contact
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into agreement with Veyo LLC to serve as CalOptima's Non-Medical Transportation Vendor for OneCare Connect, OneCare and Medi-Cal members, except those enrolled in Kaiser. Contract to be effective January 1, 2019 for a three (3) year term with two (2) additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
CalOptima has provided NMT services to Medicare beneficiaries through American Logistics Corporation (ALC) since 2008. This service was provided as a supplemental benefit to members of CalOptima's OneCare program, and upon its inception, to OneCare Connect members. On July 1, 2016, NMT benefits were extended to children accessing Early and Periodic Screening Diagnostic and Treatment (EPSDT) services through the Medi-Cal program. The contract with ALC was amended to include the additional benefit coverage.

On June 29, 2017, the California Department of Health care Services (DHCS) released All Plan Letter (APL) 17-010 providing Managed Care Plans (MCP) including CalOptima with guidance for Non-Emergency Medical Transportation and NMT services. The APL specified that, effective July 1, 2017, MCPs were expected to provide NMT services for all Medi-Cal members. These services include round trip transportation for medically necessary covered and carved-out Medi-Cal services. NMT services may be provided by passenger car, taxi cab, or any other form of public or private conveyance as well as gas mileage reimbursement under certain conditions.

On August 3, 2017, the CalOptima Board of Directors ratified an amendment to the ALC contract to provide the expanded benefit and authorized the CEO to issue a Request for Proposal (RFP) to solicit bids from vendors to provide NMT services for CalOptima members effective April 1, 2018.

On December 7, 2017, the Board authorized staff to extend the existing ALC contract through December 31, 2018. This extension allowed staff additional time to clarify operational concerns which was essential to drafting a comprehensive Scope of Work for the RFP and to assess the RFP responses to identify the provider for this service.

Discussion
The RFP was issued by CalOptima in December 2017 and included a Scope of Work and the CalOptima contract. Three qualified vendors participated and their responses to the RFP were

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reviewed by CalOptima's evaluation team, which consisted of representatives from the following departments: Customer Service, Medical Management, Contracting, Finance, Claims Administration, Regulatory Affair and Compliance, and Information Services. The selected vendor will be obligated to coordinate the NMT transportation needs of all members. As such, the RFP responders were evaluated based on services provided, ability to manage administrative services which included eligibility verification, reporting, technical capabilities, interpreter services, claims administration and adequacy of vehicles. In addition, the three vendors underwent an interview process conducted by the evaluation team and were assessed based on their presentations and qualification.

The evaluation team's final weighted scoring for the RFP is as follows:

Vendor	Score
Veyo LLC	85.91
American Logistics Company, LLC	79.09
Access2Care, LLC	71.36

The RFP evaluation team identified Veyo LLC as the vendor that best meets CalOptima's need for a safe, reliable, regulatorily compliant, technologically advanced, and cost-effective transportation vendor. Accordingly, staff recommends contracting with Veyo, LLC for an initial three (3) year term with option to extend the contract for two (2) additional one-year terms.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes approximately $7.03 million for Medi-Cal, OneCare Connect, and OneCare non-medical transportation expenses. Based on projected utilization trends, the budgeted amount is expected to be sufficient to cover the costs of providing NMT services in FY 2018-19, under the proposed reimbursement terms with Veyo, LLC. Therefore, the recommended action to enter into agreement with Veyo, effective January 1, 2019, is a budgeted item with no expected additional fiscal impact.

Rationale for Recommendation

Based on the review of the possible vendors, Staff recommends contracting with Veyo, LLC to maintain compliance with NMT requirements and to ensure members receive safe, reliable transportation to covered services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 7, 2017, Consider Authorizing Extension of Contract with American Logistics for Non-Medical Transportation Services
    a. Board Action dated September 3, 2015, Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic
    b. Board Action dated April 7, 2016, Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016

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c. Board Action dated August 3, 2017, Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit
d. July 17, 2017 DHCS ALL Plan Letter 17-010 (Revised) Non-Emergency Medical and Non-Medical Transportation Services

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
16. Consider Authorizing Extension of Contract with American Logistics for Non-Medical Transportation Services

Contact
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Action
Authorize the CEO, with the assistance of legal counsel, to amend CalOptima's contract with American Logistics for non-medical transportation (NMT) for CalOptima Medi-Cal members to extend this agreement through December 31, 2018. All other terms and conditions will remain the same.

Background/Discussion
Medi-Cal managed care plan (MCP) benefits include emergency transportation, non-emergency medical transportation (NEMT) and, prior to July 1, 2017, non-medical transportation (NMT) only for children accessing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. However, AB 2394 (Garcia, 2016) amends the covered outpatient services delineated in Welfare & Institutions Code section 14312 to expressly include NMT for all Medi-Cal members, including adults, effective July 1, 2017, "subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services."

Prior to July 1, 2017, CalOptima contracted with American Logistics to provide taxi servcies for OneCare and OneCare Connect members, as well as Medi-Cal members receiving EPSDT services. The agreement with American Logistics covering transporation to and from EPSDT services was authorized by the CalOptima Board on September 3, 2015, with the contract covering Medicare services authorized by the Board on April 7, 2016 and executed on July 1, 2016. Considering the short lead time between the DHCS's issuance of APL 17-010 on June 29, 2017 and the required implementation date (the following day), CalOptima staff amended the American Logistics contract through March 31, 2018 to broaden the scope of work to include the Medi-Cal NMT benefit to ensure that the benefit was available to members while a longer term solution was being developed. This action was ratified by the Board at the August 3, 2017 meeting.

Also on August 3, 2017, the Board of Directors authorized staff to issue a RFP to solicit bids from vendors to provide NMT services for CalOptima Medi-Cal members with an effective date of April 1, 2018.

Staff is in the process of issuing a RFP. However, staff has determined that more time is needed to issue, assess and identify successful provider(s) to supply NMT services and to implement the services with providers. The Department of Health Care Services (DHCS) has indicated that a Dual Plan Letter will be issued to provide additional guidance regarding NMT services for Cal

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MediConnect plans which has not been released yet. Additional information to address operational concerns has also been provided by DHCS, most recently on November 13, 2017. The enhanced information provided by the State has been instrumental in crafting a statement of work for the RFP. Consequentily, to allow sufficient time for the RFP process while all the updates from DHCS is being incorporated and ensure that there is no disruption to member access to this important transportation benefit, staff is requesteng Board authority to extend the American Logistics contract through December 31, 2018. It is anticipated that contract(s) with the vendor(s) selected through the RFP process will take effect on January 1, 2019.

Fiscal Impact

Because the NMT benefit was added by a DHCS APL 17-010 on June 29, 2017 and took effect the following day, funding for this mandated benefit was not included in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget. Based on draft capitation rates received from DHCS, projected costs for the NMT benefit are approximately $4.83 million for FY 2017-18. Staff anticipates that funding for NMT services will be sufficient to fully cover the costs of the benefit. Management plans to include expenses related to NMT services for the period July 1, 2018, through December 31, 2018, in the FY 2018-19 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends extension of the current contract with American Logistics through December 2018 for NMT services to ensure that CalOptima Medi-Cal beneficiaries have access to this important benefit while the RFP process is being completed.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated September 3, 2015, Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)
2. Board Action dated April 7, 2016, Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016
3. Board Action dated August 3, 2017, Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit
    a. July 17, 2017 DHCS All Plan Letter 17-010 (Revised) Non-Emergency Medical and Non-Medical Transportation Services

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 3, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. F. Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)

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. Extend current OneCare/OneCare Connect taxi services contract for an additional six months from January 1, 2016 through June 30, 2016;
2. Amend budget based on Department of Health Care Services (DHCS) requirements for taxi services for qualifying Medi-Cal children and their caregiver and/or guardian per 2015 EPSDT guidelines for the 2015-2016 fiscal year;
3. Amend contracts with existing taxi services providers to include the Medi-Cal program EPSDT benefit; and
4. Issue a Request for Proposal (RFP) for taxi services for the OneCare, OneCare Connect and Medi-Cal lines of business, and authorize the CEO to contract with vendor(s) selected through this process, with contracts to be effective July 1, 2016 for a two-year term, with three additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background and Discussion

Taxi transportation is a supplemental benefit for OneCare (OC) and a required benefit for OneCare Connect (OCC) members. CalOptima has contracted with American Logistics since January 1, 2008 for services to OneCare members, as a result of an RFP process was conducted in 2007. At its November 6, 2008 meeting, the Board authorized CalOptima's OC Taxi Transportation supplemental benefit, including extension of CalOptima's contract with American Logistics. At its January 2013 meeting, the Board authorized staff to leverage the OC provider network as the basis for the Duals Delivery system, and OCC was added to the current OC contract. The current contract expires December 31, 2015, based on the previous contract extensions.

Currently, the OC and OCC benefits allow for thirty (30) one-way trips per calendar year for each Member. To access this benefit, Members call American Logistics directly and schedule their taxi pick-up in order to receive one-way transportation to their appointment. This is an important benefit for dual eligible beneficiaries, for many of whom availability of transportation may determine whether they are able to obtain appropriate medical services.

The Department of Health Care Services (DHCS), through the EPSDT guidance, requires that non-medical transportation via taxi be made available to qualifying children in the Medi-Cal program. Based on projected membership and expected cost per member per month (PMPM) for Fiscal Year (FY) 2015-16, a budget of $200,000 is requested to meet this requirement, and CalOptima's current

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contract with the taxi provider for OneCare and OneCare Connect are to be amended to include Medi-Cal for the qualifying EPSDT children.
As mentioned above, American Logistics has been the sole taxi provider contracted January 1, 2008 as a result of an RFQ released in 2007. In accordance with vendor management best practices, it is appropriate to complete a new RFP process, with the targeted effective date of new contract(s) of July 1, 2016.

CalOptima's Medical Management and Customer Service staff have reviewed the utilization performance of this provider, evaluated the access needs of CalOptima members, and determined that American Logistics adequately meets CalOptima's requirements for the extended contract period. The extension is requested to allow for an appropriate time frame to complete an RFP process and review all candidates. Therefore, staff recommends extending the current contract for an additional six months, through June 30, 2015.

Fiscal Impact
Based on forecasted OneCare and OneCare Connect enrollment for FY 2015-2016, the fiscal impact of the recommended action to extend the existing OneCare/OneCare Connect taxi services contract for an additional six months from January 1, 2016, through June 30, 2016, is approximately $2,709,863. The recommended action is a budgeted item under the CalOptima FY 2015-16 Operating Budget approved by the Board on June 4, 2015.

Based on projected membership and expected cost PMPM for qualifying Medi-Cal children enrollment for FY 2015-16, the fiscal impact of the recommended action is expected to be approximately $200,000. This is an unbudgeted item. Funding for this recommended action is expected to be available from anticipated increase in net assets in the current fiscal year.

Rationale for Recommendation
CalOptima staff recommends authorizing an extension to the contract with American Logistics for six months to ensure that OneCare and OneCare Connect members continue to have access to covered services, authorize budget and contract amendment as soon as possible for EPSDT requirement per DHCS, and issuing an RFP for a taxi services effective July 1, 2016 to ensure that members have access to taxi services prospectively.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

8/28/2015 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with American Logistics to serve as CalOptima's Taxi Vendor for OneCare Connect, OneCare, and Medi-Cal EPSDT members effective July 1, 2016, for a two (2) year term with three (3) additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current taxi services contract for CalOptima's Medicare programs has been in place since January 1, 2008. It was awarded to American Logistics through a competitive procurement process. The agreement expires on June 30, 2016.

On September 3, 2015, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for Taxi services for the contract period commencing July 1, 2016.

Following CalOptima's standard RFP process, an RFP was issued and a total of three responses were received.

Discussion
The responses to the RFP were reviewed by CalOptima's evaluation team consisting of the Senior Program Manager for Medicare, Customer Service Director, Customer Service Manager, Executive Director Medical Operations, Contracts Manager, and representatives from the following departments: Finance, Compliance, and Information Services. All vendors were provided a Scope of Work document and the CalOptima base contract at the time of the RFP.

The evaluation team's final weighted scoring for the RFP is as follows:

Vendor	Score
American Logistics	3.96
Access2Care	3.66
Veyo	3.19

Based upon the weighted scores each vendor received, American Logistics finished with the highest score at 3.96 out of a possible 5.0 of the evaluation. Access2Care finished second with a score of 3.66.

American Logistics was the only bidder who proved to have an established transportation network in the Orange County service area.

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Fiscal Impact
Under the terms of the proposed contract, consolidated taxi expenses are projected to decrease 4.9% in the next fiscal year. Management will include expenses associated with the proposed contract in the CalOptima FY 2016-17 operating budgets.

Rationale for Recommendation
CalOptima staff believes that contracting with the highest scoring taxi vendor, American Logistics, will meet the goal of continuing to ensure that CalOptima members receive safe, reliable transportation services in a cost-effective manner. CalOptima staff reviewed qualified taxi vendor responses and identified the candidate believed to best meet CalOptima's needs for safe, reliable, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with the existing taxi vendor as a result of completion of the RFP process authorized by the Board in September, 2015.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *04/01/2016*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Ratify 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. Authorize the Chief Executive Officer (CEO), 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. Authorize the CEO to conduct a Request for Proposal (RFP) process to solicit bids from vendors providing non-medical transportation for CalOptima Medi-Cal, effective April 1, 2018.

Background

Medi-Cal managed care plan (MCP) benefits include emergency transportation, non-emergency medical transportation (NEMT) and, prior to July 1, 2017, non-medical transportation (NMT) only for children accessing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. However, AB 2394 (Garcia, 2016) amends the covered outpatient services delineated in Welfare & Institutions Code section 14312 to expressly include NMT for all Medi-Cal members, including adults, effective July 1, 2017, "subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services."

On June 29, 2017, the California Department of Health Care Services (DHCS) released All Plan Letter (APL) 17-010 providing MCPs with guidance for NEMT and NMT. Per the APL, beginning July 1, 2017, MCPs were expected to update their NEMT policy and procedures and begin providing NMT for all Medi-Cal members. NMT services include round trip transportation for medically necessary covered and carved-out Medi-Cal services. MCPs are required to provide NMT by passenger car, taxicab, or any other form of public or private conveyance (including private vehicle), as well as gas mileage reimbursement under certain conditions.

Transportation must be physically and geographically accessible and consistent with disability rights laws. One attendant, such as a parent, spouse or guardian may accompany the member. Additionally, a minor can travel without a parent for services which do not require parental consent and otherwise with parental consent.

Prior authorization may, at the discreation of the MCP, be required and reauthorized every 12 months when necessary. When applicable, the MCP is responsible for ensuring that parental consent is obtained in advance of arranging transportation. For NMT requests by private conveyance (e.g.,

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family members, friends, neighbors, etc.), members must attest, in person, by phone, or electronically, that no other methods of transporation are reasonably available and alternatives have been reasonably exhausted. The attestation may include confirmation that the member:

- Has no valid driver's license;
- No working vehicle available in the household;
- Is unable to travel or wait for medical or dental services alone; or
- Has a physical, cognitvie, mental, or developmental limitation.

Reimbursement for private conveyance includes only mileage at the Internal Revenue Service (IRS) standard mileage rates for medical purposes (the 2017 reimbursement rate is $0.17 per mile) and can be made only for drivers compliant with California driving requirements, which includes a valid driver's license, vehicle registration and vehicle insurance. Neither the legislation nor the APL establish any additional specific requirements or criteria for driver eligibility.

Prior to July 1, 2017, CalOptima contracted with American Logistics to provide taxi servcies for OneCare and OneCare Connect members, as well as Medi-Cal members receiving EPSDT services. The agreement with American Logistics covering transporation to and from EPSDT services was authorized by the CalOptima Board on September 3, 2015, with the contract covering Medicare services authorized by the Board on April 7, 2016 and executed on July 1, 2016. Considering the short lead time between the DHCS's issuance of APL 17-010 on June 29, 2017 and the required implementation date (the following day), CalOptima staff amended the American Logistics contract on a short term basis to broaden the scope of work to include the Medi-Cal NMT benefit to ensure that the benefit was available to members while a longer term solution was being developed.

Discussion

CalOptima staff leveraged an existing transportation contract to ensure that the effective date for the new NMT requirement was met. On July 1, 2017, CalOptima began providing the expanded NMT services including the amended contract with American Logistics, as well as via taxi, bus, and private conveyance arranged by members. This benefit is separate from other existing transportation benefits, and members can continue to access emergency and NEMT services in accordance with existing processes. To access NMT services, members can contact CalOptima's Customer Service Department to discuss and coordinate transportation.

Should all other reasonable transportation options be exhausted and private conveyance be required, CalOptima's Customer Service Department will issue a reference number, and members can arrange for their own transportation, with their private drivers submitting gas mileage receipts for reimbursement to CalOptima. In order to receive reimbursement, private drivers will also be required to submit proof that they meet California driving requirements which include valid driver's license, vehicle registration, and evidence of vehicle insurance.

In order to ensure that qualifying Medi-Cal members have access to public conveyance options, bus and taxi services are being offered. CalOptima will continue to procure passes from the Orange County Transit Authority (OCTA) for both bus and OC ACCESS, for members who are unable to use regular bus service due to functional limitations caused by a disability. For taxi services, the

scope of work of the current contract with American Logistics (CalOptima's contracted provider for OneCare and OneCare Connect) has been amended through March 31, 2018 as a short term measure to ensure that this transportation benefit is available to Medi-Cal members.

During this nine month period, CalOptima staff will consider longer term options for providing the NMT benefit and conduct an RFP to identify potential vendors and return to the Board with the RFP results and recommendations. In addition, staff is in the process of developing a comprehensive transportation program, and will be returning to the Board with recommendations and policy updates.

Fiscal Impact
The recommended action to ratify the amendment to the American Logistics contract, amend contracts with existing providers, and conduct an RFP process is expected to result in an increase in both claims and administration expense for CalOptima. However, because non-medical transportation is a newly-mandated benefit and since no projected utilization data has been provided by DHCS, the fiscal impact of this benefit is not currently known. CalOptima staff will continue to work with DHCS to ensure that funding for non-medical transportation will be appropriate and sufficient to fully cover the costs of the benefit. On a prospective basis, staff will update the Board as appropriate on the expenses associated with providing this benefit. Long term, staff anticipates that the program will be budget neutral to CalOptima.

Rationale for Recommendation
CalOptima staff recommends the above actions in order to be compliant with the NMT requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated September 3, 2015, Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)
2. Board Action dated April 7, 2016, Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016
3. July 17, 2017 DHCS All Plan Letter 17-010 (Revised) Non-Emergency Medical and Non-Medical Transportation Services

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: July 17, 2017

ALL PLAN LETTER 17-010 (*REVISED)*

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION SERVICES

PURPOSE:
This All Plan Letter (APL) provides Medi-Cal managed care health plans (MCPs) with guidance regarding Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. With the passage of Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016), which amended Section 14132 of the Welfare and Institutions Code (WIC), the Department of Health Care Services (DHCS) is clarifying MCPs' obligations to provide and coordinate NEMT and NMT services. In addition, this APL provides guidance on the application of NEMT and NMT services due to the Medicaid Mental Health Parity Final Rule (CMS-2333-F)[1]. *Revised text is found in italics.*

BACKGROUND:
DHCS administers the Medi-Cal Program, which provides comprehensive health care services to millions of low-income families and individuals through contracts with MCPs. Pursuant to Social Security Act (SSA) Section 1905(a)(29) and Title 42 of the Code of Federal Regulations (CFR) Sections 440.170, 441.62, and 431.53, MCPs are required to establish procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for qualifying members to receive medically necessary transportation services. NEMT services are authorized under SSA Section 1902 (a)(70), 42 CFR Section 440.170, and Title 22 of the California Code of Regulations (CCR) Sections 51323, 51231.1, and 51231.2.

AB 2394 amended WIC Section 14132(ad)(1) to provide that, effective July 1, 2017, NMT is covered, subject to utilization controls and permissible time and distance standards, for MCP members to obtain covered Medi-Cal medical, dental, mental health, and substance use disorder services. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services and must make their best effort to refer for and coordinate NMT for all Medi-Cal services

[1] CMS-2333-F

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not covered under the MCP contract. Effective October 1, 2017, in part to comply with CMS-2333-F and to have a uniform delivery system, MCPs must also provide NMT for Medi-Cal services that are not covered under the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system.

REQUIREMENTS:

Non-Emergency Medical Transportation
NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant to Health and Safety Code (HSC) Section 1250[2].

MCPs must ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS[3]. MCPs are also required to authorize, at a minimum, the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs. For Medi-Cal services that are not covered by the MCP's contract, the MCP must make its best effort to refer for and coordinate NEMT. MCPs must ensure that there are no limits to receiving NEMT as long as the member's medical services are medically necessary and the NEMT has prior authorization.

MCPs are required to provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services[4]. MCPs are required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches[5]. MCPs shall also ensure door-to-door assistance for all members receiving NEMT services.

Unless otherwise provided by law, MCPs must provide transportation for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, MCPs may arrange NEMT for a minor who is unaccompanied by a parent or a guardian.

[2] 22 CCR Section 51323 (b)(2)(C)
[3] Exhibit A, Attachment 1 (Organization and Administration of the Plan)
[4] 22 CCR Section 51323 (a)
[5] Manual of Criteria for Medi-Cal Authorization, Chapter 12.1 Criteria for Medical Transportation and Related Services

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MCPs must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.

MCPs must provide the following four available modalities of NEMT transportation in accordance with the Medi-Cal Provider Manual[6] and the CCR[7] when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care:

1. MCPs must provide **NEMT ambulance services** for[8]:
    - Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
    - Transfers from an acute care facility to another acute care facility.
    - Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
    - Transport for members with chronic conditions who require oxygen if monitoring is required.

2. MCPs must provide **litter van services** when the member's medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following:
    - Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport[9].
    - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance[10].

3. MCPs must provide **wheelchair van services** when the member's medical and physical condition does not meet the need for litter van services, but meets any of the following:
    - Renders the member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport[11].

[6] Medi-Cal Provider Manual: Medical Transportation – Ground
[7] 22 CCR Section 51323(a) and (c)
[8] Medi-Cal Provider Manual: Medical Transportation – Ground, page 9, Ambulance: Qualified Recipients
[9] 22 CCR Section 51323 (2)(A)(1)
[10] 22 CCR Section 51323 (2)(B)
[11] 22 CCR Section 51323 (3)(A)

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- Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation[12].
- Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance[13].

Members with the following conditions may qualify for wheelchair van transport when their providers submit a signed Physician Certification Statement (PCS) form (as described below)[14]:

- Members who suffer from severe mental confusion.
- Members with paraplegia.
- Dialysis recipients.
- Members with chronic conditions who require oxygen but do not require monitoring.

4. MCPs must provide **NEMT by air** only under the following conditions[15]:
   - When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or mental health or substance use disorder provider.

NEMT Physician Certification Statement Forms

MCPs and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization. In order to ensure consistency amongst all MCPs, all NEMT PCS forms must include, at a minimum, the components listed below:

- Function Limitations Justification: For NEMT, the physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate *without* assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport).

[12] 22 CCR Section 51323 (3)(B)
[13] 22 CCR Section 51323 (3)(C)
[14] Medi-Cal Provider Manual: Medical Transportation – Ground, page 11, Wheelchair Van
[15] 22 CCR Section 51323 (c)(2)

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- Certification Statement: Prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested.

Each MCP must have a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their physician by telephone, electronically, in person, or by another method established by the MCP.

Non-Medical Transportation
NMT has been a covered benefit when provided as an EPSDT service[16]. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services. For all Medi-Cal services not covered under the MCP contract, MCPs must make their best effort to refer for and coordinate NMT.

Effective October 1, 2017, MCPs must provide NMT for all Medi-Cal services, including those not covered by the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system.

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. Physicians may authorize NMT for members if they are currently using a wheelchair but the limitation is such that the member is able to ambulate without assistance from the driver. The NMT requested must be the least costly method of transportation that meets the member's needs.

MCPs are contractually required to provide members with a Member Services Guide that includes information on the procedures for obtaining NMT transportation services[17]. The Member Services Guide must include a description of NMT services and the conditions under which NMT is available.

At a minimum, MCPs must provide the following NMT services[18]:

- Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle)[19], as well as mileage reimbursement for medical purposes[20] when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.

[16] WIC 14132 (ad)(7)
[17] Exhibit A, Attachment 13 (Member Services), Written Member Information
[18] WIC Section 14132(ad)
[19] Vehicle Code (VEH) Section 465
[20] IRS Standard Mileage Rate for Business and Medical Purposes

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- Round trip NMT is available for the following:
    - Medically necessary covered services.
    - Members picking up drug prescriptions that cannot be mailed directly to the member.
    - Members picking up medical supplies, prosthetics, orthotics and other equipment.
- MCPs must provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

Conditions for Non-Medical Transportation Services:

- MCP may use prior authorization processes for approving NMT services and re-authorize services every 12 months when necessary.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of initial NMT authorization request.
- With the written consent of a parent or guardian, MCPs may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. MCPs must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.
- NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to the MCP in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
    - Has no valid driver's license.
    - Has no working vehicle available in the household.
    - Is unable to travel or wait for medical or dental services alone.
    - Has a physical, cognitive, mental, or developmental limitation.

Non-Medical Transportation Private Vehicle Authorization Requirements

The MCPs must authorize the use of private conveyance (private vehicle)[21] when no other methods of transportation are reasonably available to the member or provided by the MCP. Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to the MCP stating other methods of transportation are not available. The attestation can be made over the

[21] VEH Section 465

phone, electronically, or in person. In order to receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include[22]:

- Valid driver's license.
- Valid vehicle registration.
- Valid vehicle insurance.

MCPs are only required to reimburse the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation[23].

Non-Medical Transportation Authorization

MCPs may authorize NMT for each member prior to the member using NMT services. If the MCP requires prior authorization for NMT services, the MCP is responsible for developing a process to ensure that members can request authorization and be approved for NMT in a timely matter. The MCP's prior authorization process must be consistently applied to medical/surgical, mental health and substance use disorder services as required by CMS-2333-F.

Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards

MCPs are contractually required to meet timely access standards[24]. MCPs that have a Knox-Keene license are also required to meet the timely access standards contained in Title 28 CCR Section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the MCPs from complying with their timely access standard obligations.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including APLs and Dual Plan Letters. MCPs must timely communicate these requirements to all delegated entities and subcontractors in order to ensure compliance.

[22] VEH Section 12500, 4000, and 16020
[23] IRS Standard Mileage Rate for Business and Medical Purposes
[24] 28 CCR Section1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)

If you have any questions regarding this APL, contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Modifications and Development of CalOptima Policies and Procedures Related to Whole-Child Model, Medicaid and CHIP Managed Care Final Rule (Final Rule), and Annual Policy Review

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Betsy Ha, Executive Director, Quality Analytics, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Richard Helmer, Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Sesha Mudunuri, Executive Director, Operations, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to modify existing and develop new Policies and Procedures in conjunction with the Whole-Child Model initiative, as follows:

1. DD.2006: Enrollment In/ Eligibility with CalOptima [Medi-Cal]
2. DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment [Medi-Cal]
3. EE.1112: Health Network Eligible Member Assignment to Primary Care Provider [Medi-Cal]
4. EE.1132: Bed Day Utilization Criteria for Physician Hospital Consortia [Medi-Cal]
5. GG.1401: Pharmacy Authorization Process [Medi-Cal]
6. GG.1409: Drug Formulary Development and Management [Medi-Cal]
7. GG.1410: Appeal Process for Pharmacy Authorization [Medi-Cal]
8. GG.1600: Access and Availability Standard [Medi-Cal]
9. GG.1650Δ: Credentialing and Recredentialing of Practitioners [All Lines of Business]

Background

Periodically, CalOptima establishes new or modifies existing Policies and Procedures to implement new or modified, laws, regulatory guidance, contracts and business practices. CalOptima has established an annual policy review process by which Policies and Procedures are updated and subject to peer review. New and modified Policy and Procedures are developed on an ad hoc basis as new laws, regulations, guidelines, or programs are established. Most recently, the following have impacted CalOptima's Policies and Procedures:

Medicaid and CHIP Managed Care Final Rule (Final Rule)

In April 2016, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register the Medicaid and CHIP Managed Care Final Rule [Medicaid Managed Care (CMS-2390-F)], which aligns key rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and key consumer protections. This Final Rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade. These regulations are sometimes referred to in aggregate as the "Mega Reg".

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The Department of Health Care Services (DHCS) has provided guidance to incorporate the requirements of the Final Rule into Managed Care Plans (MCPs). On June 1, 2017, the CalOptima Board of Directors approved an amendment to CalOptima's contract with DHCS to include Final Rule requirements. Implementation of the Final Rule will be a multi-year process through at least July 2019.

Whole-Child Model

CalOptima expects to integrate California Children's Services (CCS) into its Medi-Cal managed care plan through the Whole-Child Model (WCM) effective January 1, 2019. On June 7, 2018, the CalOptima Board of Directors authorized execution of an Amendment to the Primary Agreement between DHCS and CalOptima with respect to implementation of the WCM program. Principle guidance is outlined in Senate Bill 586, signed by Governor Brown on September 25, 2016, and the DHCS's All Plan Letter (APL) 18-011 released on June 28, 2018. In addition, DHCS has provided additional reporting requirements and implementation deliverables.

Following is additional information regarding the new and modified policies:

1. ***DD.2006: Eligibility in/Enrollment with CalOptima Direct*** defines the criteria by which CalOptima enrolls a Member in CalOptima Direct or remains in a Health Network. This policy is being updated to allow members to remain with their current Health Network when CalOptima receives notification from the state eligibility file the members address cannot be verified. In addition, to be consistent with current practice, the age limitations were removed from the policy.

2. ***DD.2006b: CalOptima Community Network Member Primary Care Provider (PCP) Selection/ Assignment*** describes the criteria by which a CalOptima Community Network (CCN) Member shall select or be assigned a Primary Care Provider (PCP). This policy is being updated to permit children receiving CCS services through WCM to select a Specialty Care provider or clinic as required by SB586.

3. ***EE.1112: Health Network Eligible Member Assignment to Primary Care Provider*** describes the criteria by which a Health Network Member shall select or be assigned a Primary Care Provider (PCP). This policy is being updated to permit children receiving CCS services through WCM to select a Specialty Care provider or clinic as required by SB586.

4. ***EE.1132: Bed Day Utilization Criteria for Physician Hospital Consortia*** outlines the criteria and methodology by which CalOptima determines bed day utilization for applicable health networks contracted under a Physician Hospital Consortium (PHC) model. CalOptima revised this policy to add bed days and emergency room bed days attributed to CCS-Eligible Conditions of CCS-Eligible Members only at Primary Hospitals and for the purpose of calculating bed day utilization and related metrics.

5. ***GG. 1401 Pharmacy Authorization Process*** defines CalOptima's Pharmacy authorization process. CalOptima revised policy pursuant to the CalOptima annual review process to ensure alignment with current operational processes, compliance with turnaround times established in the Final Rule and DHCS requirements for implementation of WCM.

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6. ***GG.1409: Drug Formulary Development and Management*** defines CalOptima's Formulary development process. CalOptima revised the policy pursuant to the CalOptima annual review process to ensure alignment with current operational processes, compliance with turnaround times established in the Final Rule and DHCS requirements.

7. ***GG:1410: Appeal Process for Pharmacy Authorization*** defines the process by which CalOptima addresses and resolves a pre-service, post-service, or expedited appeal for pharmaceutical services, in accordance with applicable statutory, regulatory, and contractual requirements. CalOptima revised the policy pursuant to the CalOptima annual review process to ensure alignment with current operational processes, as well as compliance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights."

8. ***GG.1600: Access and Availability Standards.*** This policy establishes required access and availability standards for members to obtain effective, appropriate and timely access to care. CalOptima revised the policy to ensure compliance with the Department of Health Care Services (DHCS), All Plan Letter (APL) 18-005: Network Certification Requirements (and attachments A through F), to ensure compliance with the DHCS APL 18-011 California Children's Services Whole-Child Model Program, as well as incorporation of and prompting retirement of CalOptima Policy EE.1108: Primary Care Practitioner Network Adequacy.

9. ***GG.1650Δ: Credentialing and Recredentialing of Practitioners*** defines the process by which CalOptima evaluates and determines whether to approve or decline practitioners (as described in Section II. of this Policy ("Practitioners")) for participation in CalOptima programs. CalOptima revised the policy to align with current operational processes, to ensure compliance with 2018 NCQA Standard and Guideline, with DHCS APL 17-019: Provider Credentialing/Recredentialing and Screening/Enrollment and DHCS APL 18-011: California Children's Services Whole Child Model Program.

Fiscal Impact

The recommended action to authorize development of new and updated Policies and Procedures related to the Whole-Child Model program (WCM) and annual review is a budgeted item, with no anticipated additional fiscal impact. Management has included projected medical and administrative expenses associated with the WCM program and the annual policy reviews in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Budgeted expenses are expected to be sufficient to cover costs resulting from revisions to aforementioned policies.

Rationale for Recommendation

To ensure that CalOptima's policies are updated and in place to meet the requirements of the Whole-Child Model initiative, adoption of the attached policies is recommended.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. DD.2006: Enrollment In/Eligibility with CalOptima Direct (redlined and clean versions)
2. DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment (redlined and clean versions)
3. EE.1112: Health Network Eligible Member Assignment to Primary Care Provider (redlined and clean versions)
4. EE.1132: Bed Day Utilization Criteria for Physician Hospital Consortia (redlined and clean versions)
5. GG.1401: Pharmacy Authorization Process (redlined and clean versions)
6. GG.1409: Drug Formulary Development and Management (redlined and clean versions)
7. GG.1410: Appeal Process for Pharmacy Authorization (redlined and clean versions)
8. GG.1600: Access and Availability Standards (redlined and clean versions)
9. GG.1650Δ: Credentialing and Recredentialing of Practitioners (redlined and clean versions)
10. DHCS All Plan Letter 17-006 Grievances and Appeal Requirements and Revised Notice Templates and "Your Rights"
11. DHCS All Plan Letter 17-019: Provider Credentialing/Recredentialing and Screening/Enrollment
12. DHCS All Plan Letter 18-005 Network Certification
13. DHCS All Plan Letter 18-011 California Children's Services Whole Child Model Program

/s/ Michael Schrader — *8/29/2018*
Authorized Signature — **Date**

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Policy #: DD.2006
Title: **Enrollment In/Eligibility with CalOptima Direct**
Department: Customer Service
Section: Not Applicable

CEO Approval: Michael Schrader
Effective Date: 10/01/95
Last Review Date:
~~07/01/16~~09/06/18
Last Revision Date:
~~07/01/16~~09/06/18

I. PURPOSE

This policy defines the criteria by which CalOptima enrolls a Member in CalOptima Direct.

II. POLICY

A. CalOptima may enroll a Member in CalOptima Direct, in accordance with this ~~policy~~Policy.

B. ~~-~~CalOptima shall enroll the following Members in CalOptima Direct Administrative (COD-A) subject to the provisions of this ~~policy~~Policy:

1. A Member who has Medicare coverage and is not enrolled in OneCare Connect:

   a. For a Member who has both Medicare Parts A and B or Medicare Part B coverage and is enrolled in CalOptima Direct pursuant to this policy, CalOptima shall not be required to assign such Members who are eligible for services through Medicare to a Medi-Cal Primary Care Provider (PCP) or require them to select a Medi-Cal PCP in accordance with the policy of the Department of Health Care Services (DHCS).

   b. For a Member who has Medicare Part A coverage, but does not have Medicare Part B coverage, and is enrolled in CalOptima Direct, pursuant to this policy, CalOptima shall assign such Member to a Medi-Cal PCP in accordance with ~~the~~DHCS policy ~~of DHCS.~~ (s).

2. A Member who becomes the responsibility of the Public Guardian or is in an Institute for Mental Disease (IMD), or with Orange County Children and Family Services and is placed outside of Orange County.

~~2.~~3. A Member with a Share of Cost (SOC) Aid Code.

~~3. A Member residing outside Orange County~~

~~a. A Member with a zip code outside of Orange County, as indicated by the State's Medi-Cal Eligibility file and for whom CalOptima is unable to verify a zip code within Orange County and has not selected a Health Network.~~

~~b.~~4. A Member who resides at the Fairview Developmental Center.

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~~c.~~5. ~~A Member who becomes~~At the ~~responsibility~~time of ~~the Public Administrator or Public Guardian, or is~~initial enrollment in ~~an Institute from Mental Disease, and is placed outside of~~ CalOptima, a Member with a non-Orange County Zip Code, or invalid address information from the State.

a. ~~CalOptima shall enroll a Member in~~ If the address and/or zip code changes to an Orange County address at a later date, CalOptima shall request that the Member select a Health Network or CalOptima Community Network (CCN), in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the Member fails to choose a Health Network or CCN, then CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

C. CalOptima shall enroll a Member in CCN, unless eligible for COD-A as described above, subject to the following provisions of this ~~policy~~Policy:

1. A Member with Long Term Care (LTC) Aid Code;

2. A Member with a Breast and Cervical Cancer Treatment Program (BCCTP) primary Aid Code;

3. A Health Network Eligible Member, except as otherwise identified in this ~~policy, who is at least twenty one (21) years old and~~Policy:

a. Is diagnosed with hemophilia;

b. Is identified by a Provider as a potential candidate for a Solid Organ Transplant at a DHCS-approved Transplant Center or a California Children's Services (CCS)-paneled Transplant Special Care Center, and the Provider has requested authorization for Covered Services, or is approved for a Bone Marrow Transplant (BMT), except if the Member is listed as Status 7;

c. Has received a Solid Organ Transplant or BMT within one hundred twenty (120) calendar days prior to the Member's effective date of enrollment in CalOptima; or

d. Is diagnosed with End Stage Renal Disease (ESRD).

D. If a Member is no longer required to be enrolled in COD-A or CCN as described in Sections II.B, or II.C, such Member:

1. Is a Health Network Eligible Member;

2. May select CalOptima Community Network or any other Health Network in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

E. CalOptima shall exclude a Health Network Eligible Member from the provisions of this policy if such Member is enrolled in a Health Maintenance Organization (HMO) that, pursuant to the Health Network's Contract, is responsible for all Covered Services for the Member.

F. COD-A is responsible for a Health Network Eligible Member until such Member selects a Health Network or is assigned to a Health Network, pursuant to CalOptima Policies DD.2008: Health

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Network and CalOptima Community Network Selection Process or AA.1207a: CalOptima Auto~~-~~ Assignment ~~Policy~~.

~~G. COD-A is responsible for all Covered Services provided during a month in which a Member has Retroactive Eligibility.~~

~~H.~~G. CalOptima Direct is not responsible for Covered Services provided to a Member outside the United States, with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22, California Code of Regulations ~~section~~, Section 51006.

III. PROCEDURE

A. ~~If~~At the time of initial enrollment in CalOptima, a Member ~~has~~with a zip code outside of Orange County, as indicated by the eligibility file sent to CalOptima by the State, or, if CalOptima is unable to verify a zip code within Orange County~~.~~ due to no address information provided by the State, such Member shall not be auto-assigned by CalOptima, and the Member shall remain in COD-A.

~~1. The~~If a Member ~~may select a Health Network or CCN. If the Member fails~~assigned to ~~select a Health Network, CalOptima shall not auto assign the Member, and the Member shall remain in~~ COD-A~~.~~

~~2. If the Member enrolls in a Health Network or CCN, in accordance with the provisions of CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process, CCN or the Health Network, as applicable, shall be responsible for all Covered Services for the Member, in accordance with the Division of Financial Responsibility (DOFR).~~

~~3. If the Member's~~ due to having a zip code outside Orange County changes his or her zip code to an Orange County zip code ~~and the Member is in COD-A~~, CalOptima shall~~:~~

~~a.~~B. ~~Request~~ request that the Member select a Health Network or CCN, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process~~;~~. If the Member fails to choose a Health Network or CCN, then CalOptima shall auto-assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

~~b. Auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto Assignment Policy; or~~

~~c. Enroll the Member in COD-A, subject to the provisions of this policy.~~

C. If a current Member assigned to a Health Network has or receives a zip code outside of Orange County as indicated by the eligibility file sent to CalOptima by the State, or CalOptima is unable to verify a zip code within Orange County at a later date, the Member may remain with their assigned Health Network unless Member makes a different Health Network choice or meets the criteria for COD-A or CCN enrollment as stated in Section II.B or II.C.

~~B.~~D. If a Health Network Eligible Member becomes the responsibility of the Public ~~Administrator or Public~~ Guardian, or is in an Institute for Mental Disease, or is with Orange County Children and Family Services and resides outside Orange County:

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1. The Member's ~~Health Network, Public Administrator or~~ Public Guardian, or the Orange County ~~Children's~~Children and Family Services may submit a written request to enroll the Member in COD-A.

    a. If CalOptima receives such request to enroll the Member in COD-A by the tenth (10th) calendar day of the month, CalOptima Direct shall assume responsibility for all Covered Services for the Member effective the first (1st) calendar day of the immediately following month.

    b. If CalOptima receives such request after the tenth (10th) calendar day of the month, COD-A shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the month after the immediately following month.

2. If the Member's ~~Health Network, Public Administrator or~~ Public Guardian, or ~~the~~ Orange County ~~Children's~~Children and Family Services does not submit a written request to enroll the Member in CalOptima Direct, the Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the ~~DOFR.~~Division of Financial Responsibility (DOFR).

3. If the Member returns to Orange County, the Public ~~Administrator or Public~~ Guardian or ~~the~~ Orange County ~~Children's~~Children and Family Services may submit a written request to enroll the Member in a Health Network or CCN.

~~C.~~E. If a Health Network Eligible Member is ~~at least twenty-one (21) years of age, and~~ diagnosed with Hemophilia:

1. The Member's Health Network shall notify CalOptima of the Member's diagnosis, in writing, using the Hemophilia Special Needs Screen Questionnaire, in accordance with CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members.

    a. If the Health Network notifies CalOptima, in writing, by the tenth (10th) calendar day of a month, CCN shall assume responsibility for all Covered Services for the Member effective the first (1st) calendar day of the immediate following month.

    b. If the Health Network notifies CalOptima, in writing, after the tenth (10th) calendar day of a month, CCN shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the month after the immediately following month.

2. The Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the DOFR, until the Health Network notifies CalOptima, in writing, to enroll the Member in CalOptima Direct, and CalOptima transitions such Member to CCN, as set forth in Section ~~IV.C.1~~III.D.2 of this ~~policy~~Policy.

~~D.~~F. If a Health Network Eligible Member, ~~who is at least twenty-one (21) years of age and~~ is identified by a Provider as a potential candidate for a Solid Organ Transplant at a DHCS-approved Transplant Center or a CCS-paneled Transplant Special Care Center, and the Provider has requested authorization for Covered Services, or the Member is approved for Bone Marrow Transplant (BMT) at a DHCS-approved Transplant Center or CCS-paneled Transplant Special Care Center, and is not listed as Status 7:

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1. The Member's Health Network shall notify CalOptima, in writing, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

    a. Except as set forth in Section III.D.1.b of this policy, CCN shall assume responsibility for all Covered Services for the Member on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the Health Network.

    b. If the Member receives a Solid Organ Transplant or BMT after the date the Health Network notifies CalOptima and before the first (1st) calendar day of the month immediately following the date CalOptima receives notice, CCN shall assume responsibility for all Covered Services for the Member on the first (1st) calendar day of the month of notice.

2. The Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the DOFR, until the Health Network notifies CalOptima, in writing, and CalOptima transitions such Member to CalOptima Direct as set forth in Section III.D.1. of this policy.

3. CCN shall be responsible for all Covered Services for the Member for three- hundred sixty-five (365) calendar days after the Member receives a Solid Organ Transplant or BMT. After three-hundred sixty-five (365) calendar days after the date the Member receives a Solid Organ Transplant or BMT, CalOptima shall request the Member select a Health Network, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

4. If CalOptima ~~or~~, the DHCS-approved Transplant Center or the CCS-paneled Transplant Special Care Center, determines that the Member is ineligible for a Solid Organ Transplant or BMT:

    a. If it has been less than three hundred sixty-five (365) calendar days after the Member transitioned to CCN, CalOptima shall transition the Member to the Member's previous Health Network, effective the first (1st) calendar day of the month immediately following the date CalOptima or the DHCS-approved Transplant Center determines that the Member is ineligible for a Solid Organ Transplant or BMT; or

    b. If it has been more than three hundred sixty-five (365) calendar days after the Member transitioned to CCN, CalOptima shall request the Member select a Health Network, in accordance with CalOptima Policy DD.2008: Health Network Selection Process, or CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto - Assignment ~~Policy~~.

~~E.~~G. If a Health Network Eligible Member received a Solid Organ Transplant or BMT within one hundred twenty (120) calendar days prior to their effective date of enrollment in CalOptima:

1. The Member's Health Network shall notify CalOptima by sending a Notification of Transplant Member, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

2. CCN shall assume responsibility for all Covered Services for the Member on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice

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from the Health Network, for a period of not less than three hundred sixty-five (365) calendar days after the date the Member received such Transplant.

3. CalOptima shall transition the Member to the Member's previous Health Network, effective no later than the first (1st) calendar day of the month immediately following the three hundred sixty fifth (365th) calendar day after the date the Member received a Solid Organ Transplant or BMT.

4. The Member's Health Network shall be responsible for all Covered Services for the Member until the Health Network submits written notice and CalOptima transitions such Member to CCN, as set forth in Section III.E.1 and III.E.2 of this ~~policy~~Policy.

~~F.~~H. If a Health Network Eligible Member~~, who is at least twenty-one (21) years of age,~~ is diagnosed with ESRD and is not already assigned to CCN:

1. The Member's Health Network shall notify CalOptima, in writing, of the Member by submitting a copy of Form CMS-2728-U3 to CalOptima's Health Network ~~Management~~Relations Department.

   a. If a Health Network submits a Form CMS-2728-U3 on or before the fifteenth (15th) calendar day of a month, CCN shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the month after the immediate following month. For example, if a Health Network submits Form CMS-2728-U3 on June 15, CCN shall assume responsibility for the Member effective August 1.

   b. If a Health Network submits a Form CMS-2728-U3 after the fifteenth (15th) day of a month, CCN shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the second (2nd) month after the immediately following month. For example, if a Health Network submits Form CMS-2728-U3 on June 16, CCN shall assume responsibility for the Member effective September 1.

   c. CalOptima shall provide the Member with a thirty (30) calendar day notice of the transition, pursuant to the CalOptima Contract with DHCS.

~~G.~~I. If CalOptima identifies a Member who meets the requirements specified in Sections II.B and II.C, of this policy, CalOptima shall transition the Member to COD-A, or CCN, and notify the Member's Health Network of such transition. CalOptima shall provide the Member~~, excluding those residing in an LTC facility~~, with a thirty (30) calendar day notice of the transition pursuant to CalOptima's contract with DHCS.

1. The Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the DOFR, until CalOptima enrolls the Member in COD-A or CCN.

~~H.~~J. If CalOptima identifies a Member who meets the requirements specified in Section II.B.1.b of this policy, CalOptima shall assign the Member a PCP as follows:

1. For an existing Member assigned to a Health Network, who gains Part A Dual status, CalOptima shall transition the Member to COD-A in the month CalOptima is notified by the State of the change to Medicare Part A eligibility.

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a. CalOptima shall assign the Member a PCP in accordance with CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

2. For a newly enrolled Member who is also Medicare Part A Dual eligible, CalOptima shall assign the Member to a PCP in accordance with the methodology described in CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

3. A Member may request to change his or her participating PCP every thirty (30) calendar days by contacting CalOptima's Customer Service Department.

IV. ATTACHMENTS

A. Notification of Transplant Member
B. Hemophilia Special Needs Screen Questionnaire
C. End Stage Renal Disease Medical Evidence Report – Medicare Entitlement and/or Patient Registration (Form CMS-2728-U3)

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Services
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1207a: CalOptima Auto~~-~~Assignment
E. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
F. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
G. CalOptima Policy FF.1001: Capitation Payment
H. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
I. CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members
J. California Health and Safety Code, §§ 104160 through 104163
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 14-015: PCP Assignment in Medi-Cal Managed Care for Dual-Eligible Beneficiaries
L. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program
~~L.~~M. Title 22, California Code of Regulations, §51006
N. Welfare and Institutions Code, §14182.17(d)(3)

VI. REGULATORY AGENCY APPROVALS

A. 10/07/15: Department of Health Care Services
B. 08/18/15: Department of Health Care Services
C. 04/01/15: Department of Health Care Services
D. 10/01/12: Department of Health Care Services

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 08/06/15: Regular Meeting of the CalOptima Board of Directors

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~~B.~~C. 03/06/14: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 03/04/10: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 11/05/09: Regular Meeting of the CalOptima Board of Directors
~~E.~~F. 06/03/08: Regular Meeting of the CalOptima Board of Directors
~~F.~~G. 10/19/06: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/01/1995	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	02/01/1996	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	03/01/1997	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	09/01/2004	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2006	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2007	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2008	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2010	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	01/01/2011	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	10/01/2012	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	03/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	05/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Reviewed	02/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	07/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/06/2018	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal

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IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.
California Children's Services Program	For the purposes of this policy, the public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Member.
CalOptima Direct (COD)	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: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Direct (COD) Member	A Member who receives all Covered Services through CalOptima Direct.
CalOptima Direct Administrative (COD A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to Members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
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.
Division of Financial Responsibility (DOFR)	A matrix that defines how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Health Maintenance Organization	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.

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Term	Definition
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.
Health Network Eligible Member	A Member who is eligible to choose a CalOptima Health Network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combined liver and small bowel; and 9. Combined kidney and pancreas.
Status 7	Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center.

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Policy #: DD.2006
Title: **Enrollment In/Eligibility with CalOptima Direct**
Department: Customer Service
Section: Not Applicable

CEO Approval: Michael Schrader
Effective Date: 10/01/95
Last Review Date: 09/06/18
Last Revision Date: 09/06/18

I. PURPOSE

This policy defines the criteria by which CalOptima enrolls a Member in CalOptima Direct.

II. POLICY

A. CalOptima may enroll a Member in CalOptima Direct, in accordance with this Policy.

B. CalOptima shall enroll the following Members in CalOptima Direct Administrative (COD-A) subject to the provisions of this Policy:

1. A Member who has Medicare coverage and is not enrolled in OneCare Connect:

   a. For a Member who has both Medicare Parts A and B or Medicare Part B coverage and is enrolled in CalOptima Direct pursuant to this policy, CalOptima shall not be required to assign such Members who are eligible for services through Medicare to a Medi-Cal Primary Care Provider (PCP) or require them to select a Medi-Cal PCP in accordance with the policy of the Department of Health Care Services (DHCS).

   b. For a Member who has Medicare Part A coverage, but does not have Medicare Part B coverage, and is enrolled in CalOptima Direct, pursuant to this policy, CalOptima shall assign such Member to a Medi-Cal PCP in accordance with DHCS policy(s).

2. A Member who becomes the responsibility of the Public Guardian or is in an Institute for Mental Disease (IMD), or with Orange County Children and Family Services and is placed outside of Orange County.

3. A Member with a Share of Cost (SOC) Aid Code.

4. A Member who resides at the Fairview Developmental Center.

5. At the time of initial enrollment in CalOptima, a Member with a non-Orange County Zip Code, or invalid address information from the State.

   a. If the address and/or zip code changes to an Orange County address at a later date, CalOptima shall request that the Member select a Health Network or CalOptima Community Network (CCN), in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the Member fails to choose a Health Network or CCN, then CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

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C. CalOptima shall enroll a Member in CCN, unless eligible for COD-A as described above, subject to the following provisions of this Policy:

1. A Member with Long Term Care (LTC) Aid Code;

2. A Member with a Breast and Cervical Cancer Treatment Program (BCCTP) primary Aid Code;

3. A Health Network Eligible Member, except as otherwise identified in this Policy:

   a. Is diagnosed with hemophilia;

   b. Is identified by a Provider as a potential candidate for a Solid Organ Transplant at a DHCS-approved Transplant Center or a California Children's Services (CCS)-paneled Transplant Special Care Center, and the Provider has requested authorization for Covered Services, or is approved for a Bone Marrow Transplant (BMT), except if the Member is listed as Status 7;

   c. Has received a Solid Organ Transplant or BMT within one hundred twenty (120) calendar days prior to the Member's effective date of enrollment in CalOptima; or

   d. Is diagnosed with End Stage Renal Disease (ESRD).

D. If a Member is no longer required to be enrolled in COD-A or CCN as described in Sections II.B, or II.C, such Member:

1. Is a Health Network Eligible Member;

2. May select CalOptima Community Network or any other Health Network in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

E. CalOptima shall exclude a Health Network Eligible Member from the provisions of this policy if such Member is enrolled in a Health Maintenance Organization (HMO) that, pursuant to the Health Network's Contract, is responsible for all Covered Services for the Member.

F. COD-A is responsible for a Health Network Eligible Member until such Member selects a Health Network or is assigned to a Health Network, pursuant to CalOptima Policies DD.2008: Health Network and CalOptima Community Network Selection Process or AA.1207a: CalOptima Auto-Assignment.

G. CalOptima Direct is not responsible for Covered Services provided to a Member outside the United States, with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22, California Code of Regulations, Section 51006.

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III. PROCEDURE

A. At the time of initial enrollment in CalOptima, a Member with a zip code outside of Orange County, as indicated by the eligibility file sent to CalOptima by the State, or, if CalOptima is unable to verify a zip code within Orange County due to no address information provided by the State, such Member shall not be auto-assigned by CalOptima, and the Member shall remain in COD-A.

B. If a Member assigned to COD-A due to having a zip code outside Orange County changes his or her zip code to an Orange County zip code, CalOptima shall request that the Member select a Health Network or CCN, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the Member fails to choose a Health Network or CCN, then CalOptima shall auto-assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

C. If a current Member assigned to a Health Network has or receives a zip code outside of Orange County as indicated by the eligibility file sent to CalOptima by the State, or CalOptima is unable to verify a zip code within Orange County at a later date, the Member may remain with their assigned Health Network unless Member makes a different Health Network choice or meets the criteria for COD-A or CCN enrollment as stated in Section II.B or II.C.

D. If a Health Network Eligible Member becomes the responsibility of the Public Guardian, or is in an Institute for Mental Disease, or is with Orange County Children and Family Services and resides outside Orange County:

1. The Member's Public Guardian, or the Orange County Children and Family Services may submit a written request to enroll the Member in COD-A.

   a. If CalOptima receives such request to enroll the Member in COD-A by the tenth (10^{th}) calendar day of the month, CalOptima Direct shall assume responsibility for all Covered Services for the Member effective the first (1^{st}) calendar day of the immediately following month.

   b. If CalOptima receives such request after the tenth (10^{th}) calendar day of the month, COD-A shall assume responsibility for all Covered Services for the Member effective no later than the first (1^{st}) calendar day of the month after the immediately following month.

2. If the Member's Public Guardian, or Orange County Children and Family Services does not submit a written request to enroll the Member in CalOptima Direct, the Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the Division of Financial Responsibility (DOFR).

3. If the Member returns to Orange County, the Public Guardian or Orange County Children and Family Services may submit a written request to enroll the Member in a Health Network or CCN.

E. If a Health Network Eligible Member is diagnosed with Hemophilia:

1. The Member's Health Network shall notify CalOptima of the Member's diagnosis, in writing, using the Hemophilia Special Needs Screen Questionnaire, in accordance with CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members.

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a. If the Health Network notifies CalOptima, in writing, by the tenth (10th) calendar day of a month, CCN shall assume responsibility for all Covered Services for the Member effective the first (1st) calendar day of the immediate following month.

b. If the Health Network notifies CalOptima, in writing, after the tenth (10th) calendar day of a month, CCN shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the month after the immediately following month.

2. The Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the DOFR, until the Health Network notifies CalOptima, in writing, to enroll the Member in CalOptima Direct, and CalOptima transitions such Member to CCN, as set forth in Section III.D.2 of this Policy.

F. If a Health Network Eligible Member, is identified by a Provider as a potential candidate for a Solid Organ Transplant at a DHCS-approved Transplant Center or a CCS-paneled Transplant Special Care Center, and the Provider has requested authorization for Covered Services, or the Member is approved for Bone Marrow Transplant (BMT) at a DHCS-approved Transplant Center or CCS-paneled Transplant Special Care Center, and is not listed as Status 7:

1. The Member's Health Network shall notify CalOptima, in writing, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

a. Except as set forth in Section III.D.1.b of this policy, CCN shall assume responsibility for all Covered Services for the Member on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the Health Network.

b. If the Member receives a Solid Organ Transplant or BMT after the date the Health Network notifies CalOptima and before the first (1st) calendar day of the month immediately following the date CalOptima receives notice, CCN shall assume responsibility for all Covered Services for the Member on the first (1st) calendar day of the month of notice.

2. The Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the DOFR, until the Health Network notifies CalOptima, in writing, and CalOptima transitions such Member to CalOptima Direct as set forth in Section III.D.1. of this policy.

3. CCN shall be responsible for all Covered Services for the Member for three- hundred sixty-five (365) calendar days after the Member receives a Solid Organ Transplant or BMT. After three-hundred sixty-five (365) calendar days after the date the Member receives a Solid Organ Transplant or BMT, CalOptima shall request the Member select a Health Network, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

4. If CalOptima, the DHCS-approved Transplant Center or the CCS-paneled Transplant Special Care Center, determines that the Member is ineligible for a Solid Organ Transplant or BMT:

a. If it has been less than three hundred sixty-five (365) calendar days after the Member transitioned to CCN, CalOptima shall transition the Member to the Member's previous

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Health Network, effective the first (1st) calendar day of the month immediately following the date CalOptima or the DHCS-approved Transplant Center determines that the Member is ineligible for a Solid Organ Transplant or BMT; or

b. If it has been more than three hundred sixty-five (365) calendar days after the Member transitioned to CCN, CalOptima shall request the Member select a Health Network, in accordance with CalOptima Policy DD.2008: Health Network Selection Process, or CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

G. If a Health Network Eligible Member received a Solid Organ Transplant or BMT within one hundred twenty (120) calendar days prior to their effective date of enrollment in CalOptima:

1. The Member's Health Network shall notify CalOptima by sending a Notification of Transplant Member, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

2. CCN shall assume responsibility for all Covered Services for the Member on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the Health Network, for a period of not less than three hundred sixty-five (365) calendar days after the date the Member received such Transplant.

3. CalOptima shall transition the Member to the Member's previous Health Network, effective no later than the first (1st) calendar day of the month immediately following the three hundred sixty fifth (365th) calendar day after the date the Member received a Solid Organ Transplant or BMT.

4. The Member's Health Network shall be responsible for all Covered Services for the Member until the Health Network submits written notice and CalOptima transitions such Member to CCN, as set forth in Section III.E.1 and III.E.2 of this Policy.

H. If a Health Network Eligible Member is diagnosed with ESRD and is not already assigned to CCN:

1. The Member's Health Network shall notify CalOptima, in writing, of the Member by submitting a copy of Form CMS-2728-U3 to CalOptima's Health Network Relations Department.

a. If a Health Network submits a Form CMS-2728-U3 on or before the fifteenth (15th) calendar day of a month, CCN shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the month after the immediate following month. For example, if a Health Network submits Form CMS-2728-U3 on June 15, CCN shall assume responsibility for the Member effective August 1.

b. If a Health Network submits a Form CMS-2728-U3 after the fifteenth (15th) day of a month, CCN shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the second (2nd) month after the immediately following month. For example, if a Health Network submits Form CMS-2728-U3 on June 16, CCN shall assume responsibility for the Member effective September 1.

c. CalOptima shall provide the Member with a thirty (30) calendar day notice of the transition, pursuant to the CalOptima Contract with DHCS.

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I. If CalOptima identifies a Member who meets the requirements specified in Sections II.B and II.C, of this policy, CalOptima shall transition the Member to COD-A, or CCN, and notify the Member's Health Network of such transition. CalOptima shall provide the Member, with a thirty (30) calendar day notice of the transition pursuant to CalOptima's contract with DHCS.

1. The Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the DOFR, until CalOptima enrolls the Member in COD-A or CCN.

J. If CalOptima identifies a Member who meets the requirements specified in Section II.B.1.b of this policy, CalOptima shall assign the Member a PCP as follows:

1. For an existing Member assigned to a Health Network, who gains Part A Dual status, CalOptima shall transition the Member to COD-A in the month CalOptima is notified by the State of the change to Medicare Part A eligibility.

   a. CalOptima shall assign the Member a PCP in accordance with CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

2. For a newly enrolled Member who is also Medicare Part A Dual eligible, CalOptima shall assign the Member to a PCP in accordance with the methodology described in CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

3. A Member may request to change his or her participating PCP every thirty (30) calendar days by contacting CalOptima's Customer Service Department.

IV. ATTACHMENTS

A. Notification of Transplant Member
B. Hemophilia Special Needs Screen Questionnaire
C. End Stage Renal Disease Medical Evidence Report – Medicare Entitlement and/or Patient Registration (Form CMS-2728-U3)

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Services
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
E. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
F. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
G. CalOptima Policy FF.1001: Capitation Payment
H. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
I. CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members
J. California Health and Safety Code, §§ 104160 through 104163
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 14-015: PCP Assignment in Medi-Cal Managed Care for Dual-Eligible Beneficiaries

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L. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program
M. Title 22, California Code of Regulations, §51006
N. Welfare and Institutions Code, §14182.17(d)(3)

VI. REGULATORY AGENCY APPROVALS

A. 10/07/15: Department of Health Care Services
B. 08/18/15: Department of Health Care Services
C. 04/01/15: Department of Health Care Services
D. 10/01/12: Department of Health Care Services

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
B. 08/06/15: Regular Meeting of the CalOptima Board of Directors
C. 03/06/14: Regular Meeting of the CalOptima Board of Directors
D. 03/04/10: Regular Meeting of the CalOptima Board of Directors
E. 11/05/09: Regular Meeting of the CalOptima Board of Directors
F. 06/03/08: Regular Meeting of the CalOptima Board of Directors
G. 10/19/06: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/01/1995	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	02/01/1996	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	03/01/1997	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	09/01/2004	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2006	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2007	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2008	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2010	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	01/01/2011	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	10/01/2012	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	03/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	05/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Reviewed	02/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal

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Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	07/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/06/2018	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal

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IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.
California Children's Services Program	For the purposes of this policy, the public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Member.
CalOptima Direct (COD)	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: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Direct (COD) Member	A Member who receives all Covered Services through CalOptima Direct.
CalOptima Direct Administrative (COD A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to Members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
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.
Division of Financial Responsibility (DOFR)	A matrix that defines how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Health Maintenance Organization	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.

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Term	Definition
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.
Health Network Eligible Member	A Member who is eligible to choose a CalOptima Health Network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combined liver and small bowel; and 9. Combined kidney and pancreas.
Status 7	Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center.

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P.O. BOX 11033, ORANGE, CA 92856 Phone: 714-246-8686

ADULT TRANSPLANT NOTIFICATION AND REQUEST FORM

Fax Submissions: Urgent: 714-796-6616 Routine: 714-796-6607

PHASE: ☐ New Referral ☐ Evaluation ☐ Listed ☐ Transplant ☐ Post-Transplant

***** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment; ELIGIBILITY must be verified at the time services are rendered.

Patient Name:_____ ☐ M ☐ F D.O.B._____ Age: _____
Last First

Mailing Address:_____ City:_____ ZIP:_____ Phone: _____

Client Index # (CIN): _____

Referring Provider:

Provider NPI#:_____ TIN#: _____

Medi-Cal ID#: _____

Address: Phone: _____

Fax: _____

Office Contact: _____

Physician's Signature: _____

Diagnosis:_____ ICD-9: _____

TRANSPLANT TYPE
(CalOptima may redirect based on contract status or center availability)

BMT:	☐ Cedars	
DLI:	☐ Cedars	
Kidney:	☐ UCI	
Kidney Pancreas:	☐ California Pacific	☐ UCSF
Liver:	☐ Cedars	☐ USC
Liver and Kidney:	☐ Cedars	☐ USC
Lung:	☐ USC	
Heart:	☐ Cedars	☐ USC
Heart and Lung:	☐ Stanford	
Small Bowel:	☐ Cedars	☐ USC

☐ Inpatient Estimated Length of Stay: _____

☐ Outpatient Letter of Agreement (LOA) Requested

Date(s) of Service:_____ Retro Date(s) of Service: _____

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting medical records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

STATUS	Authorization Number #
☐ Approved ☐ Modified ☐ Denied	Signature: Date:
☐ Not Medically Indicated ☐ Not a Covered Benefit	Comments:
☐ Services Available In Network	

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CalOptima
A Public Agency
Better. Together.

Special Needs Screen Questionnaire for Member with Hemophilia Transitioning from Health Networks to CalOptima Direct

☐ Hemophilia A ☐ Hemophilia B ☐ Hemophilia C ☐ von Willebrands Disease

Name: CIN #: Phone No: ( ) -

Health Network: HN Contact: Phone No: ( ) -

Primary Care Physician: Phone No: ( ) -

Treating Specialists: Phone No: ( ) -

Is Member currently in Case Management?

*If member is in case management, submit a case summary.

Planned Admissions or scheduled surgeries:

Name of Provider/Vendor: Phone No: ( ) -

Ordering Physician: Phone No: ( ) -

Date of Procedure: - - Type of Procedure:

Comments (include CPT and ICD-9 codes requested/authorized):

What factor is utilized?

Name of Provider/Vendor: Phone No: ( ) -

Ordering Physician: Phone No: ( ) -

Comments (include CPT and ICD-9 codes requested/authorized):

Has the member been hospitalized in the past six months? ☐ Yes ☐ No

If yes:

Hospital:

Diagnosis:

RX

(Please make copies of this page if additional space needed for medications)

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of person completing this form: Date: - -

PLEASE SEND A COPY OF ALL OPEN AUTHORIZATIONS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0046

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS *Check one:* ☐ Initial ☐ Re-entitlement ☐ Supplemental

1. Name *(Last, First, Middle Initial)*

2. Medicare Claim Number | 3. Social Security Number | 4. Date of Birth *(mm/dd/yyyy)*

5. Patient Mailing Address *(Include City, State and Zip)* | 6. Phone Number *(including area code)*

7. Sex ☐ Male ☐ Female

8. Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino (Complete Item 9)

9. Country/Area of Origin or Ancestry

10. Race *(Check all that apply)*
☐ White
☐ Black or African American
☐ American Indian/Alaska Native
Print Name of Enrolled/Principal Tribe
☐ Asian
☐ Native Hawaiian or Other Pacific Islander*
*complete Item 9

11. Is patient applying for ESRD Medicare coverage? ☐ Yes ☐ No

12. Current Medical Coverage *(Check all that apply)*
☐ Medicaid ☐ Medicare ☐ Employer Group Health Insurance
☐ DVA ☐ Medicare Advantage ☐ Other ☐ None

13. Height INCHES ____ OR CENT METERS ____

14. Dry Weight POUNDS ____ OR KILOGRAMS ____

15. Primary Cause of Renal Failure *(Use ICD-10-CM Code)*

16. Employment Status *(6 mos prior and current status)*

Prior	Current	
☐	☐	Unemployed
☐	☐	Employed Full Time
☐	☐	Employed Part Time
☐	☐	Homemaker
☐	☐	Retired due to Age/Preference
☐	☐	Retired (Disability)
☐	☐	Medical Leave of Absence
☐	☐	Student

17. Co-Morbid Conditions *(Check all that apply currently and/or during last 10 years)* *See instructions

a. ☐ Congestive heart failure
b. ☐ Atherosclerotic heart disease ASHD
c. ☐ Other cardiac disease
d. ☐ Cerebrovascular disease, CVA, TIA*
e. ☐ Peripheral vascular disease*
f. ☐ History of hypertension
g. ☐ Amputation
h. ☐ Diabetes, currently on insulin
i. ☐ Diabetes, on oral medications
j. ☐ Diabetes, without medications
k. ☐ Diabetic retinopathy
l. ☐ Chronic obstructive pulmonary disease
m. ☐ Tobacco use (current smoker)
n. ☐ Malignant neoplasm, Cancer
o. ☐ Toxic nephropathy
p. ☐ Alcohol dependence
q. ☐ Drug dependence*
r. ☐ Inability to ambulate
s. ☐ Inability to transfer
t. ☐ Needs assistance with daily activities
u. ☐ Institutionalized
☐ 1. Assisted Living
☐ 2. Nursing Home
☐ 3. Other Institution
v. ☐ Non-renal congenital abnormality
w. ☐ None

18. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoetin or equivalent? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
b. Was patient under care of a nephrologist? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 mon hs ☐ 6-12 months ☐ >12 months
c. Was patient under care of kidney dietitian? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
d. What access was used on first outpatient dialysis: ☐ AVF ☐ Graft ☐ Ca heter ☐ Other
If not AVF, then: Is maturing AVF present? ☐ Yes ☐ No
Is maturing graft present? ☐ Yes ☐ No

19. Laboratory Values Within 45 Days Prior to the Most Recent ESRD Episode. (Lipid Profile within 1 Year of Most Recent ESRD Episode).

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a.1. Serum Albumin (g/dl)			d. HbA1c	%	
a.2. Serum Albumin Lower Limit			e. Lipid Profile TC		
a.3. Lab Method Used (BCG or BCP)			LDL		
b. Serum Creatinine (mg/dl)			HDL		
c. Hemoglobin (g/dl)			TG		

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT

20. Name of Dialysis Facility | 21. Medicare Provider Number *(for item 20)*

22. Primary Dialysis Setting
☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

23. Primary Type of Dialysis
☐ Hemodialysis (Sessions per week____/hours per session____)
☐ CAPD ☐ CCPD ☐ Other

24. Date Regular Chronic Dialysis Began *(mm/dd/yyyy)* | 25. Date Patient Started Chronic Dialysis at Current Facility *(mm/dd/yyyy)*

26. Has patient been informed of kidney transplant options? ☐ Yes ☐ No

27. If patient NOT informed of transplant options, please check all that apply:
☐ Medically unfit
☐ Patient has not been assessed
☐ Patient declines information
☐ Psychologically unfit
☐ Unsuitable due to age
☐ Other

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

28. Date of Transplant *(mm/dd/yyyy)*	29. Name of Transplant Hospital	30. Medicare Provider Number for Item 29

Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.

31. Enter Date *(mm/dd/yyyy)*	32. Name of Preparation Hospital	33. Medicare Provider number for Item 32

34. Current Status of Transplant *(if functioning, skip items 36 and 37)*	35. Type of Donor:
☐ Functioning ☐ Non-Functioning	☐ Deceased ☐ Living Related ☐ Living Unrelated
36. If Non-Functioning, Date of Return to Regular Dialysis *(mm/dd/yyyy)*	37. Current Dialysis Treatment Site
	☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)

38. Name of Training Provider	39. Medicare Provider Number of Training Provider (for Item 38)
40. Date Training Began *(mm/dd/yyyy)*	41. Type of Training
	☐ Hemodialysis a. ☐ Home b. ☐ In Center ☐ CAPD ☐ CCPD ☐ Other
42. This Patient is Expected to Complete *(or has completed)* Training and will Self-dialyze on a Regular Basis. ☐ Yes ☐ No	43. Date When Patient Completed, or is Expected to Complete, Training *(mm/dd/yyyy)*

I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.

44. Printed Name and Signature of Physician personally familiar with the patient's training			45. UPIN of Physician in Item 44
a.) Printed Name	b.) Signature	c.) Date *(mm/dd/yyyy)*	

E. PHYSICIAN IDENTIFICATION

46. Attending Physician *(Print)*	47. Physician's Phone No. *(include Area Code)*	48. UPIN of Physician in Item 46

PHYSICIAN ATTESTATION

I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.

49. Attending Physician's Signature of Attestation *(Same as Item 46)*	50. Date *(mm/dd/yyyy)*
51. Physician Recertification Signature	52. Date *(mm/dd/yyyy)*

53. Remarks

F. OBTAIN SIGNATURE FROM PATIENT

I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.

54. Signature of Patient *(Signature by mark must be witnessed.)*	55. Date *(mm/dd/yyyy)*

G. PRIVACY STATEMENT

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-70-0520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 or as updated and republished. Collection of your Social Security number is authorized by Executive Order 9397. Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health. Additional disclosures may be found in the *Federal Register* notice cited above. You should be aware that P.L.100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

INSTRUCTIONS FOR COMPLETION OF END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

For whom should this form be completed:

This form SHOULD NOT be completed for those patients who are in acute renal failure. Acute renal failure is a condition in which kidney function can be expected to recover after a short period of dialysis, i.e., several weeks or months.

This form MUST BE completed within 45 days for ALL patients beginning any of the following:

Check the appropriate block that identifies the reason for submission of this form.

Initial

For all patients who initially receive a kidney transplant instead of a course of dialysis. For patients for whom a regular course of dialysis has been prescribed by a physician because they have reached that stage of renal impairment that a kidney transplant or regular course of dialysis is necessary to maintain life. The first date of a regular course of dialysis is the date this prescription is implemented whether as an inpatient of a hospital, an outpatient in a dialysis center or facility, or a home patient.

The form should be completed for all patients in this category even if the patient dies within this time period.

Re-entitlement

For beneficiaries who have already been entitled to ESRD Medicare benefits and those benefits were terminated because their coverage stopped 3 years post-transplant but now are again applying for Medicare ESRD benefits because they returned to dialysis or received another kidney transplant.

For beneficiaries who stopped dialysis for more than 12 months, have had their Medicare ESRD benefits terminated and now returned to dialysis or received a kidney transplant. These patients will be reapplying for Medicare ESRD benefits.

Supplemental

Patient has received a transplant or trained for self-care dialysis within the first 3 months of the first date of dialysis and initial form was submitted.

All items except as follows: To be completed by the attending physician, head nurse, or social worker involved in this patient's treatment of renal disease.

Items 15, 17-18, 26-27, 49-50: To be completed by the attending physician.
Item 44: To be signed by the attending physician or the physician familiar with the patient's self-care dialysis training.
Items 54 and 55: To be signed and dated by the patient.

1. Enter the patient's legal name (Last, first, middle initial). Name should appear exactly the same as it appears on patient's social security or Medicare card.
2. If the patient is covered by Medicare, enter his/her Medicare claim number as it appears on his/her Medicare card.
3. Enter the patient's own social security number. This number can be verified from his/her social security card.
4. Enter patient's date of birth (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.
5. Enter the patient's mailing address (number and street or post office box number, city, state, and ZIP code.)
6. Enter the patient's home area code and telephone number.
7. Check the appropriate block to identify sex.
8. Check the appropriate block to identify ethnicity. Definitions of the ethnicity categories for Federal statistics are as follows:

   Not Hispanic or Latino—A person of culture or origin not described below, regardless of race.

   Hispanic or Latino—A person of Cuban, Puerto Rican, or Mexican culture or origin regardless of race. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.
9. Country/Area of origin or ancestry—Complete if information is available or if directed to do so in question 8.
10. Check the appropriate block(s) to identify race. Definitions of the racial categories for Federal statistics are as follows:

    White—A person having origins in any of the original white peoples of Europe, the Middle East or North Africa.

    Black or African American—A person having origins in any of the black racial groups of Africa. This includes native-born Black Americans, Africans, Haitians and residents of non-Spanish speaking Caribbean Islands of African descent.

    American Indian/Alaska Native—A person having origins in any of the original peoples of North America and South America (including Central America) and who maintains Tribal affiliation or community attachment. Print the name of the enrolled or principal tribe to which the patient claims to be a member.

    Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

    Native Hawaiian or Other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.

DISTRIBUTION OF COPIES:

- Forward one copy of this form to the Social Security office servicing the claim.
- Forward one copy of this form to the ESRD Network Organization.
- Retain one copy of this form in the patient's medical records file.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0046. The time required to complete this information collection estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the ime estimate(s) or suggestions for improving this form, please write to: CMS, Attention: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

11. Check the appropriate yes or no block to indicate if patient is applying for ESRD Medicare. Note: Even though a person may already be entitled to general Medicare coverage, he/she should reapply for ESRD Medicare coverage.

12. Check all the blocks that apply to this patient's current medical insurance status.

Medicaid—Patient is currently receiving State Medicaid benefits.

Medicare—Patient is currently entitled to Federal Medicare benefits.

Employer Group Health Insurance—Patient receives medical benefits through an employee health plan that covers employees, former employees, or the families of employees o former employees.

DVA—Patient is receiving medical care from a Department of Veterans Affairs facility.

Medicare Advantage—Patient is receiving medical benefits under a Medicare Advantage organization.

Other Medical Insurance—Patient is receiving medical benefits under a health insurance plan that is not Medicare, Medicaid, Department of Veterans Affairs, HMO/M+C organization, nor an employer group health insurance plan. Examples of other medical insurance are Railroad Retirement and CHAMPUS beneficiaries.

None—Patient has no medical insurance plan.

13. Enter the patient's most recent recorded height in inches OR centimeters at time form is being completed. If entering height in centimeters, round to the nearest centimeter. Estimate or use last known height for those unable to be measured. (Example of inches - 62. DO NOT PUT 5'2") NOTE: For amputee patients, enter height prior to amputation.

14. Enter the patient's most recent recorded dry weight in pounds OR kilograms at time form is being completed. If entering weight in kilograms, round to the nearest kilogram.

NOTE: For amputee patients, enter actual dry weight.

15. To be completed by the attending physician. Enter the ICD10-CM Code to indicate the primary cause of end stage renal disease.

16. Check the first box to indicate employment status 6 months prior to renal failure and the second box to indicate current employment status. Check only one box for each time period. If patient is under 6 years of age, leave blank.

17. To be completed by the attending physician. Check all co-morbid conditions that apply.

*Cerebrovascular Disease includes history of stroke/cerebrovascular accident (CVA) and transient ischemic attack (TIA).

*Peripheral Vascular Disease includes absent foot pulses, prior typical claudication, amputations for vascular disease, gangrene and aortic aneurysm.

*Drug dependence means dependent on illicit drugs.

18. Prior to ESRD therapy, check the appropriate box to indicate whether the patient received exogenous erythropoietin (EPO) or equivalent, was under the care of a nephrologist and/or was under the care of a kidney dietitian. Provide vascular access information as to the type of access used (Arterio-Venous Fistula (AVF), graft, catheter (including port device) or other type of access) when the patient first received outpatient dialysis. If an AVF access was not used, was a maturing AVF or graft present?

NOTE: For those patients re-entering the Medicare program after benefits were terminated, Items 19a thru 19c should contain initial laboratory values within 45 days prior to the most recent ESRD episode. Lipid profiles and HbA1c should be within 1 year of the most recent ESRD episode. Some tests may not be required for patients under 21 years of age.

19a1. Enter the serum albumin value (g/dl) and date test was taken. This value and date must be within 45 days prior to first dialysis treatment or kidney transplant.

19a2. Enter the lower limit of the normal range for serum albumin from the laboratory which performed the serum albumin test entered in 19a1.

19a3. Enter the serum albumin lab method used (BCG or BCP).

19b. Enter the serum creatinine value (mg/dl) and date test was taken. THIS FIELD MUST BE COMPLETED. Value must be within 45 days prior to first dialysis treatment or kidney transplant.

19c. Enter the hemoglobin value (g/dl) and date test was taken. This value and date must be within 45 days prior to the first dialysis treatment or kidney transplant.

19d. Enter the HbA1c value and the date the test was taken. The date must be within 1 year prior to the first dialysis treatment or kidney transplant.

19e. Enter the Lipid Profile values and date test was taken. These values: TC–Total Cholesterol; LDL–LDL Cholesterol; HDL–HDL Cholesterol; TG–Triglycerides, and date must be within 1 year prior to the first dialysis treatment or kidney transplant.

20. Enter the name of the dialysis facility where patient is currently receiving care and who is completing this form for patient.

21. Enter the 6-digit Medicare identification code of the dialysis facility in item 20.

22. If the person is receiving a regular course of dialysis treatment, check the appropriate anticipated long-term treatment setting at the time this form is being completed.

23. If the patient is, or was, on regular dialysis, check the anticipated long-term primary type of dialysis: Hemodialysis, (enter the number of sessions prescribed per week and the hours that were prescribed for each session), CAPD (Continuous Ambulatory Peritoneal Dialysis) and CCPD (Continuous Cycling Peritoneal Dialysis), or Other. Check only one block. NOTE: Other has been placed on this form to be used only to report IPD (Intermittent Peritoneal Dialysis) and any new method of dialysis that may be developed prior to the renewal of this form by Office of Management and Budget.

24. Enter the date (month, day, year) that a "regular course of chronic dialysis" began. The beginning of the course of dialysis is counted from the beginning of regularly scheduled dialysis necessary for the treatment of end stage renal disease (ESRD) regardless of the dialysis setting. The date of the first dialysis treatment after the physician has determined that this patient has ESRD and has written a prescription for a "regular course of dialysis" is the "Date Regular Chronic Dialysis Began" regardless of whether this prescription was implemented in a hospital/ inpatient, outpatient, or home setting and regardless of any acute treatments received prior to the implementation of the prescription.

NOTE: For these purposes, end stage renal disease means irreversible damage to a person's kidneys so severely affecting his/her ability to remove or adjust blood wastes that in order to maintain life he or she must have either a course of dialysis or a kidney transplant to maintain life.

If re-entering the Medicare program, enter beginning date of the current ESRD episode. Note in Remarks, Item 53, that patient is restarting dialysis.

25. Enter date patient started chronic dialysis at current facility of dialysis services. In cases where patient transferred to current dialysis facility, this date will be after the date in Item 24.

26. Enter whether the patient has been informed of their options for receiving a kidney transplant.

27. If the patient has not been informed of their options (answered "no" to Item 26), then enter all reasons why a

kidney transplant was not an option for this patient at this time.

28. Enter the date(s) of the patient's kidney transplant(s). If reentering the Medicare program, enter current transplant date.
29. Enter the name of the hospital where the patient received a kidney transplant on the date in Item 28.
30. Enter the 6-digit Medicare identification code of the hospital in Item 29 where the patient received a kidney transplant on the date entered in Item 28.
31. Enter date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation. This includes hospitalization for transplant workup in order to place the patient on a transplant waiting list.
32. Enter the name of the hospital where patient was admitted as an inpatient in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation.
33. Enter the 6-digit Medicare identification number for hospital in Item 32.
34. Check the appropriate functioning or non-functioning block.
35. Enter the type of kidney transplant organ donor, Deceased, Living Related or Living Unrelated, that was provided to the patient.
36. If transplant is nonfunctioning, enter date patient returned to a regular course of dialysis. If patient did not stop dialysis post-transplant, enter transplant date.
37. If applicable, check where patient is receiving dialysis treatment following transplant rejection. A nursing home or skilled nursing facility is considered as home setting

Self-dialysis Training Patients (Medicare Applicants Only)

Normally, Medicare entitlement begins with the third month after the month a patient begins a regular course of dialysis treatment. This 3-month qualifying period may be waived if a patient begins a self-dialysis training program in a Medicare approved training facility and is expected to self-dialyze after the completion of the training program. Please complete items 38-43 if the patient has entered into a self-dialysis training program. Items 38-43 must be completed if the patient is applying for a Medicare waiver of the 3-month qualifying period for dialysis benefits based on participation in a self-care dialysis training program.

38. Enter the name of the provider furnishing self-care dialysis training.
39. Enter the 6-digit Medicare identification number for the training provider in Item 38.
40. Enter the date self-dialysis training began.
41. Check the appropriate block which describes the type of self-care dialysis training the patient began. If the patient trained for hemodialysis, enter whether the training was to perform dialysis in the home setting or in the facility (in center). If the patient trained for IPD (Intermittent Peritoneal Dialysis), report as Other.
42. Check the appropriate block as to whether or not the physician certifies that the patient is expected to complete the training successfully and self-dialyze on a regular basis.
43. Enter date patient completed or is expected to complete self-dialysis training.
44. Enter printed name and signature of the attending physician or the physician familiar with the patient's self-care dialysis training.
45. Enter the Unique Physician Identification Number (UPIN) of physician in Item 44. (See Item 48 for explanation of UPIN.)
46. Enter the name of the physician who is supervising the patient's renal treatment at the time this form is completed.
47. Enter the area code and telephone number of the physician who is supervising the patient's renal treatment at the time this form is completed.
48. Enter the physician's UPIN assigned by CMS.

    A system of physician identifiers is mandated by Section 9202 of the Consolidated Omn bus Budget Reconciliation Act of 1985. It requires a unique identifier for each physician who provides services for which Medicare payment is made. An identifier is assigned to each physician regardless of his or her practice configuration. The UPIN is established in a national Registry of Medicare Physician Identification and Eligibility Records (MPIER). Transamerica Occidental Life Insurance Company is the Registry Carrier that establishes and maintains the national registry of physicians receiving Part Medicare payment. Its address is: UPIN Registry, Transamerica Occidental Life, P.O. Box 2575, Los Angeles, CA 90051-0575.
49. To be signed by the physician supervising the patient's kidney treatment. Signature of physician identified in Item 46. A stamped signature is unacceptable.
50. Enter date physician signed this form.
51. To be signed by the physician who is currently following the patient. If the patient had decided initially not to file an application for Medicare, the physician will be re-certifying that the patient is end stage renal, based on the same medical evidence, by signing the copy of the CMS-2728 that was originally submitted and returned to the provider. If you do not have a copy of the original CMS-2728 on file, complete a new form.
52. The date physician re-certified and signed the form.
53. This remarks section may be used for any necessary comments by either the physician, patient, ESRD Network or social security field office.
54. The patient's signature authorizing the release of information to the Department of Hea th and Human Services must be secured here. If the patient is unable to sign the form, it should be signed by a relative, a person assuming responsibility for the patient or by a survivor.
55. The date patient signed form.

Back to Agenda

Policy #: DD.2006b
Title: **CalOptima Community Network Member Primary Care Provider Selection/Assignment**
Department: Customer Service
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/01/11
Last Review Date: 09/06/18~~09/01/17~~
Last Revised Date: 09/06/18~~09/01/17~~

I. PURPOSE

This policy describes the criteria by which a CalOptima Community Network (CCN) Member shall select or be assigned a Primary Care Provider (PCP).

II. POLICY

A. CalOptima recognizes that it is in the best interest of a Member to establish a medical home and maintain continuity of care with a PCP.

B. As part of CalOptima's commitment to these objectives, a CCN Member is encouraged to select a participating PCP in accordance with the terms and conditions of this policy. If a CCN Member does not select a participating PCP, CalOptima shall assign the Member to a participating PCP in accordance with this policy.

C. CalOptima shall only assign a Member to a participating PCP who has been credentialed as a PCP by CalOptima.

D. A Member shall have the right to select a participating Community Health Center, or Non-Physician Medical Practitioner, as his or her PCP. If a Member chooses a participating Non-Physician Medical Practitioner as his or her PCP, the Member shall be assigned directly to the supervising physician and not the Non-Physician Medical Practitioner.

E. A Member categorized as a senior or person with a disability (SPD) shall have the right to choose as a PCP a specialist physician who is a participating Provider, is willing to perform the role of the PCP, and has met CalOptima's requirements for a specialist to act as a PCP.

F. A Member eligible for the California Children's Services (CCS) Program, or the Member's parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall have the right to request a specialist as a PCP if the specialist agrees to serve in a PCP role and is a CCS-paneled provider qualified to treat the required range of CCS-Eligible Conditions of the CCS child or youth, in accordance with CCS program rules and regulations.

~~F.~~G. CalOptima shall make reasonable efforts to ensure that a Member expressing a desire to continue his or her existing relationship with a participating CCN PCP is assigned to such PCP.

~~G.~~H. A Member who selects or is assigned to a participating Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as his or her PCP:

1. Shall be assigned directly to the FQHC or RHC; and

2. Shall not be assigned to an individual PCP performing services on behalf of the FQHC or RHC.

~~H.~~I. CalOptima shall disclose to a Member the reason for which he or she could not select or be assigned to a specific PCP.

~~I.~~J. A Member may change his or her CCN-participating PCP once every thirty (30) calendar days in accordance with this policy.

~~J.~~K. If CCN terminates a participating PCP, or a participating PCP terminates the contractual relationship with CCN, CalOptima shall assign a new CCN-participating PCP to an affected Member within seven (7) calendar days after the effective date of the termination. CalOptima shall make a good faith effort to give written notice of termination of a contracted Provider to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated provider within fifteen (15) calendar days of receipt of termination notice and at least thirty (30) calendar days prior to the termination of the contract.

III. PROCEDURE

A. PCP Selection or Assignment for a Newly Enrolled CCN Member

1. A newly eligible Member who chooses CCN or is Auto-Assigned to CCN shall have thirty (30) calendar days, or up to forty-five (45) calendar days if the Member's date of eligibility with CalOptima Direct (COD) was after the fifteenth (15th) calendar day in the eligibility month, to select a CCN-participating PCP.

2. A Member assigned directly to CCN, in accordance with CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct, shall be assigned a PCP in accordance with the terms of this policy.

3. If a Member does not select a participating PCP as described in Section III.A.1 of this Policy, or for a Member assigned directly to CCN as described in Section III.A.2 of this Policy, CalOptima shall assign the Member to a participating PCP based on the following criteria:

   a. If the Member was eligible with CalOptima within the last three hundred sixty-five (365) calendar days, CalOptima shall assign the Member to the last PCP on record that is currently a CCN-participating PCP.

   b. If Member does not meet criteria outlined in Section III.A.3.a, and has a family member in CCN, CalOptima shall assign the Member to the same PCP, subject to any age and gender restrictions applicable to the PCP.

4. Notwithstanding the above, if an SPD or a CCS Member does not select a CCN-participating PCP, CalOptima shall use Fee-For-Service (FFS) utilization data or other data sources (including electronic data), if available, for purposes of PCP assignment.

5. In the event III.A.3-4 do not apply, CalOptima shall assign the Member to a participating PCP open for new assignment based on the following:

    a. The geographic location of the participating PCP's office in relation to the Member's residence, in accordance with CalOptima Policy GG.1600: Access and Availability Standards;

    b. The Member's language; then

    c. The Member's age.

    d. If more than one (1) PCP meets all assignment criteria, a PCP will be assigned based on a rotation to allow balanced distribution.

B. If a Member selects a participating PCP that is not accepting new Members, CalOptima shall:

1. Inform the Member to choose a participating PCP to avoid Auto-Assignment.

2. Contact the PCP, if a Member contacts CalOptima and indicates an existing relationship with a participating PCP not accepting new Members, and make all reasonable efforts to ensure that the Member may continue an existing relationship with the participating PCP.

3. Assign the Member to a CCN-participating PCP, in accordance with Section III.A of this policy, if CalOptima is unable to obtain a CCN-participating PCP from the Member.

C. A Member may request to change his or her participating PCP every thirty (30) calendar days by contacting CalOptima's Customer Service Department.

1. If the Member requests a PCP change before seeing his or her assigned PCP prior to the sixteenth (16^{th}) of the current month, CalOptima shall make the change effective the first (1^{st}) calendar day of the current month.

2. If the Member requests a PCP change after seeing his or her assigned PCP after the sixteenth (16^{th}) of the current month, CalOptima shall make the change effective the first (1^{st}) calendar day of the immediately following month.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Community Network (CCN) Primary Care Provider (PCP) Selection Form and Guide
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Contract for Health Care Services
D. CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct
E. CalOptima Policy GG.1600: Access and Availability Standards

F. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program
~~F.~~G. Welfare and Institutions Code, ~~Section~~§§ 14087.325 and 14094.14
~~G.~~H. Title 22, California Code of Regulations (CCR), §55170
~~H.~~I. Title 42, Code of Federal Regulations (CFR), §438.10(f)(5)

VI. REGULATORY AGENCY APPROVALS

A. 10/09/17: Department of Health Care Services
B. 04/07/15: Department of Health Care Services
C. 07/12/10: Department of Health Care Services

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 03/06/14: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 11/05/09: 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	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	03/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	07/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	01/01/2013	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	03/01/2015	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	09/01/2016	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	09/01/2017	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	09/06/2018	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection/Assignment	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009Δ: Access by Member's Personal Representative.
Auto-Assignment	The process by which a CalOptima Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Provider and/or Health Network.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Member.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network; and 3. Ability to function as a Primary Care Provider (PCP).
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.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public

Term	Definition
	Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Member	For the purposes of this policy, 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, or the United States Social Security Administration, who is enrolled in the CalOptima program and the CalOptima Community Network.
Non-Physician Medical Practitioner	A nurse midwife, physician's assistant, or nurse practitioner who provides primary care.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182(b)(11).
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Rural Health Clinic (RHC)	A type of provider located in a non-urbanized area, as determined by the U.S. Census Bureau, and defined in section 1861(aa)(2) of the Social Security Act as engaged primarily in providing outpatient services to beneficiaries in underserved areas through nurse practitioners, physician assistants and clinical psychologists.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

1

Policy #: DD.2006b
Title: **CalOptima Community Network Member Primary Care Provider Selection/Assignment**
Department: Customer Service
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/01/11
Last Review Date: 09/06/18
Last Revised Date: 09/06/18

I. PURPOSE

This policy describes the criteria by which a CalOptima Community Network (CCN) Member shall select or be assigned a Primary Care Provider (PCP).

II. POLICY

A. CalOptima recognizes that it is in the best interest of a Member to establish a medical home and maintain continuity of care with a PCP.

B. As part of CalOptima's commitment to these objectives, a CCN Member is encouraged to select a participating PCP in accordance with the terms and conditions of this policy. If a CCN Member does not select a participating PCP, CalOptima shall assign the Member to a participating PCP in accordance with this policy.

C. CalOptima shall only assign a Member to a participating PCP who has been credentialed as a PCP by CalOptima.

D. A Member shall have the right to select a participating Community Health Center, or Non-Physician Medical Practitioner, as his or her PCP. If a Member chooses a participating Non-Physician Medical Practitioner as his or her PCP, the Member shall be assigned directly to the supervising physician and not the Non-Physician Medical Practitioner.

E. A Member categorized as a senior or person with a disability (SPD) shall have the right to choose as a PCP a specialist physician who is a participating Provider, is willing to perform the role of the PCP, and has met CalOptima's requirements for a specialist to act as a PCP.

F. A Member eligible for the California Children's Services (CCS) Program, or the Member's parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall have the right to request a specialist as a PCP if the specialist agrees to serve in a PCP role and is a CCS-paneled provider qualified to treat the required range of CCS-Eligible Conditions of the CCS child or youth, in accordance with CCS program rules and regulations.

G. CalOptima shall make reasonable efforts to ensure that a Member expressing a desire to continue his or her existing relationship with a participating CCN PCP is assigned to such PCP.

H. A Member who selects or is assigned to a participating Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as his or her PCP:

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1. Shall be assigned directly to the FQHC or RHC; and

2. Shall not be assigned to an individual PCP performing services on behalf of the FQHC or RHC.

I. CalOptima shall disclose to a Member the reason for which he or she could not select or be assigned to a specific PCP.

J. A Member may change his or her CCN-participating PCP once every thirty (30) calendar days in accordance with this policy.

K. If CCN terminates a participating PCP, or a participating PCP terminates the contractual relationship with CCN, CalOptima shall assign a new CCN-participating PCP to an affected Member within seven (7) calendar days after the effective date of the termination. CalOptima shall make a good faith effort to give written notice of termination of a contracted Provider to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated provider within fifteen (15) calendar days of receipt of termination notice and at least thirty (30) calendar days prior to the termination of the contract.

III. PROCEDURE

A. PCP Selection or Assignment for a Newly Enrolled CCN Member

1. A newly eligible Member who chooses CCN or is Auto-Assigned to CCN shall have thirty (30) calendar days, or up to forty-five (45) calendar days if the Member's date of eligibility with CalOptima Direct (COD) was after the fifteenth (15^{th}) calendar day in the eligibility month, to select a CCN-participating PCP.

2. A Member assigned directly to CCN, in accordance with CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct, shall be assigned a PCP in accordance with the terms of this policy.

3. If a Member does not select a participating PCP as described in Section III.A.1 of this Policy, or for a Member assigned directly to CCN as described in Section III.A.2 of this Policy, CalOptima shall assign the Member to a participating PCP based on the following criteria:

   a. If the Member was eligible with CalOptima within the last three hundred sixty-five (365) calendar days, CalOptima shall assign the Member to the last PCP on record that is currently a CCN-participating PCP.

   b. If Member does not meet criteria outlined in Section III.A.3.a, and has a family member in CCN, CalOptima shall assign the Member to the same PCP, subject to any age and gender restrictions applicable to the PCP.

4. Notwithstanding the above, if an SPD or a CCS Member does not select a CCN-participating PCP, CalOptima shall use Fee-For-Service (FFS) utilization data or other data sources (including electronic data), if available, for purposes of PCP assignment.

5. In the event III.A.3-4 do not apply, CalOptima shall assign the Member to a participating PCP open for new assignment based on the following:

a. The geographic location of the participating PCP's office in relation to the Member's residence, in accordance with CalOptima Policy GG.1600: Access and Availability Standards;

b. The Member's language; then

c. The Member's age.

d. If more than one (1) PCP meets all assignment criteria, a PCP will be assigned based on a rotation to allow balanced distribution.

B. If a Member selects a participating PCP that is not accepting new Members, CalOptima shall:

1. Inform the Member to choose a participating PCP to avoid Auto-Assignment.

2. Contact the PCP, if a Member contacts CalOptima and indicates an existing relationship with a participating PCP not accepting new Members, and make all reasonable efforts to ensure that the Member may continue an existing relationship with the participating PCP.

3. Assign the Member to a CCN-participating PCP, in accordance with Section III.A of this policy, if CalOptima is unable to obtain a CCN-participating PCP from the Member.

C. A Member may request to change his or her participating PCP every thirty (30) calendar days by contacting CalOptima's Customer Service Department.

1. If the Member requests a PCP change before seeing his or her assigned PCP prior to the sixteenth (16th) of the current month, CalOptima shall make the change effective the first (1st) calendar day of the current month.

2. If the Member requests a PCP change after seeing his or her assigned PCP after the sixteenth (16th) of the current month, CalOptima shall make the change effective the first (1st) calendar day of the immediately following month.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Community Network (CCN) Primary Care Provider (PCP) Selection Form and Guide
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Contract for Health Care Services
D. CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct
E. CalOptima Policy GG.1600: Access and Availability Standards
F. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program
G. Welfare and Institutions Code, §§ 14087.325 and 14094.14
H. Title 22, California Code of Regulations (CCR), §55170
I. Title 42, Code of Federal Regulations (CFR), §438.10(f)(5)

VI. REGULATORY AGENCY APPROVALS

A. 10/09/17: Department of Health Care Services
B. 04/07/15: Department of Health Care Services
C. 07/12/10: Department of Health Care Services

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
B. 03/06/14: Regular Meeting of the CalOptima Board of Directors
C. 11/05/09: 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	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	03/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	07/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	01/01/2013	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	03/01/2015	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	09/01/2016	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	09/01/2017	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	09/06/2018	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection/Assignment	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009Δ: Access by Member's Personal Representative.
Auto-Assignment	The process by which a CalOptima Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Provider and/or Health Network.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Member.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network; and 3. Ability to function as a Primary Care Provider (PCP).
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.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.

Term	Definition
Member	For the purposes of this policy, 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, or the United States Social Security Administration, who is enrolled in the CalOptima program and the CalOptima Community Network.
Non-Physician Medical Practitioner	A nurse midwife, physician's assistant, or nurse practitioner who provides primary care.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, “Primary Care Practitioner” or “PCP” shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182(b)(11).
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Rural Health Clinic (RHC)	A type of provider located in a non-urbanized area, as determined by the U.S. Census Bureau, and defined in section 1861(aa)(2) of the Social Security Act as engaged primarily in providing outpatient services to beneficiaries in underserved areas through nurse practitioners, physician assistants and clinical psychologists.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

1

Policy #:	EE.1112
Title:	**Health Network Eligible Member Assignment to Primary Care Provider**
Department:	~~Health Network Relations~~Network Operations
Section:	~~Not Applicable~~Health Network Relations
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/95
Last Review Date:	~~11/01/17~~09/06/18
Last Revised Date:	~~11/01/17~~09/06/18

I. PURPOSE

This policy establishes the guidelines by which a Health Network shall assign and report a Health Network Member to a Primary Care Provider (PCP).

II. POLICY

A. A Health Network Eligible Member shall have a choice of PCP at the time the Member selects a Health Network for enrollment~~,~~ and may change his or her PCP within the CalOptima network~~,~~ on a monthly basis for any reason, in accordance with CalOptima Policy DD.2008: Health Network Selection Process.

1. A Member eligible for the California Children's Services (CCS) Program, or the Member's parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall have the right to request a specialist or clinic as a PCP if the specialist or clinic agrees to serve in a PCP role and is a CCS-paneled provider qualified to treat the required range of CCS-Eligible Conditions of the CCS child or youth, in accordance with CCS program rules and regulations.

2. An SPD Member shall have the right to request a specialist or Community Health Center as a PCP if the specialist or Community Health Center agrees to serve in the PCP role.

B. If a Member does not select a PCP at the time of Health Network selection, a Health Network shall assign such Member to a PCP within seven (7) calendar days after receipt of the eligibility file, and no later than forty-five (45) calendar days after the Member's enrollment with CalOptima.

C. A Health Network shall only assign a Member to a PCP who has been credentialed in accordance with CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners; and registered with CalOptima as a PCP by the Health Network.

D. Except for a Senior and Persons with Disabilities (SPD) Member, a Health Network shall assign a Member to a PCP, taking into consideration:

1. The geographic location of the PCP's office in relation to the Member's residence, in accordance with CalOptima Policy GG.1600: Access and Availability Standards;

2. The Member's language preference, if available; and

3. The Member's age.

E. For an SPD Member who does not select a PCP within thirty (30) calendar days of the effective date of enrollment with CalOptima, a Health Network shall use Fee-For-Service (FFS) utilization data provided by the Department of Health Care Services (DHCS) or other data sources, including electronic data, to establish existing Provider relationships for the purpose of PCP assignment, ~~including a Specialty Care Provider or clinic if a SPD Member indicates a preference for either, and the Specialty Care Provider or clinic agree to serve as a PCP,~~ and shall comply with all state and federal privacy laws in the provision and use of data.

F. A Health Network shall make reasonable efforts to ensure that a Member expressing a desire to continue his or her existing relationship with a contracted PCP in the CalOptima network is assigned to such PCP.

G. A Member who selects or is assigned to a Community Health Center, such as a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), as his or her PCP:

1. Shall be assigned directly to the Community Health Center; and

2. Shall not be assigned to individual PCP performing services on behalf of the Community Health Center.

H. A Health Network shall notify the PCP that a Member has selected the PCP, or that the Health Network assigned the Member to the PCP, within ten (10) calendar days after completion of the selection or assignment.

I. A Health Network shall disclose to a Member the reason for which he or she could not select or be assigned to a specific PCP.

J. A Health Network shall notify CalOptima via the PCP Upload of a Member's assignment to a PCP, in accordance with Section III.C of this policy.

K. A Member may change his or her PCP monthly, for any reason, within his or her selected Health Network. The Health Network shall process a Health Network Eligible Member's request to change his or her PCP.

L. If a Health Network terminates a PCP, or a PCP terminates the contractual relationship with the Health Network, the Health Network shall assign a new PCP to a Member affected by the termination of his or her PCP within seven (7) calendar days after the effective date of the termination. A Health Network shall notify the affected Members, in writing, of the change of availability of Covered Services, in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

III. PROCEDURE

A. Primary Care Provider Selection

1. A Health Network Eligible Member shall have the opportunity to select a PCP at the time of Health Network selection during the first thirty (30) calendar days after enrollment/eligibility.

2. A Member shall have the right to select a Community Health Center or a Non-Physician Medical Practitioner. If a Member chooses a Non-Physician Medical Practitioner as his or her PCP, the Member shall be assigned directly to the supervising physician, and not the Non-Physician Medical Practitioner.

3. An SPD Member shall have the right to request a specialist or Community Health Center as a PCP if the specialist or Community Health Center agrees to serve in the PCP role.

4. A Member eligible for the California Children's Services (CCS) Program, or the Member's parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall have the right to request a specialist or clinic as a PCP if the specialist or clinic agrees to serve in a PCP role and is a CCS-paneled provider qualified to treat the required range of CCS-Eligible Conditions of the CCS child or youth.

B. Member Assignment to Primary Care Provider

1. If a Member selects a Health Network~~,~~ but does not select a PCP at the time of Health Network Selection, the Health Network shall assign the Member to a PCP within seven (7) calendar days after receipt of the eligibility file.

2. If a Member selects neither a Health Network nor a PCP at the time of Health Network selection, CalOptima shall:

   a. Auto-assign the Member to a Health Network, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment; and

   b. Defer the Member's assignment to a PCP to the assigned Health Network, except for a Member who is assigned directly to a Community Health Center.

   c. The Health Network shall assign the Member to a PCP within seven (7) calendar days after receipt of the eligibility file.

C. A Health Network shall report Member assignments and changes of a PCP in the PCP Upload File.

D. A Health Network shall correct PCP Upload File errors within ten (10) calendar days of receipt.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
D. CalOptima Policy DD.2008: Health Network Selection Process
E. CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services
F. CalOptima Policy GG.1600: Access and Availability Standards
G. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners

H. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program
~~H.~~I. PCP Upload File Submission Schedule
~~I.~~J. PCP Upload Submission Procedures
~~J.~~K. Title 22, California Code of Regulations (CCR), §55170
~~K.~~L. Welfare and Institutions Code, ~~§~~§§ 14087.325 and 14094.14

VI. REGULATORY AGENCY APPROVALS

A. 03/03/15: Department of Health Care Services
B. 02/24/13: Department of Health Care Services
C. 08/06/10: Department of Health Care Services
D. 11/25/09: Department of Health Care Services

VII. BOARD ACTIONS

~~Not Applicable~~A. 09/06/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/01/1995	EE.1112	Primary Care Physician Assignment to Members	Medi-Cal
Revised	01/01/1996	EE.1112	Primary Care Physician Assignment to Members	Medi-Cal
Revised	07/01/2001	EE.1112	Primary Care Physician Assignment to Members	Medi-Cal
Revised	05/01/2002	EE.1112	Primary Care Physician Assignment to Members	Medi-Cal
Revised	09/01/2002	EE.1112	Primary Care Physician Assignment to Members	Medi-Cal
Revised	07/01/2007	EE.1112	Primary Care Physician Assignment to Members	Medi-Cal
Revised	01/01/2009	EE.1112	Health Network Eligible Member Assignment to a PCP	Medi-Cal
Revised	07/01/2010	EE.1112	Health Network Eligible Member Assignment to a PCP	Medi-Cal
Revised	12/01/2012	EE.1112	Health Network Eligible Member Assignment to a PCP	Medi-Cal
Revised	09/01/2014	EE.1112	Health Network Eligible Member Assignment to a PCP	Medi-Cal
Revised	10/01/2015	EE.1112	Health Network Eligible Member Assignment to a PCP	Medi-Cal
Revised	09/01/2016	EE.1112	Health Network Eligible Member Assignment to a PCP	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	11/01/2017	EE.1112	Health Network Eligible Member Assignment to Primary Care Provider	Medi-Cal
Revised	09/06/2018	EE.1112	Health Network Eligible Member Assignment to Primary Care Provider	Medi-Cal

1

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009Δ: Access by Member's Personal Representative.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network; and 3. Ability to function as a Primary Care Provider (PCP).
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, California Code of Regulations (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.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
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.

Term	Definition
Health Network Eligible Member	A member who is eligible to choose a CalOptima Health Network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Non-Physician Medical Practitioner	A nurse midwife, physician's assistant, or nurse practitioner who provides primary care.
PCP Upload File	A file provided by Health Networks to CalOptima to report on Member Primary Care Provider (PCP) changes. A Health Network shall submit the PCP Upload File to CalOptima in the time, format, and manner specified by CalOptima.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Rural Health Clinic (RHC)	An entity defined in Title 22, California Code of Regulations, Section 51115.5.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.
~~Specialty Care Provider~~	~~A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.~~

1

Policy #: EE.1112
Title: **Health Network Eligible Member Assignment to Primary Care Provider**
Department: Network Operations
Section: Health Network Relations

CEO Approval: Michael Schrader _____

Effective Date: 10/01/95
Last Review Date: 09/06/18
Last Revised Date: 09/06/18

I. PURPOSE

This policy establishes the guidelines by which a Health Network shall assign and report a Health Network Member to a Primary Care Provider (PCP).

II. POLICY

A. A Health Network Eligible Member shall have a choice of PCP at the time the Member selects a Health Network for enrollment and may change his or her PCP within the CalOptima network on a monthly basis for any reason, in accordance with CalOptima Policy DD.2008: Health Network Selection Process.

1. A Member eligible for the California Children's Services (CCS) Program, or the Member's parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall have the right to request a specialist or clinic as a PCP if the specialist or clinic agrees to serve in a PCP role and is a CCS-paneled provider qualified to treat the required range of CCS-Eligible Conditions of the CCS child or youth, in accordance with CCS program rules and regulations.

2. An SPD Member shall have the right to request a specialist or Community Health Center as a PCP if the specialist or Community Health Center agrees to serve in the PCP role.

B. If a Member does not select a PCP at the time of Health Network selection, a Health Network shall assign such Member to a PCP within seven (7) calendar days after receipt of the eligibility file, and no later than forty-five (45) calendar days after the Member's enrollment with CalOptima.

C. A Health Network shall only assign a Member to a PCP who has been credentialed in accordance with CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners; and registered with CalOptima as a PCP by the Health Network.

D. Except for a Senior and Persons with Disabilities (SPD) Member, a Health Network shall assign a Member to a PCP, taking into consideration:

1. The geographic location of the PCP's office in relation to the Member's residence, in accordance with CalOptima Policy GG.1600: Access and Availability Standards;

2. The Member's language preference, if available; and

3. The Member's age.

E. For an SPD Member who does not select a PCP within thirty (30) calendar days of the effective date of enrollment with CalOptima, a Health Network shall use Fee-For-Service (FFS) utilization data provided by the Department of Health Care Services (DHCS) or other data sources, including electronic data, to establish existing Provider relationships for the purpose of PCP assignment, and shall comply with all state and federal privacy laws in the provision and use of data.

F. A Health Network shall make reasonable efforts to ensure that a Member expressing a desire to continue his or her existing relationship with a contracted PCP in the CalOptima network is assigned to such PCP.

G. A Member who selects or is assigned to a Community Health Center, such as a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), as his or her PCP:

1. Shall be assigned directly to the Community Health Center; and

2. Shall not be assigned to individual PCP performing services on behalf of the Community Health Center.

H. A Health Network shall notify the PCP that a Member has selected the PCP, or that the Health Network assigned the Member to the PCP, within ten (10) calendar days after completion of the selection or assignment.

I. A Health Network shall disclose to a Member the reason for which he or she could not select or be assigned to a specific PCP.

J. A Health Network shall notify CalOptima via the PCP Upload of a Member's assignment to a PCP, in accordance with Section III.C of this policy.

K. A Member may change his or her PCP monthly, for any reason, within his or her selected Health Network. The Health Network shall process a Health Network Eligible Member's request to change his or her PCP.

L. If a Health Network terminates a PCP, or a PCP terminates the contractual relationship with the Health Network, the Health Network shall assign a new PCP to a Member affected by the termination of his or her PCP within seven (7) calendar days after the effective date of the termination. A Health Network shall notify the affected Members, in writing, of the change of availability of Covered Services, in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

III. PROCEDURE

A. Primary Care Provider Selection

1. A Health Network Eligible Member shall have the opportunity to select a PCP at the time of Health Network selection during the first thirty (30) calendar days after enrollment/eligibility.

2. A Member shall have the right to select a Community Health Center or a Non-Physician Medical Practitioner. If a Member chooses a Non-Physician Medical Practitioner as his or her PCP, the Member shall be assigned directly to the supervising physician, and not the Non-Physician Medical Practitioner.

3. An SPD Member shall have the right to request a specialist or Community Health Center as a PCP if the specialist or Community Health Center agrees to serve in the PCP role.

4. A Member eligible for the California Children's Services (CCS) Program, or the Member's parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall have the right to request a specialist or clinic as a PCP if the specialist or clinic agrees to serve in a PCP role and is a CCS-paneled provider qualified to treat the required range of CCS-Eligible Conditions of the CCS child or youth.

B. Member Assignment to Primary Care Provider

1. If a Member selects a Health Network but does not select a PCP at the time of Health Network Selection, the Health Network shall assign the Member to a PCP within seven (7) calendar days after receipt of the eligibility file.

2. If a Member selects neither a Health Network nor a PCP at the time of Health Network selection, CalOptima shall:

a. Auto-assign the Member to a Health Network, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment; and

b. Defer the Member's assignment to a PCP to the assigned Health Network, except for a Member who is assigned directly to a Community Health Center.

c. The Health Network shall assign the Member to a PCP within seven (7) calendar days after receipt of the eligibility file.

C. A Health Network shall report Member assignments and changes of a PCP in the PCP Upload File.

D. A Health Network shall correct PCP Upload File errors within ten (10) calendar days of receipt.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
D. CalOptima Policy DD.2008: Health Network Selection Process
E. CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services
F. CalOptima Policy GG.1600: Access and Availability Standards
G. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
H. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program
I. PCP Upload File Submission Schedule
J. PCP Upload Submission Procedures
K. Title 22, California Code of Regulations (CCR), §55170

L. Welfare and Institutions Code, §§ 14087.325 and 14094.14

VI. REGULATORY AGENCY APPROVALS

A. 03/03/15: Department of Health Care Services
B. 02/24/13: Department of Health Care Services
C. 08/06/10: Department of Health Care Services
D. 11/25/09: Department of Health Care Services

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/01/1995	EE.1112	Primary Care Physician Assignment to Members	Medi-Cal
Revised	01/01/1996	EE.1112	Primary Care Physician Assignment to Members	Medi-Cal
Revised	07/01/2001	EE.1112	Primary Care Physician Assignment to Members	Medi-Cal
Revised	05/01/2002	EE.1112	Primary Care Physician Assignment to Members	Medi-Cal
Revised	09/01/2002	EE.1112	Primary Care Physician Assignment to Members	Medi-Cal
Revised	07/01/2007	EE.1112	Primary Care Physician Assignment to Members	Medi-Cal
Revised	01/01/2009	EE.1112	Health Network Eligible Member Assignment to a PCP	Medi-Cal
Revised	07/01/2010	EE.1112	Health Network Eligible Member Assignment to a PCP	Medi-Cal
Revised	12/01/2012	EE.1112	Health Network Eligible Member Assignment to a PCP	Medi-Cal
Revised	09/01/2014	EE.1112	Health Network Eligible Member Assignment to a PCP	Medi-Cal
Revised	10/01/2015	EE.1112	Health Network Eligible Member Assignment to a PCP	Medi-Cal
Revised	09/01/2016	EE.1112	Health Network Eligible Member Assignment to a PCP	Medi-Cal
Revised	11/01/2017	EE.1112	Health Network Eligible Member Assignment to Primary Care Provider	Medi-Cal
Revised	09/06/2018	EE.1112	Health Network Eligible Member Assignment to Primary Care Provider	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009Δ: Access by Member's Personal Representative.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network; and 3. Ability to function as a Primary Care Provider (PCP).
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, California Code of Regulations (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.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
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.

Term	Definition
Health Network Eligible Member	A member who is eligible to choose a CalOptima Health Network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Non-Physician Medical Practitioner	A nurse midwife, physician's assistant, or nurse practitioner who provides primary care.
PCP Upload File	A file provided by Health Networks to CalOptima to report on Member Primary Care Provider (PCP) changes. A Health Network shall submit the PCP Upload File to CalOptima in the time, format, and manner specified by CalOptima.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Rural Health Clinic (RHC)	An entity defined in Title 22, California Code of Regulations, Section 51115.5.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

1

Policy #: EE.1132
Title: **Bed Day Utilization Criteria for Physician Hospital Consortia**
Department: Network Operations
Section: Health Network Relations

CEO Approval: Michael Schrader _____

Effective Date: 01/01/08
Last Review Date: ~~11/01/17~~09/06/18
Last Revised Date: ~~11/01/17~~09/06/18

I. PURPOSE

This policy delineates criteria for a Health Network's continued participation in the CalOptima Medi-Cal program as a Physician Hospital Consortium (PHC) after June 30, 2009.

II. POLICY

A. Physician Hospital Consortium (PHC) is a physician group contractually aligned with at least one (1) hospital, as described in CalOptima's Health Network Service Agreement.

B. As of July 1, 2009, and unless otherwise approved by CalOptima Board Action, Health Networks participating as a PHC in the CalOptima Medi-Cal program shall be subject to this policy. Health Networks participating as a Pediatric PHC are excluded from the conditions of participation outlined in this policy.

C. To be considered for continued participation as a PHC in the CalOptima Medi-Cal program after June 30, 2009, a Health Network, except for a Pediatric PHC, shall demonstrate annually that it meets the following criteria:

1. The Health Network provides at least seventy percent (70%) of the hospital Bed Days for Covered Services provided to its Members at the Primary Hospital, an Affiliated Orange County System Hospital, or an Alternate Hospital, as described in Section III.B of this policy.

D. CalOptima's Enterprise Analytics Department shall calculate Bed Day utilization for contracted PHCs. Health Network Relations Department shall ~~calculate and~~ review a PHC's compliance with the seventy percent (70%) Bed Day threshold and shall provide an annual Bed Day summary report to each PHC.

E. The Primary Physician Group and Primary Hospital of a Health Network that meets the criteria set forth in Sections II.A and II.B of this policy may continue to participate in the CalOptima Medi-Cal program as a PHC.

F. CalOptima may terminate a Physician and Hospital contract in the event of non-compliance in accordance with Section III.C of this policy.

III. PROCEDURE

A. Calculation and Review of Bed Day Utilization for Compliance with the Seventy Percent (70%) Threshold:

1. CalOptima shall calculate and review a PHC's Bed Day utilization on an annual basis.

DRAFT

2. CalOptima shall limit the Bed Day threshold calculation to the following criteria:

   a. CalOptima shall only consider utilization in hospitals located in Orange County. CalOptima shall not consider utilization in a hospital that is located outside of Orange County for any part of the calculation.

   b. CalOptima shall only consider emergency room Bed Days, including emergency room Bed Days attributed to a California Children's Services (CCS)-Eligible Condition of a CCS-eligible Member at ~~primary hospitals~~Primary Hospitals and exclude emergency room Bed Days at ~~non-primary~~Non-Primary hospitals.

   c. CalOptima shall only consider Bed Days attributed to a CCS-Eligible Condition for CCS-eligible Members at Primary Hospitals and exclude CCS Bed Days at Non-Primary Hospitals.

   ~~c.~~d. CalOptima shall base utilization on paid emergency, urgent, elective, and other admission Encounters for the Medi-Cal Program only.

3. CalOptima shall calculate the Bed Day utilization using the previous year's data.

4. CalOptima shall only count acute Bed Days at the Primary Hospital, Affiliated Orange County System Hospital, or Alternate Hospital, as described in Section III.B of this policy, toward the seventy percent (70%) threshold.

B. CalOptima shall make the exception to allow the use of an Alternate Hospital under the following conditions:

1. The PHC shall select one (1) Alternate Hospital partner;

2. The PHC may divert less than ten percent (10%) of admissions to the Alternate Hospital partner; and

3. The PHC Hospital shall hold a contract directly with the Alternate Hospital. The Alternate Hospital shall meet payment and other contractual requirements and shall release CalOptima of all liability.

C. Annual Bed Day Summary Report

1. CalOptima shall provide an annual written notice to the Primary Physician Group and Primary Hospital of their continued PHC participating status no later than June of each calendar year.

2. A PHC not meeting the seventy percent (70%) Bed Day threshold shall have thirty (30) calendar days to comment or appeal the finding if the PHC disagrees with CalOptima's summary results.

   a. CalOptima shall review the PHC's submission and notify the PHC of its final determination within ten (10) calendar days after receipt of the submitted documentation.

   b. If, upon final review, CalOptima determines that a PHC Hospital does not meet the seventy percent (70%) Bed Day threshold, CalOptima shall terminate Physician and Hospital

contracts no sooner than one hundred twenty (120) calendar days after notification of non-compliance.

D. In the event of contract termination as a result of non-compliance, and if the Primary Physician Group wishes to continue to participate in the CalOptima Medi-Cal program, such Primary Physician Group may participate as a Shared Risk Group, subject to all applicable financial and operational criteria outlined in CalOptima policy. The Primary Physician Group shall transmit a signed CalOptima Medi-Cal Shared Risk Group agreement to CalOptima.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Health Network Service Agreement

VI. REGULATORY AGENCY APPROVALS

A. ~~May 2010~~05/28/10: Department of Health Care Services

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 02/04/10: ~~—~~Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 04/02/09: ~~—~~Regular M~~m~~eeting of the CalOptima Board of Directors
~~C.~~D. 06/05/07: ~~—~~Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2008	EE.1132	Bed Day Utilization Criteria for Physician Hospital Consortia	Medi-Cal
Revised	03/01/2010	EE.1132	Bed Day Utilization Criteria for Physician Hospital Consortia	Medi-Cal
Revised	11/01/2017	EE.1132	Bed Day Utilization Criteria for Physician Hospital Consortia	Medi-Cal
Revised	09/06/2018	EE.1132	Bed Day Utilization Criteria for Physician Hospital Consortia	Medi-Cal

IX. GLOSSARY

Term	Definition
Affiliated Orange County System Hospital	A hospital located in Orange County, California, that is owned directly through the same wholly-owned entity, as the Primary Hospital.
Alternate Hospital	For the purposes of this policy, a hospital, other than the PHC Primary Hospital, selected by and contracted directly with the PHC. The Alternate Hospital shall meet payment and other contractual requirements and shall release CalOptima of all liability.
Bed Day	For the purposes of this policy, a calculation of admission days as defined by CalOptima's Data Standard Workgroup and calculated by CalOptima's data warehouse.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.
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.
Health Network Service Agreement	The written agreement between CalOptima and a Health Network to provide Covered Services to Members.
Non-Primary Hospital	For the purposes of this policy, refers to any other hospital besides the primary hospital affiliated with a primary physician group contracted for services with CalOptima under a physician hospital consortium agreement.
Pediatric PHC	For the purposes of this policy, a PHC contracted with CalOptima whose membership is limited to persons under 21 years of age.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services.
Primary Hospital	A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).

Term	Definition
Primary Physician Group	A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

1

Policy #: EE.1132
Title: **Bed Day Utilization Criteria for Physician Hospital Consortia**
Department: Network Operations
Section: Health Network Relations

CEO Approval: Michael Schrader _____

Effective Date: 01/01/08
Last Review Date: 09/06/18
Last Revised Date: 09/06/18

I. PURPOSE

This policy delineates criteria for a Health Network's continued participation in the CalOptima Medi-Cal program as a Physician Hospital Consortium (PHC) after June 30, 2009.

II. POLICY

A. Physician Hospital Consortium (PHC) is a physician group contractually aligned with at least one (1) hospital, as described in CalOptima's Health Network Service Agreement.

B. As of July 1, 2009, and unless otherwise approved by CalOptima Board Action, Health Networks participating as a PHC in the CalOptima Medi-Cal program shall be subject to this policy. Health Networks participating as a Pediatric PHC are excluded from the conditions of participation outlined in this policy.

C. To be considered for continued participation as a PHC in the CalOptima Medi-Cal program after June 30, 2009, a Health Network, except for a Pediatric PHC, shall demonstrate annually that it meets the following criteria:

1. The Health Network provides at least seventy percent (70%) of the hospital Bed Days for Covered Services provided to its Members at the Primary Hospital, an Affiliated Orange County System Hospital, or an Alternate Hospital, as described in Section III.B of this policy.

D. CalOptima's Enterprise Analytics Department shall calculate Bed Day utilization for contracted PHCs. Health Network Relations Department shall review a PHC's compliance with the seventy percent (70%) Bed Day threshold and shall provide an annual Bed Day summary report to each PHC.

E. The Primary Physician Group and Primary Hospital of a Health Network that meets the criteria set forth in Sections II.A and II.B of this policy may continue to participate in the CalOptima Medi-Cal program as a PHC.

F. CalOptima may terminate a Physician and Hospital contract in the event of non-compliance in accordance with Section III.C of this policy.

III. PROCEDURE

A. Calculation and Review of Bed Day Utilization for Compliance with the Seventy Percent (70%) Threshold:

1. CalOptima shall calculate and review a PHC's Bed Day utilization on an annual basis.

DRAFT

2. CalOptima shall limit the Bed Day threshold calculation to the following criteria:

    a. CalOptima shall only consider utilization in hospitals located in Orange County. CalOptima shall not consider utilization in a hospital that is located outside of Orange County for any part of the calculation.

    b. CalOptima shall only consider emergency room Bed Days, including emergency room Bed Days attributed to a California Children's Services (CCS)-Eligible Condition of a CCS-eligible Member at Primary Hospitals and exclude emergency room Bed Days at Non-Primary hospitals.

    c. CalOptima shall only consider Bed Days attributed to a CCS-Eligible Condition for CCS-eligible Members at Primary Hospitals and exclude CCS Bed Days at Non-Primary Hospitals.

    d. CalOptima shall base utilization on paid emergency, urgent, elective, and other admission Encounters for the Medi-Cal Program only.

3. CalOptima shall calculate the Bed Day utilization using the previous year's data.

4. CalOptima shall only count acute Bed Days at the Primary Hospital, Affiliated Orange County System Hospital, or Alternate Hospital, as described in Section III.B of this policy, toward the seventy percent (70%) threshold.

B. CalOptima shall make the exception to allow the use of an Alternate Hospital under the following conditions:

1. The PHC shall select one (1) Alternate Hospital partner;

2. The PHC may divert less than ten percent (10%) of admissions to the Alternate Hospital partner; and

3. The PHC Hospital shall hold a contract directly with the Alternate Hospital. The Alternate Hospital shall meet payment and other contractual requirements and shall release CalOptima of all liability.

C. Annual Bed Day Summary Report

1. CalOptima shall provide an annual written notice to the Primary Physician Group and Primary Hospital of their continued PHC participating status no later than June of each calendar year.

2. A PHC not meeting the seventy percent (70%) Bed Day threshold shall have thirty (30) calendar days to comment or appeal the finding if the PHC disagrees with CalOptima's summary results.

    a. CalOptima shall review the PHC's submission and notify the PHC of its final determination within ten (10) calendar days after receipt of the submitted documentation.

    b. If, upon final review, CalOptima determines that a PHC Hospital does not meet the seventy percent (70%) Bed Day threshold, CalOptima shall terminate Physician and Hospital

contracts no sooner than one hundred twenty (120) calendar days after notification of non-compliance.

D. In the event of contract termination as a result of non-compliance, and if the Primary Physician Group wishes to continue to participate in the CalOptima Medi-Cal program, such Primary Physician Group may participate as a Shared Risk Group, subject to all applicable financial and operational criteria outlined in CalOptima policy. The Primary Physician Group shall transmit a signed CalOptima Medi-Cal Shared Risk Group agreement to CalOptima.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Health Network Service Agreement

VI. REGULATORY AGENCY APPROVALS

A. 05/28/10: Department of Health Care Services

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
B. 02/04/10: Regular Meeting of the CalOptima Board of Directors
C. 04/02/09: Regular Meeting of the CalOptima Board of Directors
D. 06/05/07: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2008	EE.1132	Bed Day Utilization Criteria for Physician Hospital Consortia	Medi-Cal
Revised	03/01/2010	EE.1132	Bed Day Utilization Criteria for Physician Hospital Consortia	Medi-Cal
Revised	11/01/2017	EE.1132	Bed Day Utilization Criteria for Physician Hospital Consortia	Medi-Cal
Revised	09/06/2018	EE.1132	Bed Day Utilization Criteria for Physician Hospital Consortia	Medi-Cal

IX. GLOSSARY

Term	Definition
Affiliated Orange County System Hospital	A hospital located in Orange County, California, that is owned directly through the same wholly-owned entity, as the Primary Hospital.
Alternate Hospital	For the purposes of this policy, a hospital, other than the PHC Primary Hospital, selected by and contracted directly with the PHC. The Alternate Hospital shall meet payment and other contractual requirements and shall release CalOptima of all liability.
Bed Day	For the purposes of this policy, a calculation of admission days as defined by CalOptima's Data Standard Workgroup and calculated by CalOptima's data warehouse.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.
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.
Health Network Service Agreement	The written agreement between CalOptima and a Health Network to provide Covered Services to Members.
Non-Primary Hospital	For the purposes of this policy, refers to any other hospital besides the primary hospital affiliated with a primary physician group contracted for services with CalOptima under a physician hospital consortium agreement.
Pediatric PHC	For the purposes of this policy, a PHC contracted with CalOptima whose membership is limited to persons under 21 years of age.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services.
Primary Hospital	A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).
Primary Physician Group	A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).

Term	Definition
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

1

Policy #:	GG.1401
Title:	**Pharmacy Authorization Process**
Department:	Medical Affairs
Section:	Pharmacy Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/96
Last Review Date:	~~07/01/01/181~~709/06/18
Last Revised Date:	~~07/01/01/181~~709/06/18

I. PURPOSE

This policy defines CalOptima's Pharmacy ~~Prior Authorization~~prior authorization process.

II. POLICY

A. CalOptima shall require ~~Prior Authorizationa~~ prior authorization (PA) for medications and supplies that:

1. Are not listed on the closed Formulary, also known as the approved drug list;

2. Are on the formulary but exceed Formulary limitations for quantity, refill frequency, or duration of therapy;

3. Do not meet on-line contingent therapy or Step-Therapy restrictions, as described on the Formulary; and/or

4. Are prescribed for clinical indications outside specified utilization management restrictions, as described on the Formulary.

B. CalOptima and its Pharmacy Benefit Manager (PBM) shall process requests for PA using the PA ~~definitions~~categorization, turn-around time, and notification standards as specified in Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy benefit.

C. Requests marked as urgent that do not meet the definition for expedited review shall be reclassified as routine requests as outlined in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy benefit.

D. CalOptima and its PBM shall maintain appropriate communication with the Prescribing Practitioner and/or Member or the Member's Authorized Representative throughout the PA process to facilitate delivery of appropriate services.

E. The PBM or CalOptima shall provide a written response ~~by facsimile to a PA request within twenty-four (24) hours after receipt of a PA request. A response may include:~~of approve, ~~defer~~modify, delay for Medical Necessity ~~information~~Information from the Prescribing Practitioner, ~~modify,~~ or deny to an authorization within twenty-four (24) hours after receipt of an expedited (preservice or concurrent) and standard request and thirty (30) calendar days for a retrospective request to the ~~request. However, only~~Prescribing Practitioner and Member. A decision to modify or deny shall be limited to a CalOptima pharmacist or Medical Director ~~may modify or deny a PA.~~

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F. In the event that all information reasonably necessary to make a determination was not received, CalOptima may extend the timeframe of an authorization request if the following are met:

~~E.~~1. For an expedited preservice request~~.~~ once, for forty-eight (48) hours, if CalOptima asks the Member, the Member's representative, or the Prescribing Provider for the specific information necessary to make the decision within twenty-four (24) hours of the receipt of the request;

2. For a standard preservice request once, for an additional fourteen (14) calendar days, if the Member or the Prescribing Practitioner requested for an extension, or CalOptima can provide justification upon request by the Department of Health Care Services (DHCS) the need for additional information and how it is in the Member's interest. If the extension was not requested by the Member, CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay. The Prescribing Provider shall be provided with an electronic Notice of Action (NOA) within twenty-four (24) hours of the decision and the member shall be given a written NOA within two (2) business days of the decision. The NOA shall include the reason for the extension, the additional information needed to render the decision, the type of expert needed to review, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. CalOptima shall send the NOA pursuant to Section III.G. of this Policy.

3. Upon receipt of all of the information reasonably necessary and requested by CalOptima, CalOptima shall approve, modify, or deny the request for Authorization within five (5) business days or seventy-two (72) hours for standard and expedited requests, respectively of the decision

~~F.~~G. Participating Pharmacies may dispense up to a ten (10) calendar day supply of the requested medication pending final decision of the PA, in accordance with CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies and CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply.

~~G.~~H. ~~Appropriately~~For appropriately prescribed pain management medications for terminally ill patients when Medically Necessary ~~shall be approved or denied~~CalOptima shall approve, modify, delay for information reasonably necessary to make a determination, or deny a PA in a timely fashion, appropriate for the nature of the Member's condition, and not to exceed seventy-two (72) hours of the CalOptima's receipt of the information requested by the plan to make the decision.

1. If the request is modified, denied, or ~~if additional~~ delay due to lack of information reasonably necessary to make a determination is required, CalOptima shall contact the provider within ~~one (1) working day~~ twenty-four (24) hours of the determination, with an explanation of the reason for the modification, denial or the need for additional information.

2. Only licensed physicians or health care professionals (competent to evaluate the clinical issues) make decisions to modify, deny, or delay (due to lack of information reasonably necessary to make a determination) a PA for pain management for terminally ill patients.

3. The requested treatment shall be deemed authorized as of the expiration of the applicable timeframe.

~~H.~~I. Newly enrolled Members may continue use of a covered benefit single-source drug which is part of a prescribed therapy in effect for the Member immediately prior to the date of enrollment, whether or not the drug is included on the Formulary, until the prescribed therapy is no longer prescribed by the Practitioner. PA may be required if the single-source drug is not on the Formulary.

J. Members determined eligible with the California Children's Services (CCS) program prior to January 1, 2019 and transitioned into the Whole Child Model program shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy for the Member's CCS-eligible condition or conditions immediately prior to the date of transition of responsibility for the Member's CCS services to CalOptima, whether or not the drug is included on the Formulary, without PA until the Member's prescribing CCS provider has completed an assessment of the child or youth, created a treatment plan, and decides that the particular medication is no longer Medically Necessary, or the medication is no longer prescribed by the Member's CCS provider.

~~I.~~K. CalOptima shall require the use of a U.S. Food and Drug Administration (FDA)-approved and nationally-marketed drugs, unless Medical Necessity can be established requiring the use of a compounded alternative. Compounded products may be dispensed only when an FDA-approved therapeutic equivalent does not exist in the marketplace or when the FDA-approved product does not meet the medical needs of the Member and a compound alternative is Medically Necessary.

~~J.~~L. CalOptima Pharmacy Management shall require generic substitution when an equivalent generic product is available for Members not meeting the following criteria ~~as listed in Section H.J.3. of this policy.~~:

1. CalOptima Pharmacy Management adheres to Title 22, S~~s~~ection 51003 of the California Code of Regulations: Authorization may be granted only for the lowest cost item or service covered by the program that meets the Member's medical needs.

2. CalOptima Pharmacy Management shall utilize the FDA bioequivalent ratings when requiring generic substitution. ~~-~~The FDA has rated all generic drugs "A" or "B."~~-~~ Only "A" rated products are considered bioequivalent and interchangeable to the brand-name equivalents by the FDA.

    a. The FDA ensures that generic drugs deliver the same amount of active ingredients in the same amount of time as the brand-name counterpart. ~~-~~For reformulations of a brand-name drug or generic versions of a drug, it reviews data showing the drug is bioequivalent to the one used in the original safety and efficacy testing. ~~-~~It requires generics to have the same quality, strength, purity, and stability as the brand name drugs. ~~-~~For these reasons, requests for brand versions should not be approved based on assumptions that there will be better efficacy or safety.

3. Prior authorization requests for use of a brand name product when a generic equivalent is available shall be considered for review when the following information is provided:

    a. Documentation from the Member's prescription profile or from the Prescribing Practitioner's progress notes that the Member has had a previous adequate trial of ~~at least two (2)~~available generic equivalents within one hundred eighty (180) calendar days of the request.

b. Documentation from the Member's prescription profile or from the Prescribing Practitioner's progress notes that the Member has had a previous adequate trial of therapeutic alternatives within one hundred eighty (180) calendar days of the request.

c. Medical justification of why the Member is unable to use the generic equivalent and cannot use an alternative therapeutic equivalent.

d. Documentation of a MedWatch form by the Prescribing Practitioner documenting the adverse event within the generic equivalent drug may be required.

e. In cases of severe shortages of generic versions due to manufacturer problems, the brand version may be approved on a temporary basis until the situation is resolved.

f. Certain drugs with a narrow therapeutic index do not require generic substitution for claims system adjudication. These drugs are listed in the CalOptima Approved Drug List.

~~K.~~M. Prior authorization decisions shall be classified as Medical Necessity and benefit (or administrative) requests. Post-service ~~Requests~~requests are excluded from the classification for Medical Necessity requests.

L. ~~For Prior Authorization requests when~~ If CalOptima fails to issue a ~~Notice of Action (~~NOA~~)~~ for Prior Authorization requests within the required time frame, it shall be considered a denial and shall constitute an Adverse Benefit Determination. The Member shall have the right to request ~~for~~ an Appeal in accordance with CalOptima Policy GG.1410: Appeals Process for Pharmacy Authorizations.

M. CalOptima Pharmacy Management shall review and update the CalOptima Prior Authorization guidelines when appropriate and, at a minimum, on an annual basis.

~~N. CalOptima shall ensure the Prior Authorization process for medications and supplies is consistently applied to medical/surgical, mental health, and substance use disorder medications and supplies.~~

~~1. Quantity limits and utilization management restrictions shall not be applied more stringently on mental health and substance abuse disorder drugs as compared to medical/surgical drugs.~~

~~2. Financial requirements or treatment limitations for mental health and substance abuse disorder drugs shall not be more restrictive than those applied to medical/surgical drugs.~~

III. PROCEDURE

A. A Prescribing Practitioner or a Participating Pharmacy representative shall submit a completed PA Form to the PBM, in accordance with the instructions on the form, or shall contact the PBM PA center by telephone. A Member or the Member's Authorized Representative may submit a ~~-~~PA by contacting CalOptima's Customer ~~Services~~Service Department or via the CalOptima website.

B. The PBM, on behalf of CalOptima, shall review and classify all pharmaceutical PA requests using the timelines specified in the Pharmacy Prior ~~-~~Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit, and based on the following:

1. Urgent Pre-service Request;

2. Urgent Concurrent Request;

3. Standard ~~request~~Request (non-urgent Pre-service Request); and

4. Post-service Request.

C. The PBM, on behalf of CalOptima, shall review all PA requests based on the Member's individual needs, in accordance with criteria established by the CalOptima PA guidelines for drug utilization review that are consistent with current medical practice and the Title 22, California Code of Regulations definition of Medical Necessity, and that have been approved by CalOptima's Pharmacy and Therapeutics (P&T) Committee. Requests shall also be evaluated by the PBM and CalOptima to consider the Member's condition, age, gender, Health Network (to ensure appropriate responsibility for coverage), place of residence, and for other payers or other insurance coverage. The PBM and CalOptima shall obtain all clinical information, relevant to a Member's care, to render a decision. The PBM's Pharmacy Technician and Clinical Pharmacist, and CalOptima's Pharmacy Technician, may only approve or defer a PA ~~-~~request. Requests that do not meet the CalOptima PA ~~guidelines~~Guidelines shall be reviewed by a CalOptima Clinical Pharmacist and/or Medical Director.

1. The PBM pharmacy technician, PBM pharmacist, a CalOptima pharmacy technician, or a CalOptima clinical pharmacist shall review all PA requests, except Post-service Requests, and render a response within twenty-four (24) hours after receipt of the PA. Concurrent urgent and Post-service Requests shall be reviewed by the PBM and CalOptima based on the timelines specified in the Pharmacy Prior ~~-~~Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

2. If the PA request has sufficient clinical information to meet the CalOptima PA guidelines, the PBM shall approve the PA and notify the Prescribing Practitioner and Participating Pharmacy representative by facsimile.

3. If the PA request has insufficient information to meet the CalOptima PA guidelines, the PBM shall defer the PA for additional Medical Necessity information and notify the Prescribing Practitioner and/or the Member's Participating Pharmacy by facsimile.

   a. The Prescribing Practitioner and/or the Member's Participating Pharmacy shall be notified of the deferral for requests with insufficient information. The notice shall include a reason for the deferral and date of when a response is needed to render a decision.

   b. If additional information is not received in the timeframe requested, the request shall be forwarded to CalOptima to modify the PA request to a Formulary alternative, delay due to missing information necessary to make a determination, or deny based on the timelines specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

4. If all information reasonably necessary is received and the information provided by the Prescribing Practitioner or Participating Pharmacy is insufficient for approval, the PBM's Pharmacist shall make recommendation to deny or modify to a Formulary alternative the PA request and shall forward the PA request to a CalOptima Pharmacist for review. CalOptima shall render a decision pursuant to timelines specified in the Pharmacy Prior Authorization and

Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

D. CalOptima shall notify the Member, the Member's Authorized Representative, if applicable, and Prescribing Practitioner, ~~in writing,~~ of any denial, delay, modification, termination, suspension, or reduction of the level of treatment or services currently underway, or medication carve out, ~~through~~in a written NOA, in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. The NOA shall be provided within the PA time frame as specified in the Pharmacy Prior Authorization and Appeals:~~-~~ Time frames for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

E. The written NOA shall contain information as required by applicable ~~State~~state and ~~Federal~~federal regulations~~,~~ and outlined in the CalOptima Policy GG.1507: ~~-~~Notification Requirements for Covered Service Requiring Prior Authorization. ~~-~~It shall also:

1. Describe the statement of action CalOptima is taking on the request~~.~~;

2. ~~Describe~~Clearly and concisely describe the specific reason(s) for the deny, modify, delay, termination, suspension, reduction of the level of treatment or services currently underway, or medication carve out decision in easy to understand language and provide a reference to the CalOptima ~~PA guidelines~~Pharmacy Prior Authorization Guidelines on which the decision was based;

3. Contain all of the following for decisions based in whole or in part on Medical Necessity:

~~3.~~a. Provide a description of the criteria or guidelines used ~~including~~to include a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guidelines;

~~4.~~b. Describe the clinical reasons for the decision and ~~explain~~ explicitly state how the Member's condition does not meet the criteria or guidelines;

~~5.~~4. Describe how the Member or Prescribing Practitioner can obtain the medication for PA requests that exceed the formulary quantity limit. CalOptima shall advise the Member or Prescribing Practitioner how to fill a prescription for a lesser quantity when a denial is made on the basis of quantity limit;

~~6.~~5. Describe how the Member or Prescribing Practitioner can obtain a formulary alternative on the CalOptima Approved Drug List without a PA;

~~7.~~6. Define how the Member and Prescribing Practitioner may request, free of charge, copies of all documents and records relevant to the NOA, including the actual benefit provision, guideline, protocol, or other criteria on which the decision was based;

~~8.~~7. Inform the Prescribing Practitioner of the availability of an appropriate Practitioner to discuss the denial and provide contact instructions;

~~9.~~8. Include the Member and Prescriber’s appeal rights, an explanation of the appeal process, and instructions on how to submit an appeal;

~~10.~~9. Explain that the Member or Prescribing Practitioner can provide written comments, documents, or other information to appeal the denial;

~~11.~~10. Include the name and direct telephone number of the decision maker on the Prescribing Practitioner notification; and

~~12.~~11. Include a "Your Rights" attachment, along with the nondiscrimination notice and language assistance taglines, as set forth in CalOptima Policy GG.1507: Notification Requirements for Covered Service Requiring Prior Authorization.

~~D.~~F. CalOptima shall communicate the ~~PA~~ decision to the Member, in writing, which shall be dated and postmarked within two (2) business days of the decision.

G. CalOptima shall notify the Prescribing Practitioner initially by facsimile, then in writing, except for decisions rendered retrospectively. The written notification shall be dated within ~~two (2) business days~~twenty-four (24) hours of the decision~~.~~.

H. In accordance with CalOptima Policy GG.1410: Appeals Process for Pharmacy Authorizations, a Prescribing Practitioner, Member, or Member's Authorized Representative may appeal any ~~request~~decision that involves the delay, modification, or denial of services based on Medical Necessity, termination, suspension, or reduction of the level of treatment or services currently under way, or a determination that the requested service was not a covered benefit within sixty (60) calendar days from the date on the NOA.

I. For ~~services that are terminated, suspended~~terminations, suspensions, or ~~are~~ reductions of previously authorized services, CalOptima shall notify Members at least ten (10) calendar days before the date of the action, with the exception of circumstances permitted under Title 42 of the Code of Federal Regulations (CFR), ~~Sections~~sections 431.213 and 431.214.

IV. ATTACHMENTS

A. Prior Authorization (PA) Form
B. Pharmacy Prior Authorization and Appeals:~~-~~ Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit
C. MedWatch F~~f~~orm

V. REFERENCES

A. 2017 NCQA Health Plan Accreditation-UM Standards
B. California Business and Professions Code, Section 4039
C. California Health and Safety Code section 1367.215(a)
D. California Welfare and Institutions Code, Sections 14185 and 14094.13 (d).
E. CalOptima Approved Drug List
F. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~A. 2017 NCQA Health Plan Accreditation-UM Standards~~
~~B. California Business and Professions Code, Section 4039~~
~~C. California Health and Safety Code section 1367.215(a)~~
~~D. California Welfare and Institutions Code, Section~~Sections ~~14185~~ and ~~14094.13 (d).~~
~~E. CalOptima Approved Drug List~~

~~F.~~G. CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies
~~G.~~H. CalOptima Policy GG.1410: Appeals Process for Pharmacy Authorizations
I. CalOptima Policy GG.1507: Notification Requirements for Covered Service Requiring Prior Authorization
~~H.~~J. CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply
~~I.~~K. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments~~.~~
L. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program
~~J.~~M. Department of Health Care Services (DHCS) Policy Letter (PL) 14-002: Requirement to Use Food and Drug Administration Approved Drugs, Rather Than Compounded Alternatives.
~~K.~~N. Title 22, California Code of Regulations, §§ 51003 and 51303
~~L.~~O. Title 42, California Code of ~~Federal~~ Regulations, §§ 431.213~~, 431.~~214~~,~~ and 438.910(b~~))~~.

VI. REGULATORY AGENCY APPROVALS

~~A. 01/25/18: Department of Health Care Services~~
~~B.~~A. 08/09/16: Department of Health Care Services
~~C.~~B. 04/19/16: Department of Health Care Services
~~D.~~C. 11/10/15: Department of Health Care Services
~~E.~~D. 07/23/14: Department of Health Care Services

VII. BOARD ACTIONS

A. 08/06/18: Regular Meeting of the CalOptima Board of Directors~~Not Applicable~~

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/1996	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	03/01/1999	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	05/01/1999	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	01/01/2001	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	03/01/2002	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	08/01/2003	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	04/01/2007	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	07/01/2011	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	01/01/2013	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	01/01/2014	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	05/01/2014	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	03/01/2015	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	10/01/2015	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	02/01/2016	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	06/01/2016	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	12/01/2016	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	07/01/2017	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	09/06/2018	GG.1401	Pharmacy Authorization Process	Medi-Cal
~~Revised~~	~~01/01/2018~~	~~GG.1401~~	~~Pharmacy Authorization Process~~	~~Medi-Cal~~

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IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access by Member's ~~Authorized~~Personal Representative.
Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Concurrent Request	A request for coverage of pharmaceutical services made while a Member is in the process of receiving the requested pharmaceutical services, even if the organization did not previously approve the earlier care.
Formulary	The approved list of outpatient medications, medical supplies and devices, and the Utilization and Contingent Therapy Protocols as approved by the CalOptima Pharmacy & Therapeutics (P&T) Committee for prescribing to Members without the need for Prior Authorization.
Grievance	An oral or written expression of dissatisfaction with any aspect of the CalOptima program, other than an Adverse Benefit Determination.
Health Risk Assessment	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.
Individual Care Plan	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Participating Pharmacy	Any pharmacy that is credentialed by and subcontracted to the Pharmacy Benefit Manager (PBM) for the specific purpose of providing pharmacy services to Members
Pharmacy Benefits Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Post-service Request	A request for coverage of pharmaceutical services that have been received by a Member, e.g., retrospective review.
Prescribing Practitioner	The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a Member.
Pre-service Request	A request for coverage of pharmaceutical services that CalOptima must approve in advance, in whole or in part.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.

Term	Definition
Step-Therapy	A utilization management process which requires a trial of a first-line formulary medication prior to receiving the second-line medication. If it is Medically Necessary for a Member to use the medication as initial therapy, the prescriber can request coverage by submitting a prior authorization request.
Urgent Request (Pharmacy)	A request for pharmaceutical services where application of the time frame for making routine or non-life-~~-~~threatening care determinations: 1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or 2. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

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Policy #:	GG.1401
Title:	**Pharmacy Authorization Process**
Department:	Medical Affairs
Section:	Pharmacy Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/96
Last Review Date:	09/06/18
Last Revised Date:	09/06/18

I. PURPOSE

This policy defines CalOptima's Pharmacy prior authorization process.

II. POLICY

A. CalOptima shall require a prior authorization (PA) for medications and supplies that:

1. Are not listed on the closed Formulary, also known as the approved drug list;

2. Are on the formulary but exceed Formulary limitations for quantity, refill frequency, or duration of therapy;

3. Do not meet on-line contingent therapy or Step-Therapy restrictions, as described on the Formulary; and/or

4. Are prescribed for clinical indications outside specified utilization management restrictions, as described on the Formulary.

B. CalOptima and its Pharmacy Benefit Manager (PBM) shall process requests for PA using the PA categorization, turn-around time, and notification standards as specified in Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy benefit.

C. Requests marked as urgent that do not meet the definition for expedited review shall be reclassified as routine requests as outlined in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy benefit.

D. CalOptima and its PBM shall maintain appropriate communication with the Prescribing Practitioner and/or Member or the Member's Authorized Representative throughout the PA process to facilitate delivery of appropriate services.

E. The PBM or CalOptima shall provide a written response of approve, modify, delay for Medical Necessity Information from the Prescribing Practitioner, or deny to an authorization within twenty-four (24) hours after receipt of an expedited (preservice or concurrent) and standard request and thirty (30) calendar days for a retrospective request to the Prescribing Practitioner and Member. A decision to modify or deny shall be limited to a CalOptima pharmacist or Medical Director.

F. In the event that all information reasonably necessary to make a determination was not received, CalOptima may extend the timeframe of an authorization request if the following are met:

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1. For an expedited preservice request once, for forty-eight (48) hours, if CalOptima asks the Member, the Member's representative, or the Prescribing Provider for the specific information necessary to make the decision within twenty-four (24) hours of the receipt of the request;

2. For a standard preservice request once, for an additional fourteen (14) calendar days, if the Member or the Prescribing Practitioner requested for an extension, or CalOptima can provide justification upon request by the Department of Health Care Services (DHCS) the need for additional information and how it is in the Member's interest. If the extension was not requested by the Member, CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay. The Prescribing Provider shall be provided with an electronic Notice of Action (NOA) within twenty-four (24) hours of the decision and the member shall be given a written NOA within two (2) business days of the decision. The NOA shall include the reason for the extension, the additional information needed to render the decision, the type of expert needed to review, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. CalOptima shall send the NOA pursuant to Section III.G. of this Policy.

3. Upon receipt of all of the information reasonably necessary and requested by CalOptima, CalOptima shall approve, modify, or deny the request for Authorization within five (5) business days or seventy-two (72) hours for standard and expedited requests, respectively of the decision

G. Participating Pharmacies may dispense up to a ten (10) calendar day supply of the requested medication pending final decision of the PA, in accordance with CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies and CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply.

H. For appropriately prescribed pain management medications for terminally ill patients when Medically Necessary CalOptima shall approve, modify, delay for information reasonably necessary to make a determination, or deny a PA in a timely fashion, appropriate for the nature of the Member's condition, and not to exceed seventy-two (72) hours of the CalOptima's receipt of the information requested by the plan to make the decision.

1. If the request is modified, denied, or delay due to lack of information reasonably necessary to make a determination is required, CalOptima shall contact the provider within twenty-four (24) hours of the determination, with an explanation of the reason for the modification, denial or the need for additional information.

2. Only licensed physicians or health care professionals (competent to evaluate the clinical issues) make decisions to modify, deny, or delay (due to lack of information reasonably necessary to make a determination) a PA for pain management for terminally ill patients.

3. The requested treatment shall be deemed authorized as of the expiration of the applicable timeframe.

I. Newly enrolled Members may continue use of a covered benefit single-source drug which is part of a prescribed therapy in effect for the Member immediately prior to the date of enrollment, whether or not the drug is included on the Formulary, until the prescribed therapy is no longer prescribed by the Practitioner. PA may be required if the single-source drug is not on the Formulary.

J. Members determined eligible with the California Children's Services (CCS) program prior to January 1, 2019 and transitioned into the Whole Child Model program shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy for the Member's CCS-eligible condition or conditions immediately prior to the date of transition of responsibility for the Member's CCS services to CalOptima, whether or not the drug is included on the Formulary, without PA until the Member's prescribing CCS provider has completed an assessment of the child or youth, created a treatment plan, and decides that the particular medication is no longer Medically Necessary, or the medication is no longer prescribed by the Member's CCS provider.

K. CalOptima shall require the use of a U.S. Food and Drug Administration (FDA)-approved and nationally-marketed drugs, unless Medical Necessity can be established requiring the use of a compounded alternative. Compounded products may be dispensed only when an FDA-approved therapeutic equivalent does not exist in the marketplace or when the FDA-approved product does not meet the medical needs of the Member and a compound alternative is Medically Necessary.

L. CalOptima Pharmacy Management shall require generic substitution when an equivalent generic product is available for Members not meeting the following criteria:

1. CalOptima Pharmacy Management adheres to Title 22, Section 51003 of the California Code of Regulations: Authorization may be granted only for the lowest cost item or service covered by the program that meets the Member's medical needs.

2. CalOptima Pharmacy Management shall utilize the FDA bioequivalent ratings when requiring generic substitution. The FDA has rated all generic drugs "A" or "B." Only "A" rated products are considered bioequivalent and interchangeable to the brand-name equivalents by the FDA.

    a. The FDA ensures that generic drugs deliver the same amount of active ingredients in the same amount of time as the brand-name counterpart. For reformulations of a brand-name drug or generic versions of a drug, it reviews data showing the drug is bioequivalent to the one used in the original safety and efficacy testing. It requires generics to have the same quality, strength, purity, and stability as the brand name drugs. For these reasons, requests for brand versions should not be approved based on assumptions that there will be better efficacy or safety.

3. Prior authorization requests for use of a brand name product when a generic equivalent is available shall be considered for review when the following information is provided:

    a. Documentation from the Member's prescription profile or from the Prescribing Practitioner's progress notes that the Member has had a previous adequate trial of available generic equivalents within one hundred eighty (180) calendar days of the request.

    b. Documentation from the Member's prescription profile or from the Prescribing Practitioner's progress notes that the Member has had a previous adequate trial of therapeutic alternatives within one hundred eighty (180) calendar days of the request.

    c. Medical justification of why the Member is unable to use the generic equivalent and cannot use an alternative therapeutic equivalent.

d. Documentation of a MedWatch form by the Prescribing Practitioner documenting the adverse event within the generic equivalent drug may be required.

e. In cases of severe shortages of generic versions due to manufacturer problems, the brand version may be approved on a temporary basis until the situation is resolved.

f. Certain drugs with a narrow therapeutic index do not require generic substitution for claims system adjudication. These drugs are listed in the CalOptima Approved Drug List.

M. Prior authorization decisions shall be classified as Medical Necessity and benefit (or administrative) requests. Post-service requests are excluded from the classification for Medical Necessity requests.

L. If CalOptima fails to issue a NOA for Prior Authorization requests within the required time frame, it shall be considered a denial and shall constitute an Adverse Benefit Determination. The Member shall have the right to request an Appeal in accordance with CalOptima Policy GG.1410: Appeals Process for Pharmacy Authorizations.

M. CalOptima Pharmacy Management shall review and update the CalOptima Prior Authorization guidelines when appropriate and, at a minimum, on an annual basis.

III. PROCEDURE

A. A Prescribing Practitioner or a Participating Pharmacy representative shall submit a completed PA Form to the PBM, in accordance with the instructions on the form, or shall contact the PBM PA center by telephone. A Member or the Member's Authorized Representative may submit a PA by contacting CalOptima's Customer Service Department or via the CalOptima website.

B. The PBM, on behalf of CalOptima, shall review and classify all pharmaceutical PA requests using the timelines specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit, and based on the following:

1. Urgent Pre-service Request;

2. Urgent Concurrent Request;

3. Standard Request (non-urgent Pre-service Request); and

4. Post-service Request.

C. The PBM, on behalf of CalOptima, shall review all PA requests based on the Member’s individual needs, in accordance with criteria established by the CalOptima PA guidelines for drug utilization review that are consistent with current medical practice and the Title 22, California Code of Regulations definition of Medical Necessity, and that have been approved by CalOptima’s Pharmacy and Therapeutics (P&T) Committee. Requests shall also be evaluated by the PBM and CalOptima to consider the Member’s condition, age, gender, Health Network (to ensure appropriate responsibility for coverage), place of residence, and for other payers or other insurance coverage. The PBM and CalOptima shall obtain all clinical information, relevant to a Member’s care, to render a decision. The PBM’s Pharmacy Technician and Clinical Pharmacist, and CalOptima’s Pharmacy Technician, may only approve or defer a PA request. Requests that do not meet the

CalOptima PA Guidelines shall be reviewed by a CalOptima Clinical Pharmacist and/or Medical Director.

1. The PBM pharmacy technician, PBM pharmacist, a CalOptima pharmacy technician, or a CalOptima clinical pharmacist shall review all PA requests, except Post-service Requests, and render a response within twenty-four (24) hours after receipt of the PA. Concurrent urgent and Post-service Requests shall be reviewed by the PBM and CalOptima based on the timelines specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

2. If the PA request has sufficient clinical information to meet the CalOptima PA guidelines, the PBM shall approve the PA and notify the Prescribing Practitioner and Participating Pharmacy representative by facsimile.

3. If the PA request has insufficient information to meet the CalOptima PA guidelines, the PBM shall defer the PA for additional Medical Necessity information and notify the Prescribing Practitioner and/or the Member's Participating Pharmacy by facsimile.

    a. The Prescribing Practitioner and/or the Member's Participating Pharmacy shall be notified of the deferral for requests with insufficient information. The notice shall include a reason for the deferral and date of when a response is needed to render a decision.

    b. If additional information is not received in the timeframe requested, the request shall be forwarded to CalOptima to modify the PA request to a Formulary alternative, delay due to missing information necessary to make a determination, or deny based on the timelines specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

4. If all information reasonably necessary is received and the information provided by the Prescribing Practitioner or Participating Pharmacy is insufficient for approval, the PBM's Pharmacist shall make recommendation to deny or modify to a Formulary alternative the PA request and shall forward the PA request to a CalOptima Pharmacist for review. CalOptima shall render a decision pursuant to timelines specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

D. CalOptima shall notify the Member, the Member's Authorized Representative, if applicable, and Prescribing Practitioner, of any denial, delay, modification, termination, suspension, or reduction of the level of treatment or services currently underway, or medication carve out, in a written NOA, in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. The NOA shall be provided within the PA time frame as specified in the Pharmacy Prior Authorization and Appeals: Time frames for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

E. The written NOA shall contain information as required by applicable state and federal regulations and outlined in the CalOptima Policy GG.1507: Notification Requirements for Covered Service Requiring Prior Authorization. It shall also:

1. Describe the statement of action CalOptima is taking on the request;

2. Clearly and concisely describe the specific reason(s) for the deny, modify, delay, termination, suspension, reduction of the level of treatment or services currently underway, or medication carve out decision in easy to understand language and provide a reference to the CalOptima Pharmacy Prior Authorization Guidelines on which the decision was based;

3. Contain all of the following for decisions based in whole or in part on Medical Necessity:

   a. Provide a description of the criteria or guidelines used to include a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guidelines;

   b. Describe the clinical reasons for the decision and explicitly state how the Member's condition does not meet the criteria or guidelines;

4. Describe how the Member or Prescribing Practitioner can obtain the medication for PA requests that exceed the formulary quantity limit. CalOptima shall advise the Member or Prescribing Practitioner how to fill a prescription for a lesser quantity when a denial is made on the basis of quantity limit;

5. Describe how the Member or Prescribing Practitioner can obtain a formulary alternative on the CalOptima Approved Drug List without a PA;

6. Define how the Member and Prescribing Practitioner may request, free of charge, copies of all documents and records relevant to the NOA, including the actual benefit provision, guideline, protocol, or other criteria on which the decision was based;

7. Inform the Prescribing Practitioner of the availability of an appropriate Practitioner to discuss the denial and provide contact instructions;

8. Include the Member and Prescriber’s appeal rights, an explanation of the appeal process, and instructions on how to submit an appeal;

9. Explain that the Member or Prescribing Practitioner can provide written comments, documents, or other information to appeal the denial;

10. Include the name and direct telephone number of the decision maker on the Prescribing Practitioner notification; and

11. Include a "Your Rights" attachment, along with the nondiscrimination notice and language assistance taglines, as set forth in CalOptima Policy GG.1507: Notification Requirements for Covered Service Requiring Prior Authorization.

F. CalOptima shall communicate the decision to the Member, in writing, which shall be dated and postmarked within two (2) business days of the decision.

G. CalOptima shall notify the Prescribing Practitioner initially by facsimile, then in writing, except for decisions rendered retrospectively. The written notification shall be dated within twenty-four (24) hours of the decision.

H. In accordance with CalOptima Policy GG.1410: Appeals Process for Pharmacy Authorizations, a Prescribing Practitioner, Member, or Member's Authorized Representative may appeal any decision that involves the delay, modification, or denial of services based on Medical Necessity, termination, suspension, or reduction of the level of treatment or services currently under way, or a determination that the requested service was not a covered benefit within sixty (60) calendar days from the date on the NOA.

I. For terminations, suspensions, or reductions of previously authorized services, CalOptima shall notify Members at least ten (10) calendar days before the date of the action, with the exception of circumstances permitted under Title 42 of the Code of Federal Regulations (CFR), sections 431.213 and 431.214.

IV. ATTACHMENTS

A. Prior Authorization (PA) Form
B. Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit
C. MedWatch Form

V. REFERENCES

A. 2017 NCQA Health Plan Accreditation-UM Standards
B. California Business and Professions Code, Section 4039
C. California Health and Safety Code section 1367.215(a)
D. California Welfare and Institutions Code, Sections 14185 and 14094.13 (d).
E. CalOptima Approved Drug List
F. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies
H. CalOptima Policy GG.1410: Appeals Process for Pharmacy Authorizations
I. CalOptima Policy GG.1507: Notification Requirements for Covered Service Requiring Prior Authorization
J. CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
L. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program
M. Department of Health Care Services (DHCS) Policy Letter (PL) 14-002: Requirement to Use Food and Drug Administration Approved Drugs, Rather Than Compounded Alternatives.
N. Title 22, California Code of Regulations, §§ 51003 and 51303
O. Title 42, California Code of Regulations, §§ 431.213-214 and 438.910(b).

VI. REGULATORY AGENCY APPROVALS

A. 08/09/16: Department of Health Care Services
B. 04/19/16: Department of Health Care Services
C. 11/10/15: Department of Health Care Services
D. 07/23/14: Department of Health Care Services

VII. BOARD ACTIONS

A. 08/06/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/1996	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	03/01/1999	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	05/01/1999	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	01/01/2001	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	03/01/2002	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	08/01/2003	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	04/01/2007	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	07/01/2011	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	01/01/2013	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	01/01/2014	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	05/01/2014	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	03/01/2015	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	10/01/2015	GG.1401	Pharmacy Authorization Process	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	02/01/2016	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	06/01/2016	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	12/01/2016	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	07/01/2017	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	09/06/2018	GG.1401	Pharmacy Authorization Process	Medi-Cal

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IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access by Member's Personal Representative.
Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Concurrent Request	A request for coverage of pharmaceutical services made while a Member is in the process of receiving the requested pharmaceutical services, even if the organization did not previously approve the earlier care.
Formulary	The approved list of outpatient medications, medical supplies and devices, and the Utilization and Contingent Therapy Protocols as approved by the CalOptima Pharmacy & Therapeutics (P&T) Committee for prescribing to Members without the need for Prior Authorization.
Grievance	An oral or written expression of dissatisfaction with any aspect of the CalOptima program, other than an Adverse Benefit Determination.
Health Risk Assessment	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.
Individual Care Plan	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Participating Pharmacy	Any pharmacy that is credentialed by and subcontracted to the Pharmacy Benefit Manager (PBM) for the specific purpose of providing pharmacy services to Members
Pharmacy Benefits Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Post-service Request	A request for coverage of pharmaceutical services that have been received by a Member, e.g., retrospective review.
Prescribing Practitioner	The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a Member.
Pre-service Request	A request for coverage of pharmaceutical services that CalOptima must approve in advance, in whole or in part.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.

Term	Definition
Step-Therapy	A utilization management process which requires a trial of a first-line formulary medication prior to receiving the second-line medication. If it is Medically Necessary for a Member to use the medication as initial therapy, the prescriber can request coverage by submitting a prior authorization request.
Urgent Request (Pharmacy)	A request for pharmaceutical services where application of the time frame for making routine or non-life-threatening care determinations: 1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or 2. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Submit requests to the Authorization Center at:

	PA Fax	Appeal Fax	Call
Medi-Cal / CalWrap Authorization	858-357-2557	714-954-2280	888-807-5705
OneCare HMO SNP (Medicare Part D)	858-357-2556	858-357-2556	800-819-5532
OneCare Connect (Medicare-Medicaid)	858-357-2556	858-357-2556	800-819-5480

Request Type ☐New ☐Renewal ☐Retroactive ☐Appeal	**Call 888-807-5705** for an override if the request is for: ▪ Hospital discharge medication less than 10 days supply **OR** ▪ LTC admission less than 14 days supply for brands or generic less than 30 days supply

PATIENT INFORMATION	**PRESCRIBER INFORMATION**
Patient Name: _____ Patient CalOptima ID #: _____ Gender: ☐Male ☐Female DOB: _____ Other Primary Insurance? ☐Yes ☐No ☐Unknown Name of Primary Insurance: _____	Prescriber Name: _____ Prescriber Phone #: _____ Prescriber Fax #: _____ Prescriber Specialty: _____ Prescriber NPI #: _____ Prescriber Signature: _____

For Medicare Part D, an enrollee, an enrollee's representative, or an enrollee's prescribing physician or other prescriber may request a coverage determination

PATIENT LOCATION INFORMATION	**PHARMACY INFORMATION**
Patient Location: ☐Home ☐B&C ☐Sub-Acute ☐SNF ☐ICF Name of Facility: _____ Facility Phone #: _____	Pharmacy Name: _____ Pharmacy NPI #: _____ Pharmacy Phone #: _____ Pharmacy Fax #: _____

☐ Urgent*

***The prescriber attests that applying the standard turn-around time could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request. Post service requests are not urgent.**

MEDICATION	**STRENGTH**	**DIRECTIONS**	**QUANTITY**
Drug Name: _____ NDC#: _____			

MEDICAL INFORMATION

What is the diagnosis? _____ **OR** ICD-10 code: _____

New Therapy? ☐Yes ☐No # Refills? _____

Medical Justification Supporting Statement *(include formulary drugs that have been tried, why the requested drug is medically required, and why formulary drugs would not be appropriate).* If applicable, include dates and reason for retroactive authorization requests.

The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member elig bility. Authorization does not guarantee payment.

Confidential information

Fax is intended only for the individual to whom it is addressed.

If you are not the intended, do not read, copy, or distribute this information. Thank You.

Back to Agenda

Attachment B (for GG.1401 and GG.1410):
Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Prior Authorization		Notification Timeframe
Type of Request	**Decision**	**Notice of Action (NOA): Practitioner and Member***
Standard (Non-urgent) Preservice - All necessary information received at time of initial request	A decision to approve, modify, or deny is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1,2].	- **Practitioner:** Within 24 hours ~~business days~~ of ~~making~~ the decision[2] (electronic and written notification) - **Member:** ~~-~~Within 2 business days of ~~making~~ the decision[2] (written notification)
Standard (Non-urgent) Preservice - Extension Needed - Additional clinical information required - Requires consultation by an Expert Reviewer - Additional examination or tests to be performed - [AKA: Deferral or Request for Information (RFI)]	- A response to defer is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 5 working days of receiving the additional information but no longer than 14 calendar days, upon receipt of the information reasonably necessary to render a decision. - The Plan may extend the standard preservice time frame due to a lack of information, for an additional 14 calendar days, under the following conditions: ~~-~~ ▪ The Member or the Member's provider may request for an extension, or ~~the Health Plan/ Provider Group~~the Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest[3,6]. ~~-~~ ▪ ~~Notice of deferral~~ The Delay notice ~~should~~ shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. - Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such[2].	- **Practitioner:** ~~-~~Within 24 hours of~~2 business days of making~~ the decision[2], not to exceed 14 calendar days from the receipt of the request ~~for service~~[3] (electronic and written notification) - **Member:** ~~-~~Within 2 business days of making the decision[2], not to exceed 14 calendar days from the receipt of the request ~~for service~~[3] (written notification) - **Note:** CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay.

Expedited (Urgent) Pre-Service - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. - All necessary information received at time of initial request	- A decision to approve, modify, or deny is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1]. - **Expedited (Urgent) Pre-Service** may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[4].	- **Practitioner:** Within 24 hours of the decision[2] ~~Within 2 business days of making the decision[2,3]~~ (electronic and written notification) - **Member:** Within 24 hours of the decision[2] ~~Within 2 business days of making the decision[2,4]~~ (written notification)

Attachment B (for GG.1401 and GG.1410):
Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Prior Authorization		Notification Timeframe
Type of Request	**Decision**	~~NABD~~ Notice of Action (NOA) Notification: Practitioner and Member
Expedited (Urgent) Pre-Service - Extension Needed - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function[2,4]. - Additional clinical information required - [AKA: Deferral or Request for Information (RFI)]	- A response to defer is required within 24 hours for all drugs that require prior authorization, in accordance to Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 72 hours of initial receipt of the request[2,4]. - The Plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions: ▪ Within 24 hours of receipt of the urgent preservice request, the Plan asks the member, the member's representative, or provider for the specific information necessary to make the decision. ▪ The Plan gives the member or member's authorized representative at least 48 hours to provide the information. ▪ The extension period, within which a decision must be made by the Plan, begins: • On the date when the Plan receives the member's response (even if not all of the information is provided), ***or*** • At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative.[3] - **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[2,4]. - The Member or the Member's provider may request for an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. - Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. - Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such[2].	- **Practitioner and Member:** Within 24 hours of the decision[2] but no later than~~2 business days of making the decision2~~72 hours from receipt of information that is reasonably necessary to make a determination~~ hours from the receipt of the request~~[3] (electronic and written notification) - **Member:** Within 2 business days of ~~making~~ the decision[2] but no later than 72 hours ~~from the receipt of the request~~from receipt of information that is reasonably necessary to make a determination[3] (written notification) - **Note:** CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay.

Attachment B (for GG.1401 and GG.1410):
Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Concurrent review of treatment regimen already in place - A request for coverage of pharmaceutical services made while a member is in the process of receiving the requested pharmaceutical services, even if the organization did not previously approve the earlier care.	- A response to defer is required within 24 hours for all drugs that require prior authorization in accordance to Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 72 hours, or as soon as a Member's health condition requires, after the receipt of the request, in accordance to NCQA ~~UM 5:~~ Timeliness of UM decision, ~~Element E: Timeliness of Pharmacy UM Decisions, 2016 HP Accreditation UM Standards~~[2,4]3]. - If the plan is unable to request for an extension of an urgent concurrent care within 24 hours **before the expiration of the prescribed period of time or number of treatments**, then the organization may treat the request as urgent preservice and make a decision within 72 hours[2]. - The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny[2].	- **Practitioner:** Within 24 hours of making the decision[2,3] (electronic and written notification) - **Member:** Within 24 hours of making the decision[2,3] (written notification)
Post-Services / Retrospective Review	▪ A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request[2,4].	- **Practitioner:** Within ~~30~~ 24 hours of making the decision ~~days of the receipt of the request~~[2,3,2] but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination ~~30 days from the receipt of the reques~~t[2,3]3] (written notification) - **Member:** Within ~~30~~ 2 business days of ~~making~~ the decision[2] but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination ~~30 days from the receipt of the request~~[3] ~~the receipt of the request~~[2,3] (written notification)

Appeals Time period to file an appeal: within 60 days of the initial denial decision[5,6]		**Notice of Appeal Resolution (NAR)** **Notification Timeframe**
Type of Request	**Decision**	**Practitioner and Member**
Routine (Standard) Preservice Appeal	A decision to approve, modify, or deny is required within 30 calendar days of the initial receipt of the request[5].	- **Practitioner:** Within 30 calendar days ~~of making the~~ from the receipt of the request ~~decision~~[5] (electronic & written notification) - **Member:** Within 30 of receipt of the request~~days of making the decision~~[5] (written notification)

Attachment B (for GG.1401 and GG.1410):
Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Expedited (Urgent) Pre-Service Appeal - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function[2,4].	- A decision to approve, modify, or deny is required within 72 hours of receiving the additional information, or as soon as a Member's health condition requires, after receipt of the request[5]. The Plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions: ▪ Within 24 hours of receipt of the urgent preservice request, the Plan asks the member or the member's representative for the specific information necessary to make the decision. ▪ The Plan gives the member or member's authorized representative at least 48 hours to provide the information. ▪ The extension period, within which a decision must be made by the Plan, begins: • On the date when the Plan receives the member's response (even if not all of the information is provided), ***or*** • At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative[5]. - **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[2,4].	- **Practitioner:** Within 72 hours ~~from the receipt of the request of making the decision[5]~~ of the decision (electronic & written notification)[5] - **Member:** Within 72 hours ~~from the receipt of the request of making the decision[5]~~ of the decision (oral and written notification)[5]
Postservice Appeal	A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request[5].	- **Practitioner:** Within 30 calendar days of the receipt of information that is reasonably necessary to make this determination[2] ~~days from the receipt of the request of making the decision[5]~~ (electronic & written notification) - **Member:** Within 30 calendar days of the receipt of information that is reasonably necessary to make this determination[2] ~~from the receipt of the request of making the decision[5]~~ (written notification).

Attachment B (for GG.1401 and GG.1410):
Pharmacy Prior Authorization and Appeals: -Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

*Decisions to approve, modify, or deny are communicated to the requesting provider; decisions resulting in denial, delay, or modification are communicated to the member.

References:

1. Welfare and Institutions Code section 14185(a)(1) ~~accessed at: http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=7.&article=5.6~~.
2. California Health and Safety Code Sections (HSC) 1367.01(h)
3. UM 5: -Timeliness of UM decision, Element ~~F~~E: Notification of Pharmacy Decisions, 201~~6~~8 HP Accreditation UM Standards.
4. UM 5: -Timeliness of UM decision, Element E: Timeliness of Pharmacy UM Decisions, 2018~~6~~ HP Accreditation UM Standards.

~~2.~~5. UM ~~8~~9: ~~Polices for Appeals~~Timeliness of Appeal Process, Element ~~A~~E: Factor 1 to 3.

~~3.~~6. All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

Attachment B (for GG.1401 and GG.1410):
Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Prior Authorization		Notification Timeframe
Type of Request	**Decision**	**Notice of Action (NOA): Practitioner and Member***
Standard (Non-urgent) Preservice - All necessary information received at time of initial request	A decision to approve, modify, or deny is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1,2].	- **Practitioner:** Within 24 hours of the decision[2] (electronic and written notification) - **Member:** Within 2 business days of the decision[2] (written notification)
Standard (Non-urgent) Preservice - Extension Needed - Additional clinical information required - Requires consultation by an Expert Reviewer - Additional examination or tests to be performed - [AKA: Deferral or Request for Information (RFI)]	- A response to defer is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 5 working days of receiving the additional information but no longer than 14 calendar days, upon receipt of the information reasonably necessary to render a decision. - The Plan may extend the standard preservice time frame due to a lack of information, for an additional 14 calendar days, under the following conditions: ▪ The Member or the Member's provider may request for an extension, or the Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest[3,6]. ▪ The Delay notice shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. - Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such[2].	- **Practitioner:** Within 24 hours of the decision[2], not to exceed 14 calendar days from the receipt of the request[3] (electronic and written notification) - **Member:** Within 2 business days of making the decision[2], not to exceed 14 calendar days from the receipt of the request[3] (written notification) - **Note:** CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay.
Expedited (Urgent) Pre-Service - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. - All necessary information received at time of initial request	- A decision to approve, modify, or deny is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1]. - **Expedited (Urgent) Pre-Service** may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[4].	- **Practitioner:** Within24 hours of the decision[2,3] (electronic and written notification) - **Member:** Within 24 hours of the decision[2,4] (written notification)

Attachment B (for GG.1401 and GG.1410):
Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Prior Authorization		Notification Timeframe
Type of Request	**Decision**	**Notice of Action (NOA) Notification: Practitioner and Member**
Expedited (Urgent) Pre-Service - Extension Needed - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function[2,4]. - Additional clinical information required - [AKA: Deferral or Request for Information (RFI)]	- A response to defer is required within 24 hours for all drugs that require prior authorization, in accordance to Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 72 hours of initial receipt of the request[2,4]. - The Plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions: ▪ Within 24 hours of receipt of the urgent preservice request, the Plan asks the member, the member's representative, or provider for the specific information necessary to make the decision. ▪ The Plan gives the member or member's authorized representative at least 48 hours to provide the information. ▪ The extension period, within which a decision must be made by the Plan, begins: • On the date when the Plan receives the member's response (even if not all of the information is provided), ***or*** • At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative.[3] - **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[2,4]. - The Member or the Member's provider may request for an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. - Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. - Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such[2].	- **Practitioner and Member:** Within 24 hours of the decision[2] but no later than72 hours from receipt of information that is reasonably necessary to make a determination[3] (electronic and written notification) - **Member:** Within 2 business days of the decision[2] but no later than 72 hours from receipt of information that is reasonably necessary to make a determination[3] (written notification) - **Note:** CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay.

Attachment B (for GG.1401 and GG.1410):
Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Concurrent review of treatment regimen already in place - A request for coverage of pharmaceutical services made while a member is in the process of receiving the requested pharmaceutical services, even if the organization did not previously approve the earlier care.	- A response to defer is required within 24 hours for all drugs that require prior authorization in accordance to Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 72 hours, or as soon as a Member's health condition requires, after the receipt of the request, in accordance to NCQA Timeliness of UM decision, [3]. - If the plan is unable to request for an extension of an urgent concurrent care within 24 hours **before the expiration of the prescribed period of time or number of treatments**, then the organization may treat the request as urgent preservice and make a decision within 72 hours[2]. - The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny[2].	- **Practitioner:** Within 24 hours of making the decision[2,3] (electronic and written notification) - **Member:** Within 24 hours of making the decision[2,3] (written notification)
Post-Services / Retrospective Review	▪ A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request[2,4].	- **Practitioner:** Within 24 hours of making the decision [2] but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination[23] (written notification) - **Member:** Within 2 business days of the decision[2] but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination[2] [3](written notification)

Appeals Time period to file an appeal: within 60 days of the initial denial decision[5,6]		**Notice of Appeal Resolution (NAR) Notification Timeframe**
Type of Request	**Decision**	**Practitioner and Member**
Routine (Standard) Preservice Appeal	A decision to approve, modify, or deny is required within 30 calendar days of the initial receipt of the request[5].	- **Practitioner:** Within 30 calendar days from the receipt of the request [5] (electronic & written notification) - **Member:** Within 30 of receipt of the request[5] (written notification)

Attachment B (for GG.1401 and GG.1410):
Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Expedited (Urgent) Pre-Service Appeal - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function[2,4].	- A decision to approve, modify, or deny is required within 72 hours of receiving the additional information, or as soon as a Member's health condition requires, after receipt of the request[5]. The Plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions: ▪ Within 24 hours of receipt of the urgent preservice request, the Plan asks the member or the member's representative for the specific information necessary to make the decision. ▪ The Plan gives the member or member's authorized representative at least 48 hours to provide the information. ▪ The extension period, within which a decision must be made by the Plan, begins: • On the date when the Plan receives the member's response (even if not all of the information is provided), ***or*** • At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative[5]. - **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[2,4].	- **Practitioner:** Within 72 hours of the decision (electronic & written notification)[5] - **Member:** Within 72 hours of the decision (oral and written notification)[5]
Postservice Appeal	A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request[5].	- **Practitioner:** Within 30 calendar days of the receipt of information that is reasonably necessary to make this determination[2 5] (electronic & written notification) - **Member:** Within 30 calendar days of the receipt of information that is reasonably necessary to make this determination[2 5] (written notification).

*Decisions to approve, modify, or deny are communicated to the requesting provider; decisions resulting in denial, delay, or modification are communicated to the member.

References:

1. Welfare and Institutions Code section 14185(a)(1)
2. California Health and Safety Code Sections (HSC) 1367.01(h)
3. UM 5: Timeliness of UM decision, Element E: Notification of Pharmacy Decisions, 2018 HP Accreditation UM Standards.
4. UM 5: Timeliness of UM decision, Element E: Timeliness of Pharmacy UM Decisions, 2018 HP Accreditation UM Standards.
5. UM 9: Timeliness of Appeal Process, Element E: Factor 1 to 3.
6. All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

U S Department of Health and Human Services

MEDWATCH

The FDA Safety Information and Adverse Event Reporting Program

For VOLUNTARY reporting of adverse events, product problems and product use errors

Form Approved: OMB No. 0910-0291, Expires: 9/30/2018
See PRA statement on reverse

FDA USE ONLY

Triage unit sequence #

FDA Rec. Date

PLEASE TYPE OR USE BLACK INK

Note: For date prompts of "dd-mmm-yyyy" please use 2-digit day, 3-letter month abbreviation, and 4-digit year; for example, 01-Jul-2015

A. PATIENT INFORMATION

1 **Patient Identifier** — In Confidence

2 **Age** ☐ Year(s) ☐ Month(s) ☐ Week(s) ☐ Days(s) or Date of Birth *(e.g., 08 Feb 1925)*

3 **Sex** ☐ Female ☐ Male

4 **Weight** ☐ lb ☐ kg

5 a **Ethnicity** *(Check single best answer)*
☐ Hispanic/Latino
☐ Not Hispanic/Latino

5 b **Race** *(Check all that apply)*
☐ Asian ☐ American Indian or Alaskan Native
☐ Black or African American ☐ White
☐ Native Hawaiian or Other Pacific Islander

B. ADVERSE EVENT, PRODUCT PROBLEM

1 **Check all that apply**
☐ **Adverse Event** ☐ **Product Problem** *(e.g., defects/malfunctions)*
☐ **Product Use Error** ☐ **Problem with Different Manufacturer of Same Medicine**

2 **Outcome Attributed to Adverse Event** *(Check all that apply)*
☐ Death *Include date (dd-mmm-yyyy)*
☐ Life-threatening ☐ Disability or Permanent Damage
☐ Hospitalization – initial or prolonged ☐ Congenital Anomaly/Birth Defects
☐ Other Serious (Important Medical Events)
☐ Required Intervention to Prevent Permanent Impairment/Damage (Devices)

3 **Date of Event** *(dd-mmm-yyyy)*

4 **Date of this Report** *(dd-mmm-yyyy)*

5 **Describe Event, Problem or Product Use Error**

6 **Relevant Tests/Laboratory Data, Including Dates**

7 **Other Relevant History, Including Preexisting Medical Conditions** *(e.g., allergies, pregnancy, smoking and alcohol use, liver/kidney problems, etc.)*

C. PRODUCT AVAILABILITY

2 **Product Available for Evaluation?** *(Do not send product to FDA)*
☐ Yes ☐ No ☐ Returned to Manufacturer on *(dd-mmm-yyyy)*

D. SUSPECT PRODUCTS

1 **Name, Manufacturer/Compounder, Strength** *(from product label)*

#1 – Name and Strength	#1 – NDC # or Unique ID
#1 – Manufacturer/Compounder	#1 – Lot #
#2 – Name and Strength	#2 – NDC # or Unique ID
#2 – Manufacturer/Compounder	#2 – Lot #

3 Dose or Amount	Frequency	Route
#1		
#2		

4 **Dates of Use** *(From/To for each) (If unknown, give duration, or best estimate) (dd-mmm-yyyy)*
#1
#2

5 **Diagnosis or Reason for Use** *(indication)*
#1
#2

6 **Is the Product Compounded?**
#1 ☐ Yes ☐ No
#2 ☐ Yes ☐ No

7 **Is the Product Over-the-Counter?**
#1 ☐ Yes ☐ No
#2 ☐ Yes ☐ No

8 **Expiration Date** *(dd-mmm-yyyy)*
#1 #2

9 **Event Abated After Use Stopped or Dose Reduced?**
#1 ☐ Yes ☐ No ☐ Doesn't apply
#2 ☐ Yes ☐ No ☐ Doesn't apply

10 **Event Reappeared After Reintroduction?**
#1 ☐ Yes ☐ No ☐ Doesn't apply
#2 ☐ Yes ☐ No ☐ Doesn't apply

E. SUSPECT MEDICAL DEVICE

1 **Brand Name**

2 **Common Device Name**

2b. **Procode**

3 **Manufacturer Name, City and State**

4 **Model #**

Lot #

Catalog #

Expiration Date *(dd-mmm-yyyy)*

Serial #

Unique Identifier (UDI) #

5 **Operator of Device**
☐ Health Professional
☐ Lay User/Patient
☐ Other

6 **If Implanted, Give Date** *(dd-mmm-yyyy)*

7 **If Explanted, Give Date** *(dd-mmm-yyyy)*

8 **Is this a single-use device that was reprocessed and reused on a patient?** ☐ Yes ☐ No

9 **If Yes to Item 8, Enter Name and Address of Reprocessor**

F. OTHER (CONCOMITANT) MEDICAL PRODUCTS

Product names and therapy dates *(Exclude treatment of event)*

G. REPORTER *(See confidentiality section on back)*

1 **Name and Address**
Last Name, First Name
Address
City, State/Province/Region
Country, ZIP/Postal Code
Phone #, Email

2 **Health Professional?** ☐ Yes ☐ No

3. **Occupation**

4 **Also Reported to:**
☐ Manufacturer/ Compounder
☐ User Facility
☐ Distributor/Importer

5 **If you do NOT want your identity disclosed to the manufacturer, please mark this box:** ☐

Submission of a report does not constitute an admission that medical personnel or the product caused or contributed to the event.

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ADVICE ABOUT VOLUNTARY REPORTING

Detailed instructions available at: http://www.fda.gov/medwatch/report/consumer/instruct.htm

Report adverse events, product problems or product use errors with:

- Medications *(drugs or biologics)*
- Medical devices *(including in-vitro diagnostics)*
- Combination products *(medication & medical devices)*
- Human cells, tissues, and cellular and tissue-based products
- Special nutritional products *(dietary supplements, medical foods, infant formulas)*
- Cosmetics
- Food *(including beverages and ingredients added to foods)*

Report product problems - quality, performance or safety concerns such as:

- Suspected counterfeit product
- Suspected contamination
- Questionable stability
- Defective components
- Poor packaging or labeling
- Therapeutic failures (product didn't work)

Report SERIOUS adverse events. An event is serious when the patient outcome is:

- Death
- Life-threatening
- Hospitalization - initial or prolonged
- Disability or permanent damage
- Congenital anomaly/birth defect
- Required intervention to prevent permanent impairment or damage (devices)
- Other serious (important medical events)

Report even if:

- You're not certain the product caused the event
- You don't have all the details

How to report:

- Just fill in the sections that apply to your report
- Use section D for all products except medical devices
- Attach additional pages if needed
- Use a separate form for each patient
- Report either to FDA or the manufacturer *(or both)*

Other methods of reporting:

- 1-800-FDA-0178 - To FAX report
- 1-800-FDA-1088 - To report by phone
- www.fda.gov/medwatch/report.htm - To report online

If your report involves a serious adverse event with a device and it occurred in a facility outside a doctor's office, that facility may be legally required to report to FDA and/or the manufacturer. Please notify the person in that facility who would handle such reporting.

If your report involves a serious adverse event with a vaccine, call 1-800-822-7967 to report.

Confidentiality: The patient's identity is held in strict confidence by FDA and protected to the fullest extent of the law. The reporter's identity, including the identity of a self-reporter, may be shared with the manufacturer unless requested otherwise.

Fold Here

Fold Here

The information in this box applies only to requirements of the Paperwork Reduction Act of 1995

The burden time for this collection of information has been estimated to average 40 minutes per response, including the time to review instructions, search existing data sources, gather and maintain the data needed, and complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to:

Department of Health and Human Services
Food and Drug Administration
Office of Chief Information Officer
Paperwork Reduction Act (PRA) Staff
PRAStaff@fda.hhs.gov

Please DO NOT RETURN this form to the PRA Staff e-mail to the left.

OMB statement:
"An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number."

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Food and Drug Administration

FORM FDA 3500 (10/15) (Back) **Please Use Address Provided Below -- Fold in Thirds, Tape and Mail**

DEPARTMENT OF
HEALTH & HUMAN SERVICES

Public Health Service
Food and Drug Administration
Rockville, MD 20857

Official Business
Penalty for Private Use $300

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UNITED STATES
OR APO/FPO

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POSTAGE WILL BE PAID BY FOOD AND DRUG ADMINISTRATION

MEDWATCH
The FDA Safety Information and Adverse Event Reporting Program
Food and Drug Administration
5600 Fishers Lane
Rockville, MD 20852-9787

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B 5 **Describe Event or Problem** *(continued)*

B 6 **Relevant Tests/Laboratory Data, Including Dates** *(continued)*

B 7 **Other Relevant History, Including Preexisting Medical Conditions** *(e g., allergies, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)* *(continued)*

F. **Concomitant Medical Products and Therapy Dates** *(Exclude treatment of event)* *(continued)*

Back to Agenda

Policy #:	GG.1409
Title:	**Drug Formulary Development and Management**
Department:	Medical Affairs
Section:	Pharmacy Management
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/99
Last Review Date:	09/06/18~~06/01/17~~
Last Revised Date:	09/06/18~~06/01/17~~

I. PURPOSE

This policy defines the process by which CalOptima shall develop and manage the drug Formulary.

II. POLICY

A. The Formulary development and management process shall ensure Member access to clinically appropriate and cost-effective pharmaceuticals, in accordance with the decisions of the CalOptima Pharmacy and Therapeutics (P&T) Committee, and consistent with the scope of benefits for pharmaceutical services, as established by the California Department of Health Care Services (DHCS) and Title 22 of the California Code of Regulations.

B. CalOptima's Pharmacy Management Department shall delegate daily formulary administrative functions to the Pharmacy Benefit Manager (PBM~~),~~) and shall ensure that these activities are conducted pursuant to CalOptima policy through oversight and monitoring of the PBM's ~~Formulary~~formulary administrative process.

C. ~~Nothing~~CalOptima's Approved Drug List (Formulary) shall be comparable to the Medi-Cal Fee-For-Service (FFS) contract drug list. Nothing herein shall require CalOptima's Approved Drug List (Formulary) to duplicate the medications, or parameters as contained on the DHCS Contract Drug List.

D. ~~CalOptima's Approved Drug List (~~CalOptima's Formulary~~)~~ shall be posted on the CalOptima website in a machine~~-~~-readable file and format and a printed version shall be made available to the Members upon request~~.~~, pursuant to Title 42 Code of Federal Regulations (CFR) S~~s~~ection 438.10(i).

E. CalOptima shall meet DHCS Formulary requirements.

F. On an annual basis, CalOptima Pharmacy Management, with the participation of physicians and pharmacists, shall review and update the Formulary and ~~Pharmaceutical Management~~ pharmaceutical management procedures.

G. CalOptima shall post a summary of the changes to the Formulary on the CalOptima website following the quarterly P&T Committee meetings.

H. CalOptima shall communicate changes and updates relating to the Formulary and pharmaceutical management procedures to Members and Prescribing Practitioners annually, and as needed after Formulary updates~~.~~ to notify them:

1. Where to find the Formulary, including restrictions and preferences such as Step Therapy protocols, on the CalOptima website;

2. How to use the Pharmaceutical Management procedures;

3. An explanation of Formulary limits and restrictions and the process for Step Therapy protocols;

4. How Prescribing Practitioners must provide information to support a Prior Authorization request; and

5. Where changes to the Formulary are posted on the CalOptima website.

III. PROCEDURE

A. Formulary Development

1. The CalOptima P&T Committee shall make reasonable effort to review a new chemical entity, new U.S. Food and Drug Administration (FDA) approved drug product, or new FDA approved indication within ninety (90) calendar days after release into the market, and shall make a decision on the formulary status of the drug within one hundred eighty (180) calendar days after its release into the market, or provide a clinical justification if the timeframe is not met.

2. The P&T Committee shall also:

   a. Approve all changes and updates to the Formulary;

   b. Approve the inclusion, or exclusion, of classes of drugs in the Formulary;

   c. On an annual basis, review the therapeutic classes in the Formulary;

   d. Consider whether or not the inclusion of a particular drug on the Formulary has any therapeutic advantages in safety and efficacy compared to other drugs in the same class, and the therapeutic advantages of a particular drug in relation to the interaction of a drug therapy regimen and the use of other health care services;

   e. Review the Prior Authorization guidelines for drugs;

   f. Base clinical decisions on the strength of scientific evidence, standards of practice, and safety and efficacy considerations;

   g. Consider use of the following resources to assist in decision-making:

      i. Peer-reviewed medical literature;

      ii. Randomized clinical trials;

      iii. Well-established Clinical Practice Guidelines (CPG);

      iv. Pharmacoeconomic studies;

v. Outcomes research data;

vi. Centers for Medicare & Medicaid Services (CMS) policies and guidelines;

vii. Centers for Disease Control and Prevention (CDC) policies and guidelines;

viii. Medi-Cal Manual;

ix. FDA policies and guidelines; and

x. Other information, as appropriate;

h. Meet on a regular basis, but not less than quarterly; and

i. Include a majority of members that are practicing physicians or practicing pharmacists, with:

i. At least one (1) practicing physician and at least one (1) practicing pharmacist that do not have a conflict of interest with respect to CalOptima and pharmaceutical manufacturers;

ii. At least one (1) practicing physician and at least one (1) practicing pharmacist that are independent experts in the care of the elderly, or disabled, persons, and represent:

1) Various clinical specialties that represent the needs of Members; and

2) Are practicing physicians and pharmacists who do not work for CalOptima.

j. Request external review by a Prescribing Practitioner with a specialty, or subspecialty, of medical practice when that specialty is not represented on the P&T Committee when additional expertise is needed.

3. As part of the Formulary decision process, the P&T Committee may elect to set specific drug usage criteria, such as:

a. Preferred drug status;

b. Contingent therapy;

c. Step Therapy protocols;

d. Duration-of-therapy limits;

e. Age or gender limits;

f. Strength-related quantity limits; and

g. Therapeutic substitution.

4. Decisions and recommendations of the P&T Committee shall be reported to CalOptima's ~~Quality Improvement~~Utilization Management Committee.

5. CalOptima's Pharmacy Management Department shall be responsible for:

   a. Presenting therapeutic drug selection and usage recommendations to the P&T Committee;

   b. Presenting Prior Authorization guidelines for the drugs under review;

   c. Presenting the annual review of therapeutic classes in the Formulary;

   d. Tracking and reporting the resulting pharmacy utilization trends to the P&T Committee for follow-up assessment of the effectiveness and outcomes of the P&T Committee's decisions;

   e. Ensuring that the P&T drug evaluations and P&T minutes contain the criteria used when making a Formulary, or preferred status decision for a drug, or drug class, and how the P&T Committee makes decisions on:

      i. Drug class reviews;

      ii. Drug classes that are preferred or covered at any level;

      iii. The Prior Authorization guidelines for drugs which are not preferred or non-Formulary;

      iv. Limiting access to drugs within certain classes; and

      v. Evidence that preferred-status drugs may produce similar, or better, results for the majority of the population compared to other drugs within the same class.

   f. Accepting Member, pharmacist, or Prescribing Provider, requests to add to, or remove, drugs from the Formulary, and reviewing the request at the next P&T meeting; and

   g. Providing at least sixty (60) calendar ~~days~~days' notice to Participating Pharmacies, via facsimile, prior to removing a medication from the Formulary, or making any changes to the preferred status of a drug.

B. Formulary Management

1. The CalOptima Pharmacy Management Department shall be responsible for the overall administration of the Formulary management process. The Pharmacy Management Department shall coordinate activities with other internal departments, as needed, to carry out its administrative responsibilities. Specific responsibilities include, but are not limited to, the following:

   a. Ensuring compliance with DHCS Formulary requirements, which include:

      i. Submitting a complete CalOptima ~~Approved Drug List~~Formulary to DHCS annually for review and approval and any changes to DHCS as File and Use;

ii. Using the Formulary as published, unless DHCS notifies CalOptima of changes that must be made;

iii. Reviewing the CalOptima ~~Approved Drug List~~ Formulary to ensure that it is comparable to the Medi-Cal Fee-For-Service (FFS) contract drugs list, except for drugs carved out of the State Contract. For this purpose, "comparable" means:

~~iv.~~a) ~~Ensuring that the~~The CalOptima ~~Approved Drug List~~Formulary shall ~~contain~~include at least one (1) drug in every therapeutic category or class listed on the Medi-Cal FFS contract drug list ~~without a Prior Authorization requirement,~~ within 6 months of its inclusion on the Medi-Cal FFS contract drug list ~~except for drugs carved out of the State Contract~~.

~~v.~~b) If CalOptima chooses to subject all drugs within the same therapeutic category to ~~prior authorization~~Prior Authorization requirements and one (1) such drug is available on the Medi-Cal FFS contract drug list without treatment authorization request requirements, CalOptima shall ~~allow the drug to be available by Prior Authorization if deemed Medically Necessary and shall also~~ submit the following for all drugs of that same mechanism of action:

~~a)~~1) Clinical rationale for ~~subjecting the prior authorization utilization control on all drugs within the individual therapeutic category with a specific mechanism of action~~such an action; and

~~b)~~2) Criteria used to adjudicate the ~~prior authorization~~Prior Authorization request ~~of the formulary option~~ and/or how the approval criteria for the formulary option(s) differ from the non-formulary options.

c) A drug not listed on the formulary must be available by Prior Authorization if deemed Medically Necessary.

~~vi.~~iv. Implementing and maintaining a process to ensure that the Formulary is reviewed and updated, no less than quarterly, by the P&T Committee, which will include CalOptima's pharmacists as voting members on the Committee;

~~vii.~~v. Ensuring that the review and update considers all drugs approved by the FDA and/or added to the Medi-Cal FFS contract drugs list;

~~viii.~~vi. Documenting deletions to the Formulary, and justifying deletions to DHCS; and

~~ix.~~vii. Ensuring drug utilization reviews are appropriately conducted by the P&T Committee and pursuant to DHCS guidelines.

b. Pharmacy utilization management tracking and reporting;

c. Assessing and reporting Formulary compliance;

d. Oversight of the PBM in the performance of the online administration of the Formulary;

e. Communication to the PBM regarding Formulary changes;

f. Publication of the Formulary and quarterly updates to the Formulary following the P&T Committee meeting on the CalOptima website: www.caloptima.org, as well as in a print version available to Members upon request. CalOptima's drug formulary information shall include:

i. An explanation of what a formulary is, which medications are covered, both generic and name brand, what tier each medication is on;

ii. How the plan decides which Prescription Drugs are included or excluded from the Formulary;

iii. How often the Formulary is updated;

iv. Information about the Formulary being available on CalOptima's website in a machine-readable file, available in a hard copy, and provide the telephone number for requesting this information; and ~~indicate~~

~~iv.~~v. Indicate that the presence of a drug on CalOptima's Formulary does not guarantee that a Member will be prescribed that drug by his or her prescribing Provider for a particular medical condition.

g. Communication to Participating Pharmacies, Members, and Prescribing Practitioners annually and after updates to the Formulary posted on the CalOptima website for the following:

i. Where to find the Formulary, including restrictions and preferences such as Step Therapy protocols, on the CalOptima website;

ii. How to use the Pharmaceutical Management procedures;

iii. An explanation of Formulary limits and restrictions and the process for Step Therapy protocols;

iv. How Prescribing Practitioners must provide information to support a Prior Authorization request; and

v. Where changes to the Formulary are posted on the CalOptima website.

vi. How the Members or Prescribing Practitioners can obtain a print version of the Formulary.

h. Coordination of the P&T Committee scheduling, agenda, actions, and minutes; and

i. Periodic updates to information published in the Member Handbook as posted on the CalOptima website.

2. CalOptima shall require the use of an FDA-approved and nationally marketed drugs unless a medical necessity can be established requiring the use of a compounded alternative. Compounded products may be dispensed only when an FDA-approved therapeutic equivalent

does not exist in the marketplace or when the FDA-approved product does not meet the medical needs of the member and a compound alternative is medically necessary.

3. All FDA-approved tobacco cessation medications including bupropion SR, Varenicline, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, and the nicotine patch, are available without a Prior Authorization for all adults.

4. Daily operations to implement, maintain, and report compliance with the Formulary shall be delegated to the PBM, and shall be carried out according to CalOptima standards. Delegated activities shall be described in the PBM Services Agreement, and shall include, but not be limited to, the following activities:

    a. Entry and maintenance of the Formulary into the Prior Authorization and claims adjudication systems, as directed by CalOptima and approved by the P&T Committee, including the accompanying preferred drugs, Step Therapy Protocols, Contingent Therapy Protocols, Therapeutic Substitution Protocols, Quantity Limits, and Duration-of-Therapy Limits;

    b. Supervision of online functions to administer the CalOptima approved Step Therapy Protocols, Contingent Therapy Protocols, Duration-of-Therapy Limits, and Quantity Limits, as listed on the Formulary; and

    c. Supervision of online functions to administer CalOptima approved online drug utilization review program and drug-to-drug interaction alerts for drugs not listed on the Formulary.

        i. Drug utilization review edits consist of alerts on duplication of therapy for the same medication, which generate a rejection at the point of dispensing, and notification to the Participating Pharmacy that duplication of therapy is present and Prior Authorization is required in order to dispense the medication.

        ii. Drug-to-drug interactions, such as Severity Level 1 drug interactions, which generate a rejection at the point of dispensing, and notification to the Participating Pharmacy that a drug-to-drug interaction is present and shall require a Prior Authorization in order to dispense the medication.

    d. Administration of the Prior Authorization process for non-Formulary medications, in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process;

    e. Claims control processes, e.g., to prevent payment for a non-Formulary medication without entry of a Prior Authorization specific to the medication and the Member to which it has been prescribed.

IV. ATTACHMENTS

A. Pharmacy & Therapeutic Committee Roster
B. MedWatch form

V. REFERENCES

A. CalOptima Approved Drug List

B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Pharmacy & Therapeutics Committee Roster
D. CalOptima Policy AA.1000: Glossary of Terms
E. CalOptima Policy GG.1401: Pharmacy Authorization Process
F. Department of Health Care Services (DHCS) Policy Letter (PL) 14-002: Requirement to Use Food and Drug Administration Approved Drugs, Rather Than Compounded Alternatives.
G. Department of Health Care Services (DHCS) Policy Letter (PL) 14-006: Comprehensive Tobacco Services for Medi-Cal Members; Preventing Tobacco Use in Children and Adolescent
H. Department of Health Care Services (DHCS) All-Plan Letter (APL) 16-010: Medi-Cal Managed Health Plan Pharmaceutical Formulary Comparability Requirement
I. Health and Safety Code, §1363.01
J. Title 22, California Code of Regulations (CCR), §51003
K. Title 42, Code of Federal Regulations (CFR), §438.10(d)(6) and (i)

VI. REGULATORY AGENCYAPPROVALS

~~A. 08/03/17: Department of Health Care Services~~
~~B.~~A. 04/19/16: Department of Health Care Services
~~C.~~B. 03/16/15: Department of Health Care Services

VII. BOARD ACTIONS

~~None to Date~~A. 09/06/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/1999	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	01/01/2000	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	04/01/2007	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	08/01/2011	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	01/01/2012	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	01/01/2013	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	09/01/2014	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	03/01/2015	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	02/01/2016	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	10/01/2016	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	06/01/2017	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	09/06/2018	GG.1409	Drug Formulary Development and Management	Medi-Cal

IX. GLOSSARY

Term	Definition
File and Use	A submission to DHCS that does not need review and approval prior to use or implementation, but which DHCS can require edits as determined
Formulary	The approved list of outpatient medications, medical supplies and devices, and the Utilization and Contingent Therapy Protocols as approved by the CalOptima Pharmacy & Therapeutics (P&T) Committee for prescribing to Members without the need for Prior Authorization.
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.
Participating Pharmacy	Any pharmacy that is credentialed by and subcontracted to the Pharmacy Benefit Manager (PBM) for the specific purpose of providing pharmacy services to Members.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Prescribing Practitioner	The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a Member.
Prior Authorization (Pharmacy)	The formulary restriction which requires approval from CalOptima before the requested medication is covered.
Severity Level 1	Those drug combinations that are clearly contraindicated in all cases and should not be dispensed or administered concurrently to the same recipient.
Step Therapy	A utilization management process which requires a trial of a first-line formulary medication prior to receiving the second-line medication. If it is Medically Necessary for a Member to use the medication as initial therapy, the prescriber can request coverage by submitting a prior authorization request.

Policy #:	GG.1409
Title:	**Drug Formulary Development and Management**
Department:	Medical Affairs
Section:	Pharmacy Management
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/99
Last Review Date:	09/06/18
Last Revised Date:	09/06/18

I. PURPOSE

This policy defines the process by which CalOptima shall develop and manage the drug Formulary.

II. POLICY

A. The Formulary development and management process shall ensure Member access to clinically appropriate and cost-effective pharmaceuticals, in accordance with the decisions of the CalOptima Pharmacy and Therapeutics (P&T) Committee, and consistent with the scope of benefits for pharmaceutical services, as established by the California Department of Health Care Services (DHCS) and Title 22 of the California Code of Regulations.

B. CalOptima's Pharmacy Management Department shall delegate daily formulary administrative functions to the Pharmacy Benefit Manager (PBM) and shall ensure that these activities are conducted pursuant to CalOptima policy through oversight and monitoring of the PBM's formulary administrative process.

C. CalOptima's Approved Drug List (Formulary) shall be comparable to the Medi-Cal Fee-For-Service (FFS) contract drug list. Nothing herein shall require CalOptima's Approved Drug List (Formulary) to duplicate the medications, or parameters as contained on the DHCS Contract Drug List.

D. CalOptima's Formulary shall be posted on the CalOptima website in a machine-readable file and format and a printed version shall be made available to the Members upon request, pursuant to Title 42 Code of Federal Regulations (CFR) Section 438.10(i).

E. CalOptima shall meet DHCS Formulary requirements.

F. On an annual basis, CalOptima Pharmacy Management, with the participation of physicians and pharmacists, shall review and update the Formulary and pharmaceutical management procedures.

G. CalOptima shall post a summary of the changes to the Formulary on the CalOptima website following the quarterly P&T Committee meetings.

H. CalOptima shall communicate changes and updates relating to the Formulary and pharmaceutical management procedures to Members and Prescribing Practitioners annually, and as needed after Formulary updates to notify them:

1. Where to find the Formulary, including restrictions and preferences such as Step Therapy protocols, on the CalOptima website;

2. How to use the Pharmaceutical Management procedures;

3. An explanation of Formulary limits and restrictions and the process for Step Therapy protocols;

4. How Prescribing Practitioners must provide information to support a Prior Authorization request; and

5. Where changes to the Formulary are posted on the CalOptima website.

III. PROCEDURE

A. Formulary Development

1. The CalOptima P&T Committee shall make reasonable effort to review a new chemical entity, new U.S. Food and Drug Administration (FDA) approved drug product, or new FDA approved indication within ninety (90) calendar days after release into the market, and shall make a decision on the formulary status of the drug within one hundred eighty (180) calendar days after its release into the market, or provide a clinical justification if the timeframe is not met.

2. The P&T Committee shall also:

   a. Approve all changes and updates to the Formulary;

   b. Approve the inclusion, or exclusion, of classes of drugs in the Formulary;

   c. On an annual basis, review the therapeutic classes in the Formulary;

   d. Consider whether or not the inclusion of a particular drug on the Formulary has any therapeutic advantages in safety and efficacy compared to other drugs in the same class, and the therapeutic advantages of a particular drug in relation to the interaction of a drug therapy regimen and the use of other health care services;

   e. Review the Prior Authorization guidelines for drugs;

   f. Base clinical decisions on the strength of scientific evidence, standards of practice, and safety and efficacy considerations;

   g. Consider use of the following resources to assist in decision-making:

      i. Peer-reviewed medical literature;

      ii. Randomized clinical trials;

      iii. Well-established Clinical Practice Guidelines (CPG);

      iv. Pharmacoeconomic studies;

      v. Outcomes research data;

vi. Centers for Medicare & Medicaid Services (CMS) policies and guidelines;

vii. Centers for Disease Control and Prevention (CDC) policies and guidelines;

viii. Medi-Cal Manual;

ix. FDA policies and guidelines; and

x. Other information, as appropriate;

h. Meet on a regular basis, but not less than quarterly; and

i. Include a majority of members that are practicing physicians or practicing pharmacists, with:

i. At least one (1) practicing physician and at least one (1) practicing pharmacist that do not have a conflict of interest with respect to CalOptima and pharmaceutical manufacturers;

ii. At least one (1) practicing physician and at least one (1) practicing pharmacist that are independent experts in the care of the elderly, or disabled, persons, and represent:

1) Various clinical specialties that represent the needs of Members; and

2) Are practicing physicians and pharmacists who do not work for CalOptima.

j. Request external review by a Prescribing Practitioner with a specialty, or subspecialty, of medical practice when that specialty is not represented on the P&T Committee when additional expertise is needed.

3. As part of the Formulary decision process, the P&T Committee may elect to set specific drug usage criteria, such as:

a. Preferred drug status;

b. Contingent therapy;

c. Step Therapy protocols;

d. Duration-of-therapy limits;

e. Age or gender limits;

f. Strength-related quantity limits; and

g. Therapeutic substitution.

4. Decisions and recommendations of the P&T Committee shall be reported to CalOptima's Utilization Management Committee.

5. CalOptima's Pharmacy Management Department shall be responsible for:

    a. Presenting therapeutic drug selection and usage recommendations to the P&T Committee;

    b. Presenting Prior Authorization guidelines for the drugs under review;

    c. Presenting the annual review of therapeutic classes in the Formulary;

    d. Tracking and reporting the resulting pharmacy utilization trends to the P&T Committee for follow-up assessment of the effectiveness and outcomes of the P&T Committee's decisions;

    e. Ensuring that the P&T drug evaluations and P&T minutes contain the criteria used when making a Formulary, or preferred status decision for a drug, or drug class, and how the P&T Committee makes decisions on:

        i. Drug class reviews;

        ii. Drug classes that are preferred or covered at any level;

        iii. The Prior Authorization guidelines for drugs which are not preferred or non-Formulary;

        iv. Limiting access to drugs within certain classes; and

        v. Evidence that preferred-status drugs may produce similar, or better, results for the majority of the population compared to other drugs within the same class.

    f. Accepting Member, pharmacist, or Prescribing Provider, requests to add to, or remove, drugs from the Formulary, and reviewing the request at the next P&T meeting; and

    g. Providing at least sixty (60) calendar days' notice to Participating Pharmacies, via facsimile, prior to removing a medication from the Formulary, or making any changes to the preferred status of a drug.

B. Formulary Management

1. The CalOptima Pharmacy Management Department shall be responsible for the overall administration of the Formulary management process. The Pharmacy Management Department shall coordinate activities with other internal departments, as needed, to carry out its administrative responsibilities. Specific responsibilities include, but are not limited to, the following:

    a. Ensuring compliance with DHCS Formulary requirements, which include:

        i. Submitting a complete CalOptima Formulary to DHCS annually for review and approval and any changes to DHCS as File and Use;

        ii. Using the Formulary as published, unless DHCS notifies CalOptima of changes that must be made;

iii. Reviewing the CalOptima Formulary to ensure that it is comparable to the Medi-Cal Fee-For-Service (FFS) contract drugs list, except for drugs carved out of the State Contract. For this purpose, "comparable" means:

a) The CalOptima Formulary shall include at least one (1) drug in every therapeutic category or class listed on the Medi-Cal FFS contract drug list within 6 months of its inclusion on the Medi-Cal FFS contract drug list.

b) If CalOptima chooses to subject all drugs within the same therapeutic category to Prior Authorization requirements and one (1) such drug is available on the Medi-Cal FFS contract drug list without treatment authorization request requirements, CalOptima shall submit the following for all drugs of that same mechanism of action:

1) Clinical rationale for such an action; and

2) Criteria used to adjudicate the Prior Authorization request and/or how the approval criteria for the formulary option(s) differ from the non-formulary options.

c) A drug not listed on the formulary must be available by Prior Authorization if deemed Medically Necessary.

iv. Implementing and maintaining a process to ensure that the Formulary is reviewed and updated, no less than quarterly, by the P&T Committee, which will include CalOptima's pharmacists as voting members on the Committee;

v. Ensuring that the review and update considers all drugs approved by the FDA and/or added to the Medi-Cal FFS contract drugs list;

vi. Documenting deletions to the Formulary, and justifying deletions to DHCS; and

vii. Ensuring drug utilization reviews are appropriately conducted by the P&T Committee and pursuant to DHCS guidelines.

b. Pharmacy utilization management tracking and reporting;

c. Assessing and reporting Formulary compliance;

d. Oversight of the PBM in the performance of the online administration of the Formulary;

e. Communication to the PBM regarding Formulary changes;

f. Publication of the Formulary and quarterly updates to the Formulary following the P&T Committee meeting on the CalOptima website: www.caloptima.org, as well as in a print version available to Members upon request. CalOptima's drug formulary information shall include:

i. An explanation of what a formulary is, which medications are covered, both generic and name brand, what tier each medication is on;

ii. How the plan decides which Prescription Drugs are included or excluded from the Formulary;

iii. How often the Formulary is updated;

iv. Information about the Formulary being available on CalOptima's website in a machine-readable file, available in a hard copy, and provide the telephone number for requesting this information; and

v. Indicate that the presence of a drug on CalOptima's Formulary does not guarantee that a Member will be prescribed that drug by his or her prescribing Provider for a particular medical condition.

g. Communication to Participating Pharmacies, Members, and Prescribing Practitioners annually and after updates to the Formulary posted on the CalOptima website for the following:

i. Where to find the Formulary, including restrictions and preferences such as Step Therapy protocols, on the CalOptima website;

ii. How to use the Pharmaceutical Management procedures;

iii. An explanation of Formulary limits and restrictions and the process for Step Therapy protocols;

iv. How Prescribing Practitioners must provide information to support a Prior Authorization request; and

v. Where changes to the Formulary are posted on the CalOptima website.

vi. How the Members or Prescribing Practitioners can obtain a print version of the Formulary.

h. Coordination of the P&T Committee scheduling, agenda, actions, and minutes; and

i. Periodic updates to information published in the Member Handbook as posted on the CalOptima website.

2. CalOptima shall require the use of an FDA-approved and nationally marketed drugs unless a medical necessity can be established requiring the use of a compounded alternative. Compounded products may be dispensed only when an FDA-approved therapeutic equivalent does not exist in the marketplace or when the FDA-approved product does not meet the medical needs of the member and a compound alternative is medically necessary.

3. All FDA-approved tobacco cessation medications including bupropion SR, Varenicline, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, and the nicotine patch, are available without a Prior Authorization for all adults.

4. Daily operations to implement, maintain, and report compliance with the Formulary shall be delegated to the PBM, and shall be carried out according to CalOptima standards. Delegated activities shall be described in the PBM Services Agreement, and shall include, but not be limited to, the following activities:

    a. Entry and maintenance of the Formulary into the Prior Authorization and claims adjudication systems, as directed by CalOptima and approved by the P&T Committee, including the accompanying preferred drugs, Step Therapy Protocols, Contingent Therapy Protocols, Therapeutic Substitution Protocols, Quantity Limits, and Duration-of-Therapy Limits;

    b. Supervision of online functions to administer the CalOptima approved Step Therapy Protocols, Contingent Therapy Protocols, Duration-of-Therapy Limits, and Quantity Limits, as listed on the Formulary; and

    c. Supervision of online functions to administer CalOptima approved online drug utilization review program and drug-to-drug interaction alerts for drugs not listed on the Formulary.

        i. Drug utilization review edits consist of alerts on duplication of therapy for the same medication, which generate a rejection at the point of dispensing, and notification to the Participating Pharmacy that duplication of therapy is present and Prior Authorization is required in order to dispense the medication.

        ii. Drug-to-drug interactions, such as Severity Level 1 drug interactions, which generate a rejection at the point of dispensing, and notification to the Participating Pharmacy that a drug-to-drug interaction is present and shall require a Prior Authorization in order to dispense the medication.

    d. Administration of the Prior Authorization process for non-Formulary medications, in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process;

    e. Claims control processes, e.g., to prevent payment for a non-Formulary medication without entry of a Prior Authorization specific to the medication and the Member to which it has been prescribed.

IV. ATTACHMENTS

A. Pharmacy & Therapeutic Committee Roster
B. MedWatch form

V. REFERENCES

A. CalOptima Approved Drug List
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Pharmacy & Therapeutics Committee Roster
D. CalOptima Policy AA.1000: Glossary of Terms
E. CalOptima Policy GG.1401: Pharmacy Authorization Process
F. Department of Health Care Services (DHCS) Policy Letter (PL) 14-002: Requirement to Use Food and Drug Administration Approved Drugs, Rather Than Compounded Alternatives.

G. Department of Health Care Services (DHCS) Policy Letter (PL) 14-006: Comprehensive Tobacco Services for Medi-Cal Members; Preventing Tobacco Use in Children and Adolescent
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I. Health and Safety Code, §1363.01
J. Title 22, California Code of Regulations (CCR), §51003
K. Title 42, Code of Federal Regulations (CFR), §438.10(d)(6) and (i)

VI. REGULATORY AGENCYAPPROVALS

A. 04/19/16: Department of Health Care Services
B. 03/16/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/1999	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	01/01/2000	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	04/01/2007	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	08/01/2011	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	01/01/2012	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	01/01/2013	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	09/01/2014	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	03/01/2015	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	02/01/2016	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	10/01/2016	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	06/01/2017	GG.1409	Drug Formulary Development and Management	Medi-Cal
Revised	09/06/2018	GG.1409	Drug Formulary Development and Management	Medi-Cal

IX. GLOSSARY

Term	Definition
File and Use	A submission to DHCS that does not need review and approval prior to use or implementation, but which DHCS can require edits as determined
Formulary	The approved list of outpatient medications, medical supplies and devices, and the Utilization and Contingent Therapy Protocols as approved by the CalOptima Pharmacy & Therapeutics (P&T) Committee for prescribing to Members without the need for Prior Authorization.
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.
Participating Pharmacy	Any pharmacy that is credentialed by and subcontracted to the Pharmacy Benefit Manager (PBM) for the specific purpose of providing pharmacy services to Members.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Prescribing Practitioner	The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a Member.
Prior Authorization (Pharmacy)	The formulary restriction which requires approval from CalOptima before the requested medication is covered.
Severity Level 1	Those drug combinations that are clearly contraindicated in all cases and should not be dispensed or administered concurrently to the same recipient.
Step Therapy	A utilization management process which requires a trial of a first-line formulary medication prior to receiving the second-line medication. If it is Medically Necessary for a Member to use the medication as initial therapy, the prescriber can request coverage by submitting a prior authorization request.

Pharmacy & Therapeutics Committee Roster

Name	Specialty	Company
Mark Fredrick M.D., Ph.D.	Family Practice	HealthCare Partners Medical Group
Alan Cortez, M.D.	Pediatric Endocrinology	Kaiser Permanente Medical Group.
Martin Grubin, M.D.	Family Practice	Care 1st Health Plan
Robin Corelli, Pharm D.	Clinical Pharmacy	UCSF School of Pharmacy
Curtis Siu, Pharm D.	Community Pharmacy	Wagner Pharmacy
Linh Lee, Pharm.D.	Specialty Pharmacy	Axium Healthcare Pharmacy, Inc

Internal Committee Members

Name	Company	Specialty
Donald Sharps, M.D., Medical Director of Behavioral Health	CalOptima	Psychiatry
Himmet Dajee , M.D., Medical Director of Medical Management	CalOptima	Cardiology
Richard Helmer, M.D., Chief Medical Office	CalOptima	Family Practice
Kris Gericke, Pharm.D., Director, Pharmacy Mgmt	CalOptima	Managed Care Pharmacy Director
Shabnam Eragi, Pharm D., Pharmacy Mgmt	CalOptima	Managed Care Pharmacy
Nicki Ghazanfarpour, Pharm.D., CGP, Pharmacy Mgmt	CalOptima	Managed Care Pharmacy
Hanh Bannister, Pharm D., Pharmacy Mgmt	CalOptima	Managed Care Pharmacy

U S Department of Health and Human Services

MEDWATCH

The FDA Safety Information and Adverse Event Reporting Program

For VOLUNTARY reporting of adverse events, product problems and product use errors

Form Approved: OMB No. 0910-0291, Expires: 9/30/2018
See PRA statement on reverse.

FDA USE ONLY

Triage unit sequence #

FDA Rec. Date

PLEASE TYPE OR USE BLACK INK

Note: For date prompts of "dd-mmm-yyyy" please use 2-digit day, 3-letter month abbreviation, and 4-digit year; for example, 01-Jul-2015.

A. PATIENT INFORMATION

1. **Patient Identifier** — In Confidence

2. **Age** ☐ Year(s) ☐ Month(s) ☐ Week(s) ☐ Days(s)
or Date of Birth *(e.g., 08 Feb 1925)* __ - ___ - ____

3. **Sex** ☐ Female ☐ Male

4. **Weight** ☐ lb ☐ kg

5 a. **Ethnicity** *(Check single best answer)*
☐ Hispanic/Latino
☐ Not Hispanic/Latino

5 b. **Race** *(Check all that apply)*
☐ Asian ☐ American Indian or Alaskan Native
☐ Black or African American ☐ White
☐ Native Hawaiian or Other Pacific Islander

B. ADVERSE EVENT, PRODUCT PROBLEM

1. **Check all that apply**
☐ **Adverse Event** ☐ **Product Problem** *(e.g., defects/malfunctions)*
☐ **Product Use Error** ☐ **Problem with Different Manufacturer of Same Medicine**

2. **Outcome Attributed to Adverse Event** *(Check all that apply)*
☐ Death *Include date (dd-mmm-yyyy):* __ - ___ - ____
☐ Life-threatening
☐ Hospitalization – initial or prolonged
☐ Other Serious (Important Medical Events)
☐ Required Intervention to Prevent Permanent Impairment/Damage (Devices)
☐ Disability or Permanent Damage
☐ Congenital Anomaly/Birth Defects

3. **Date of Event** *(dd-mmm-yyyy)* __ - ___ - ____

4. **Date of this Report** *(dd-mmm-yyyy)* __ - ___ - ____

5. **Describe Event, Problem or Product Use Error**

6. **Relevant Tests/Laboratory Data, Including Dates**

7. **Other Relevant History, Including Preexisting Medical Conditions** *(e.g., allergies, pregnancy, smoking and alcohol use, liver/kidney problems, etc.)*

C. PRODUCT AVAILABILITY

2. **Product Available for Evaluation?** *(Do not send product to FDA)*
☐ Yes ☐ No ☐ Returned to Manufacturer on *(dd-mmm-yyyy)* __ - ___ - ____

D. SUSPECT PRODUCTS

1. **Name, Manufacturer/Compounder, Strength** *(from product label)*

#1 – Name and Strength	#1 – NDC # or Unique ID
#1 – Manufacturer/Compounder	#1 – Lot #
#2 – Name and Strength	#2 – NDC # or Unique ID
#2 – Manufacturer/Compounder	#2 – Lot #

3. **Dose or Amount** / **Frequency** / **Route**
#1
#2

4. **Dates of Use** *(From/To for each) (If unknown, give duration, or best estimate) (dd-mmm-yyyy)*
#1
#2

5. **Diagnosis or Reason for Use** *(indication)*
#1
#2

6. **Is the Product Compounded?**
#1 ☐ Yes ☐ No
#2 ☐ Yes ☐ No

7. **Is the Product Over-the-Counter?**
#1 ☐ Yes ☐ No
#2 ☐ Yes ☐ No

8. **Expiration Date** *(dd-mmm-yyyy)*
#1 __ - ___ - ____ #2 __ - ___ - ____

9. **Event Abated After Use Stopped or Dose Reduced?**
#1 ☐ Yes ☐ No ☐ Doesn't apply
#2 ☐ Yes ☐ No ☐ Doesn't apply

10. **Event Reappeared After Reintroduction?**
#1 ☐ Yes ☐ No ☐ Doesn't apply
#2 ☐ Yes ☐ No ☐ Doesn't apply

E. SUSPECT MEDICAL DEVICE

1. **Brand Name**

2. **Common Device Name** | 2b. **Procode**

3. **Manufacturer Name, City and State**

4. **Model #** | **Lot #**
Catalog # | **Expiration Date** *(dd-mmm-yyyy)* __ - ___ - ____
Serial # | **Unique Identifier (UDI) #**

5. **Operator of Device**
☐ Health Professional
☐ Lay User/Patient
☐ Other

6. **If Implanted, Give Date** *(dd-mmm-yyyy)* __ - ___ - ____

7. **If Explanted, Give Date** *(dd-mmm-yyyy)* __ - ___ - ____

8. **Is this a single-use device that was reprocessed and reused on a patient?** ☐ Yes ☐ No

9. **If Yes to Item 8, Enter Name and Address of Reprocessor**

F. OTHER (CONCOMITANT) MEDICAL PRODUCTS

Product names and therapy dates *(Exclude treatment of event)*

G. REPORTER *(See confidentiality section on back)*

1. **Name and Address**
Last Name | First Name
Address
City | State/Province/Region
Country | ZIP/Postal Code
Phone # | Email

2. **Health Professional?** ☐ Yes ☐ No

3. **Occupation**

4. **Also Reported to:**
☐ Manufacturer/Compounder
☐ User Facility
☐ Distributor/Importer

5. **If you do NOT want your identity disclosed to the manufacturer, please mark this box:** ☐

 Submission of a report does not constitute an admission that medical personnel or the product caused or contributed to the event.

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ADVICE ABOUT VOLUNTARY REPORTING

Detailed instructions available at: http://www.fda.gov/medwatch/report/consumer/instruct.htm

Report adverse events, product problems or product use errors with:

- Medications *(drugs or biologics)*
- Medical devices *(including in-vitro diagnostics)*
- Combination products *(medication & medical devices)*
- Human cells, tissues, and cellular and tissue-based products
- Special nutritional products *(dietary supplements, medical foods, infant formulas)*
- Cosmetics
- Food *(including beverages and ingredients added to foods)*

Report product problems - quality, performance or safety concerns such as:

- Suspected counterfeit product
- Suspected contamination
- Questionable stability
- Defective components
- Poor packaging or labeling
- Therapeutic failures (product didn't work)

Report SERIOUS adverse events. An event is serious when the patient outcome is:

- Death
- Life-threatening
- Hospitalization - initial or prolonged
- Disability or permanent damage
- Congenital anomaly/birth defect
- Required intervention to prevent permanent impairment or damage (devices)
- Other serious (important medical events)

Report even if:

- You're not certain the product caused the event
- You don't have all the details

How to report:

- Just fill in the sections that apply to your report
- Use section D for all products except medical devices
- Attach additional pages if needed
- Use a separate form for each patient
- Report either to FDA or the manufacturer *(or both)*

Other methods of reporting:

- 1-800-FDA-0178 - To FAX report
- 1-800-FDA-1088 - To report by phone
- www.fda.gov/medwatch/report.htm - To report online

If your report involves a serious adverse event with a device and it occurred in a facility outside a doctor's office, that facility may be legally required to report to FDA and/or the manufacturer. Please notify the person in that facility who would handle such reporting.

If your report involves a serious adverse event with a vaccine, call 1-800-822-7967 to report.

Confidentiality: The patient's identity is held in strict confidence by FDA and protected to the fullest extent of the law. The reporter's identity, including the identity of a self-reporter, may be shared with the manufacturer unless requested otherwise.

-Fold Here-

-Fold Here-

The information in this box applies only to requirements of the Paperwork Reduction Act of 1995

The burden time for this collection of information has been estimated to average 40 minutes per response, including the time to review instructions, search existing data sources, gather and maintain the data needed, and complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to:

Department of Health and Human Services
Food and Drug Administration
Office of Chief Information Officer
Paperwork Reduction Act (PRA) Staff
PRAStaff@fda.hhs.gov

Please DO NOT RETURN this form to the PRA Staff e-mail to the left.

OMB statement:
"An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number."

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Food and Drug Administration

FORM FDA 3500 (10/15) (Back) **Please Use Address Provided Below -- Fold in Thirds, Tape and Mail**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Food and Drug Administration
Rockville, MD 20857

Official Business
Penalty for Private Use $300

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES OR APO/FPO

BUSINESS REPLY MAIL
FIRST CLASS MAIL PERMIT NO 946 ROCKVILLE MD

POSTAGE WILL BE PAID BY FOOD AND DRUG ADMINISTRATION

MEDWATCH
The FDA Safety Information and Adverse Event Reporting Program
Food and Drug Administration
5600 Fishers Lane
Rockville, MD 20852-9787

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B.5. **Describe Event or Problem** *(continued)*

B.6. **Relevant Tests/Laboratory Data, Including Dates** *(continued)*

B.7. **Other Relevant History, Including Preexisting Medical Conditions** *(e.g., allergies, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)* *(continued)*

F. Concomitant Medical Products and Therapy Dates *(Exclude treatment of event)* *(continued)*

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Policy #: GG.1410
Title: **Appeal Process for Pharmacy Authorization**
Department: Medical Affairs
Section: Pharmacy Management

CEO Approval: Michael Schrader _____

Effective Date: 05/01/08
Last Review Date: ~~07/01/17~~09/06/18
Last Revised Date: ~~07/01/17~~09/06/18

I. PURPOSE

This policy defines the process by which CalOptima addresses and resolves a Pre-service, Post-service, or expedited Appeal for Pharmaceutical Services, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima shall process requests for Appeals using the definition, turn-around time, and notification standards as specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit. A request marked as an Urgent Request that does not meet the definition for expedited review shall be reclassified as a routine request as outlined in this attachment. CalOptima shall maintain appropriate communication with the Prescribing Practitioner and/or Member or the Member's Authorized Representative throughout the Appeal process to facilitate delivery of appropriate services.

B. Upon receipt of a Notice of Action (NOA) notifying a Prescribing Practitioner or a Member of a CalOptima pharmacy decision that a Pharmaceutical Service request has been modified; denied; carved out of a treatment; or terminated, reduced, or suspended, a Prescribing Practitioner, a Member, or an Authorized Representative, including an attorney, shall have the right to Appeal the decision.

C. A pharmacy Appeal shall be a separate process from the Provider Complaint, Member Complaint, or Member State Fair Hearing, as specified in CalOptima Policies GG.1510: Appeals Process for Decisions Regarding Care and Services, HH.1101: CalOptima Provider Complaint, HH.1102: CalOptima Member Complaint, and HH.1108: State Hearings Process and Procedures.

D. ~~A~~If the Member wishes to have an Authorized Representative, act on the Member's behalf in the appeals process, a Member must authorize the appointment, in writing, of an Authorized Representative to represent the Member in the Appeal process, or the Authorized Representative shall submit a copy of a Durable Power of Attorney for health care, or similar legal appointment or representative document, or must otherwise be recognized under California law as a legal representative of the Member.

E. A Prescribing Practitioner on behalf of the Member, the Member, or the Member's Authorized Representative may request a pharmacy Appeal by submitting a written or verbal Appeal request within sixty (60) calendar days from the date written on the NOA received from CalOptima, in accordance with the provisions of this policy. Appeals filed by the Prescribing Practitioner on behalf of the Member shall require written consent from the Member.

DRAFT

F. CalOptima shall document the reason for the Appeal, who requested the Appeal, how the Appeal was received, and any actions taken on the appeal.

G. CalOptima shall ensure prompt review and full investigation of the substance for an Appeal, including any aspects of clinical care involved.

H. CalOptima shall give a Member, Authorized Representiave or Provider a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Appeal, evidence, facts, and law in support of the Appeal. In the case of an Appeal subject to an expedited review, CalOptima shall inform the Member, Authorized Representative or Provider of the limited time available to present evidence.

I. The ~~Oral~~person making the final decision for the proposed resolution of an Appeal has neither participated in any prior decisions related to the Appeal, nor is a subordinate of someone who has participated in a prior decision and has clinical expertise in treating the Member's condition or disease if deciding on any of the following:

1. An Appeal of a denial based on lack of Medical Necessity; and

2. Any Appeal involving clinical issues.

M. CalOptima shall ensure that at least one person reviewing the Appeal who is a practitioner in the same or similar specialty.

N. Members shall exhaust CalOptima's Appeal process prior to requesting a State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process.

O. A Member may receive continuation of benefits while the pharmacy Appeal is pending resolution if:

1. The Member files the pharmacy Appeal request within ten (10) calendar days of the mailing date of the NOA;

2. The authorized Prescribing Practitioner orders the medication;

3. The pharmacy Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

4. The period covered by the original authorization has not expired; and

5. The Member verbally requests an extension of the benefits by calling the CalOptima Customer Service Department.

P. CalOptima may extend the timeframe to resolve the Appeal by up to fourteen (14) calendar days at the request of the Member or if there is a need for additional information and how the delay is in the Member's best interest.

Q. For any extensions not requested by the Member, CalOptima must provide the Member with written notice of the reason for the delay and the right to file a Grievance within two (2) calendar days from the oral notification of the extension.

R. For Appeals resolved in favor of the Member, CalOptima shall authorize the request no later than seventy-two (72)-hours from the date reversing the determination.

S. CalOptima shall make reasonable efforts to provide oral notification to the Member of the resolution of an expedited Appeal.

T. CalOptima shall provide culturally and linguistically appropriate notices of the Appeals process to Members, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

U. Effective no sooner than January 1, 2019, Members eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model program shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process.

III. PROCEDURE

A. Request for a Pharmacy Appeal

1. A Member, or their Authorized Representative, may request a pharmacy Appeal, verbally or in writing, within sixty (60) calendar days from the date on the NOA from CalOptima by:

   a. Telephone or in-person to CalOptima's Customer Service Department; or

   b. Facsimile, or in writing, to CalOptima's Grievance and Appeals Resolution Services (GARS).

~~F.~~2. Telelphone Appeals from Members, excluding expedited Appeals, shall be followed by a written, signed Appeal. The date of the oral Appeal shall establish the filing date for the Appeal. CalOptima shall provide the Member with an Appeal form along with the Member's written acknowledgement notification. In the event that CalOptima does not receive a written, signed Appeal from the Member, CalOptima shall neither dismiss ~~nor~~or delay the resolution of the Appeal.

3. A Prescribing Practitioner may request a Pharmacy Appeal within sixty (60) calendar days from the date on the NOA received from CalOptima regarding Pharmaceutical Services for a Member. The request shall include all relevant material, such as clinical documentation or other documentation supporting the request, and the Prescribing Practitioner shall clearly label the request with "Appeal" or "Expedited Appeal." A Prescribing Practitioner may request a pharmacy Appeal by:

   a. Facsimile or telephone to CalOptima's Pharmacy Benefits Manager (PBM); or

   b. Telephone, or in writing, via mail or facsimile, to CalOptima's GARS, Customer Service, or Pharmacy Management Departments.

4. Oral Appeal requests, excluding expedited Appeals, from a Member, or their Authorized Representative, or a Prescribing Practitioner shall be followed by a written and signed Appeal request. The date of the oral Appeal shall establish the filing date for the Appeal. CalOptima shall provide the Appeal Form to the Member along with the acknowledgement notice. In the event that CalOptima does not receive a written and signed Appeal from the Member, CalOptima shall neither dismiss nor delay resolution of the Appeal.

5. CalOptima shall ensure that the Member or Authorized Representative, is given a reasonable opportunity to present, in writing or verbally, comments, documents or other information relating to the pharmacy Appeal, including evidence, facts, and law in support of the pharmacy Appeal. A Prescribing Practitioner may also contact a CalOptima physician, or a health care professional reviewer, to discuss the NOA for modification, denial, termination, or carve out of a service, or to obtain a copy of the criteria used to make the decision. In the case of a pharmacy Appeal subject to expedited review, the CalOptima Customer Service Department or the CalOptima Pharmacy Management Department shall inform the Member or Authorized Representative of the limited time available to present evidence.

~~G.~~6. Upon request by the Member ~~or,~~ Authorized Representative, or Prescribing Practitioner, CalOptima shall provide the opportunity, before and during the Appeals process, to examine or obtain a copy of the Member's case file, including medical records, and any other relevant documents and records considered during the Appeals process, free of charge and sufficiently in advance of the resolution timeframe for Appeal.

~~H.~~7. CalOptima shall provide written acknowledgement to the Member, dated and postmarked within five (5) calendar days of the receipt of a standard Appeal request.

8. ~~CalOptima shall ensure that the Member or Authorized Representative is given a reasonable opportunity to present, in writing or verbally, comments, documents or other information relating to the pharmacy Appeal, including evidence, facts, and law in support of the pharmacy Appeal.~~ CalOptima shall process appeals based on the following timeframes:

~~I.~~1. ~~In the case of a pharmacy Appeal subject to expedited review, the CalOptima Customer Service Department or the CalOptima Pharmacy Management Department shall inform the Member or Authorized Representative of the limited time available to present evidence.~~

~~J. A Prescribing Practitioner may contact a CalOptima physician, or a health care professional reviewer, to discuss the NOA for modification, denial, termination, or carve out of a service, or to obtain a copy of the criteria used to make the decision.~~

~~K.~~A. ~~CalOptima shall make reasonable efforts to provide oral notification to the Member of the resolution of an expedited Appeal.~~

~~L. CalOptima shall ensure the individual reviewing the pharmacy Appeal was not involved in the initial decision and the reviewer is not a subordinate of the initial reviewer.~~

~~M. Members shall exhaust CalOptima's Appeal process prior to requesting a State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process.~~

~~N.~~M. ~~A Member may receive continuation of benefits while the pharmacy Appeal is pending resolution if:~~

~~1. The Member files the pharmacy Appeal request within ten (10) calendar days of the mailing date of the NOA;~~

~~2.~~1. ~~The authorized Prescribing Practitioner orders the medication;~~

~~3.~~1. ~~The pharmacy Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;~~

~~4.~~1. ~~The period covered by the original authorization has not expired; and~~

~~5.~~1. ~~The Member verbally requests an extension of the benefits by calling the CalOptima Customer Service Department.~~

~~O.~~M. ~~For Appeals resolved in favor of the Member, CalOptima shall authorize the request no later than seventy-two (72) hours from the date reversing the determination.~~

~~III.~~I. ~~PROCEDURE~~

~~A. Timelines and notification standards for Appeals~~

~~1.~~a. The decision for a pre-service Appeal and notification to the Prescribing Practitioner and Member shall be made within thirty (30) calendar days of the initial receipt of the request.

~~2.~~b. The decision for a post-service Appeal and notification to the Prescribing Practitioner and Member shall be made within thirty (30) calendar days of the initial receipt of the request.

~~3.~~c. The decision for an expedited appeal and notification to the Prescribing Practitioner and Member shall be made within seventy-two (72) hours, or as soon as a Member's health condition requires, after the receipt of the request.

~~4.~~d. The plan may extend the Appeal timeframe for either standard or expedited Appeals by up to fourteen (14) calendar days if either of these two (2) conditions apply:

~~a.~~i. The Member requests the extension.

~~b.~~ii. CalOptima demonstrates to the satisfaction of DHCS, upon request, that there is a need for additional information and the delay is in the Member's best interest.

~~i.~~e. For any extension not requested by the Member, CalOptima shall provide the Member with written notice of the reason for the delay within two (2) calendar days and notify the Member of the right to file a Grievance if the Member disagrees with the extension.

~~ii.~~f. CalOptima shall make reasonable efforts to provide the Member with oral notice of the extension.

~~iii.~~g. CalOptima shall resolve the Appeal as expeditiously as the Member's health condition requires, but in no event may extend resolution beyond the initial fourteen (14) calendar day extension.

~~iv.~~h. In the event that CalOptima fails to adhere to the notice and timing requirements of an Appeal, the Member is deemed to have exhausted the CalOptima internal Appeal process and may initiate a State Hearing request.

~~5.~~9. Members shall be notified of the Appeal decision by mail, unless the request is an expedited Appeal, then CalOptima shall make reasonable efforts to provide oral notification to the Member of the resolution. Prescribing Practitioners shall be notified of the Appeal decision by fax and mail based on the notification standards as specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

~~B.~~A. ~~Request for a Pharmacy Appeal~~

~~1. A Member, or their Authorized Representative, may request a pharmacy Appeal, verbally or in writing, within sixty (60) calendar days from the date on the NOA from CalOptima by:~~

~~a. Telephone or in person to CalOptima's Customer Service Department; or~~

~~b.~~a. ~~Facsimile, or in writing, to CalOptima's Grievance and Appeals Resolution Services (GARS).~~

~~2.~~1. ~~A Prescribing Practitioner may request a Pharmacy Appeal within sixty (60) calendar days from the date on the NOA received from CalOptima regarding Pharmaceutical Services for a Member. The request shall include all relevant material, such as clinical documentation or other documentation supporting the request, and the Prescribing Practitioner shall clearly label the request with "Appeal" or "Expedited Appeal." A Prescribing Practitioner may request a pharmacy Appeal by:~~

~~a. Facsimile or telephone to CalOptima's Pharmacy Benefits Manager (PBM); or~~

~~b.~~a. ~~Telephone, or in writing, via mail or facsimile, to CalOptima's GARS, Customer Service, or Pharmacy Management Departments.~~

~~3. Telephone Appeal requests, excluding expedited Appeals, from a Member, or their Authorized Representative, or a Prescribing Practitioner shall be followed by a written and signed Appeal request. The date of the oral Appeal shall establish the filing date for the Appeal. CalOptima shall provide the Appeal Form to the Member along with the acknowledgement notice. In the event that CalOptima does not receive a written and signed Appeal from the Member, CalOptima shall neither dismiss nor delay resolution of the Appeal.~~

~~C.~~B. Pharmacy Appeal Processing

1. Upon receipt of a Pharmacy Appeal from a Member, the Member's Authorized Representative, or Prescribing Practitioner, CalOptima's Pharmacy Management Department shall:

   a. Acknowledge the receipt of a standard Appeal request to the Member, dated and postmarked within five (5) calendar days of the receipt of the Appeal. The Acknowledgement notice shall advise the Member that the Appeal has been received, include the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the Appeal. The acknowledgement letter shall include the nondiscrimination notice and the language assistance taglines.

   ~~i.~~b. ~~For oral Member initiated~~Oral Appeals from Members, excluding expedited Appeals, shall be followed by a written, signed Appeal ~~requests,~~. The date of the oral Appeal shall establish the filing date for the Appeal. CalOptima shall provide the Member with an Appeal ~~Request Form in~~form along with the Member's written acknowledgement notification. In the event that CalOptima does not receive a written, signed Appeal from the member, CalOptima shall neither dismiss or delay the resolution of the Appeal.

   ~~b.~~c. Review the initial Pharmacy decision and all documents related to the determination of Medical Necessity of the service requested, including any additional information supplied by the Member, the Member's Authorized Representative, or the Prescribing Practitioner.

~~c.~~d. Prepare the case file for review by a new health care professional reviewer who was not involved in the initial decision, except if the decision is found fully in favor of the Member, in which case the person making the initial decision may reverse the prior decision.

~~d.~~e. A CalOptima Clinical Pharmacist shall:

i. Fully investigate the content of the Appeal without giving deference to the previous denial decision;

ii. Document the substance of the Appeal, including any aspects of clinical care involved;

iii. Document the findings of their Appeal review; and

iv. Document the reasons for the Appeal decision if upheld or overturned.

~~e.~~f. A CalOptima Clinical Pharmacist, or Medical Director, may reverse a denial decision and overturn an Appeal. For Appeal requests that do not meet the CalOptima Clinical Guidelines, the CalOptima Clinical Pharmacist shall send a recommendation to a Medical Director to review for a potential appeal upheld decision.

~~f.~~g. CalOptima may utilize a specialist health care professional consultant in the same or similar specialty that typically treats the Medical Condition, as appropriate.

2. CalOptima Pharmacy Management Department shall ~~reclassify~~process an expedited Appeal as standard ~~review~~Appeal timeframe, if the Appeal request does not meet the criteria for expedited review.

~~a. If the application of the timeframe for making routine or non-life-threatening care determinations:~~
a. An exepedited Appeal may be granted, if a standard Appeal timeframe:

i. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or

ii. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

b. CalOptima's Pharmacy Management Department shall document and notify the Prescribing Practitioner of the appeal status change to standard appeal.

3. Pharmacy Notice of Appeal Resolution (NAR)

a. The CalOptima Pharmacy Management Department shall mail the Member and the Prescribing Practitioner a Notice of Appeal Resolution (NAR) for all Pharmaceutical Services Appeal requests.

b. The NAR shall include information as described in this Section.

c. If CalOptima upholds a pharmacy decision for a Pharmaceutical Service based in whole or in part on findings that the Pharmaceutical Service is not Medically Necessary or not a

Covered Service, the NAR shall clearly specify the applicable reference that excludes that service along with the member's right to request for a State Hearing within one hundred twenty (120) calendar days from the date of on the NAR.

d. The NAR shall include the following information:

i. The ~~result~~results of the resolution and the date it was completed.

ii. For denial determination based in whole or in part on medical necessity, CalOptima shall include clear and concise reason reasons for the determination and clearly reference the criteria, clinical guidelines, or medical policies on which the Appeal decision is based.

iii. For determination in which the requested service is not a covered benefit, CalOptima shall include the provision in the DHCS contract or Member Handbook that excludes the service with the page where the provision is found and direct the Member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applied to the requested services.

~~ii.~~iv. The titles and qualifications, specialty~~,~~ (for appeal upheld decision), and contact information of the individual healthcare practitioners participating in the appeal review and in the decision of the appeal;

~~iii. The benefit provision in the DHCS Contract or Member Handbook, prior authorization guideline, or protocol on which the Appeal decision is based. CalOptima shall identify the document and page where the provision is found, direct the Member to the applicable provision and explain in clear and concise language how the exclusion applied to the specific requested treatment.~~

~~iv. For overturn or uphold decisions, CalOptima shall provide a clear and concise reason for the decision and clearly state the criteria, clinical guideline, or medical policies used in making the decision;~~

v. Information explaining that the Member may obtain, upon request to CalOptima's Customer Service Department, using the phone number provided on the notice, copies of their Appeal file documentation and a copy of the actual guideline used to make the Appeal decision free of charge;

vi. A nondiscrimination notice and the language assistance taglines, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

vii. The notification for an upheld Appeal decision shall also include the "Your Rights" Attachment. The Your Rights attachment shall contain the following:

1) The Member's right to request a State Hearing within one hundred twenty (120) calendar days from the date on the NAR, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures;

2) The Member's right to have a representative act on his or her behalf for the State Hearing; and

~~3) "Your Rights" Attachment.~~
3) The Member's right to request and receive continuation of benefits within 10 days calendar days of when the NOA was sent.

IV. ATTACHMENTS

A. Notice of Appeal Resolution (NAR) - Decision Uphold (MCAL MM-17-35)
B. Notice of Appeal Resolution (NAR) - Decision Overturn (MCAL MM-17-33)
C. Centers for Medicare and Medicaid Appointment of Representative Form
D. Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Policy AA.1000: Glossary of Terms
~~C.~~D. CalOptima Policy DD.2002: Cultural and Linguistic Services
~~D.~~E. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
~~E.~~G. CalOptima Policy HH.1101: CalOptima Provider Complaint
~~F.~~H. CalOptima Policy HH.1102: CalOptima Member Complaint
~~G.~~I. CalOptima Policy HH.1108: State Hearings Process and Procedures
~~H.~~J. Title 22, California Code of Regulations, §§51003 and 51303
~~I.~~K. Title 28, California Code of Regulations, §1300.68
~~J.~~L. Title 42, Code of Federal Regulations, §§438.402(b)(2), 438.406, 438.420(a) – (c)
~~K.~~M. All plan letter, 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.
N. Welfare & Institutions Code, § 14094.13 (d).
O. All plan letter, 18-011: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

A. 08/09/16: Department of Health Care Services
B. 04/26/16: Department of Health Care Services
C. 08/11/14: Department of Health Care Services

VII. BOARD ACTIONS

A. ~~None to Da~~09/06/18: Regular Meeting of the CalOptima Board of Directors~~te~~

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	07/01/2008	GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal
Effective	05/01/2008	GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal
Revised	06/01/2009	GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2011	GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal
Revised	11/01/2011	GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal
Revised	01/01/2013	GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal
Revised	05/01/2014	GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal
Revised	09/01/2014	GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal
Revised	01/01/2015	GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal
Revised	02/01/2016	GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal
Revised	06/01/2016	GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal
Revised	12/01/2016	GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal
Revised	07/01/2017	GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal
Revised	09/06/2018	GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal

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IX. GLOSSARY

Term	Definition
Acknowlegement Letter	A written statement acknowledging receipt of an appeal.
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Appeal	A type of Grievances that involve the delay, modification, denial of services based on medical necessity, or a determination that the requested service was not a covered benefit.
Appeal Resolution	An outcome for appeal request as a result of an adverse benefit determination.
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009Δ: ~~Access by~~Accessby Member's Authorized Representative.
Covered Service	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.
Delay Determination	The failure to act within the required timeframes for standard resolution of a prior authorization request.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Modification Determination	A limited authorization or in denial in part, of a payment or rerquested service.
Notice of Action (NOA)	A NOA is a formal letter informing the Member and Presciber of an Adverse Benefit Determination.
Notice of Appeal Resolution (NAR)	A NAR is a formal letter informing the Member that an Adverse Benefit Determination has been overturned or upheld.
Pharmaceutical Services	Covered drugs and related professional services provided to a Member pursuant to applicable state and federal laws, CalOptima's Pharmacy Services Program Manual, and the standard of practice of the pharmacy profession of the state in which the Pharmacy is located.
Pharmacy Benefits Manager	The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Post-service Request	A request for coverage of pharmaceutical services that have been received by a Member, e.g., retrospective review.

Term	Definition
Prescribing Practitioner	The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a Member.
Pre-service Request	A request for coverage of pharmaceutical services that CalOptima must approve in advance, in whole or in part.
Urgent Request	A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: 1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or 2. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

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Policy #: GG.1410
Title: **Appeal Process for Pharmacy Authorization**
Department: Medical Affairs
Section: Pharmacy Management

CEO Approval: Michael Schrader _____

Effective Date: 05/01/08
Last Review Date: 09/06/18
Last Revised Date: 09/06/18

I. PURPOSE

This policy defines the process by which CalOptima addresses and resolves a Pre-service, Post-service, or expedited Appeal for Pharmaceutical Services, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima shall process requests for Appeals using the definition, turn-around time, and notification standards as specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit. A request marked as an Urgent Request that does not meet the definition for expedited review shall be reclassified as a routine request as outlined in this attachment. CalOptima shall maintain appropriate communication with the Prescribing Practitioner and/or Member or the Member's Authorized Representative throughout the Appeal process to facilitate delivery of appropriate services.

B. Upon receipt of a Notice of Action (NOA) notifying a Prescribing Practitioner or a Member of a CalOptima pharmacy decision that a Pharmaceutical Service request has been modified; denied; carved out of a treatment; or terminated, reduced, or suspended, a Prescribing Practitioner, a Member, or an Authorized Representative, including an attorney, shall have the right to Appeal the decision.

C. A pharmacy Appeal shall be a separate process from the Provider Complaint, Member Complaint, or Member State Fair Hearing, as specified in CalOptima Policies GG.1510: Appeals Process for Decisions Regarding Care and Services, HH.1101: CalOptima Provider Complaint, HH.1102: CalOptima Member Complaint, and HH.1108: State Hearings Process and Procedures.

D. If the Member wishes to have an Authorized Representative, act on the Member's behalf in the appeals process, a Member must authorize the appointment, in writing, of an Authorized Representative to represent the Member in the Appeal process, or the Authorized Representative shall submit a copy of a Durable Power of Attorney for health care, or similar legal appointment or representative document, or must otherwise be recognized under California law as a legal representative of the Member.

E. A Prescribing Practitioner on behalf of the Member, the Member, or the Member's Authorized Representative may request a pharmacy Appeal by submitting a written or verbal Appeal request within sixty (60) calendar days from the date written on the NOA received from CalOptima, in accordance with the provisions of this policy. Appeals filed by the Prescribing Practitioner on behalf of the Member shall require written consent from the Member.

F. CalOptima shall document the reason for the Appeal, who requested the Appeal, how the Appeal was received, and any actions taken on the appeal.

G. CalOptima shall ensure prompt review and full investigation of the substance for an Appeal, including any aspects of clinical care involved.

H. CalOptima shall give a Member, Authorized Representiave or Provider a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Appeal, evidence, facts, and law in support of the Appeal. In the case of an Appeal subject to an expedited review, CalOptima shall inform the Member, Authorized Representative or Provider of the limited time available to present evidence.

I. The person making the final decision for the proposed resolution of an Appeal has neither participated in any prior decisions related to the Appeal, nor is a subordinate of someone who has participated in a prior decision and has clinical expertise in treating the Member's condition or disease if deciding on any of the following:

1. An Appeal of a denial based on lack of Medical Necessity; and

2. Any Appeal involving clinical issues.

M. CalOptima shall ensure that at least one person reviewing the Appeal who is a practitioner in the same or similar specialty.

N. Members shall exhaust CalOptima's Appeal process prior to requesting a State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process.

O. A Member may receive continuation of benefits while the pharmacy Appeal is pending resolution if:

1. The Member files the pharmacy Appeal request within ten (10) calendar days of the mailing date of the NOA;

2. The authorized Prescribing Practitioner orders the medication;

3. The pharmacy Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

4. The period covered by the original authorization has not expired; and

5. The Member verbally requests an extension of the benefits by calling the CalOptima Customer Service Department.

P. CalOptima may extend the timeframe to resolve the Appeal by up to fourteen (14) calendar days at the request of the Member or if there is a need for additional information and how the delay is in the Member's best interest.

Q. For any extensions not requested by the Member, CalOptima must provide the Member with written notice of the reason for the delay and the right to file a Grievance within two (2) calendar days from the oral notification of the extension.

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R. For Appeals resolved in favor of the Member, CalOptima shall authorize the request no later than seventy-two (72)-hours from the date reversing the determination.

S. CalOptima shall make reasonable efforts to provide oral notification to the Member of the resolution of an expedited Appeal.

T. CalOptima shall provide culturally and linguistically appropriate notices of the Appeals process to Members, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

U. Effective no sooner than January 1, 2019, Members eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model program shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process.

III. PROCEDURE

A. Request for a Pharmacy Appeal

1. A Member, or their Authorized Representative, may request a pharmacy Appeal, verbally or in writing, within sixty (60) calendar days from the date on the NOA from CalOptima by:

   a. Telephone or in-person to CalOptima's Customer Service Department; or

   b. Facsimile, or in writing, to CalOptima's Grievance and Appeals Resolution Services (GARS).

2. Telelphone Appeals from Members, excluding expedited Appeals, shall be followed by a written, signed Appeal. The date of the oral Appeal shall establish the filing date for the Appeal. CalOptima shall provide the Member with an Appeal form along with the Member's written acknowledgement notification. In the event that CalOptima does not receive a written, signed Appeal from the Member, CalOptima shall neither dismiss or delay the resolution of the Appeal.

3. A Prescribing Practitioner may request a Pharmacy Appeal within sixty (60) calendar days from the date on the NOA received from CalOptima regarding Pharmaceutical Services for a Member. The request shall include all relevant material, such as clinical documentation or other documentation supporting the request, and the Prescribing Practitioner shall clearly label the request with "Appeal" or "Expedited Appeal." A Prescribing Practitioner may request a pharmacy Appeal by:

   a. Facsimile or telephone to CalOptima's Pharmacy Benefits Manager (PBM); or

   b. Telephone, or in writing, via mail or facsimile, to CalOptima's GARS, Customer Service, or Pharmacy Management Departments.

4. Oral Appeal requests, excluding expedited Appeals, from a Member, or their Authorized Representative, or a Prescribing Practitioner shall be followed by a written and signed Appeal request. The date of the oral Appeal shall establish the filing date for the Appeal. CalOptima shall provide the Appeal Form to the Member along with the acknowledgement notice. In the event that CalOptima does not receive a written and signed Appeal from the Member, CalOptima shall neither dismiss nor delay resolution of the Appeal.

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5. CalOptima shall ensure that the Member or Authorized Representative, is given a reasonable opportunity to present, in writing or verbally, comments, documents or other information relating to the pharmacy Appeal, including evidence, facts, and law in support of the pharmacy Appeal. A Prescribing Practitioner may also contact a CalOptima physician, or a health care professional reviewer, to discuss the NOA for modification, denial, termination, or carve out of a service, or to obtain a copy of the criteria used to make the decision. In the case of a pharmacy Appeal subject to expedited review, the CalOptima Customer Service Department or the CalOptima Pharmacy Management Department shall inform the Member or Authorized Representative of the limited time available to present evidence.

6. Upon request by the Member, Authorized Representative, or Prescribing Practitioner, CalOptima shall provide the opportunity, before and during the Appeals process, to examine or obtain a copy of the Member's case file, including medical records, and any other relevant documents and records considered during the Appeals process, free of charge and sufficiently in advance of the resolution timeframe for Appeal.

7. CalOptima shall provide written acknowledgement to the Member, dated and postmarked within five (5) calendar days of the receipt of a standard Appeal request.

8. CalOptima shall process appeals based on the following timeframes:

    a. The decision for a pre-service Appeal and notification to the Prescribing Practitioner and Member shall be made within thirty (30) calendar days of the initial receipt of the request.

    b. The decision for a post-service Appeal and notification to the Prescribing Practitioner and Member shall be made within thirty (30) calendar days of the initial receipt of the request.

    c. The decision for an expedited appeal and notification to the Prescribing Practitioner and Member shall be made within seventy-two (72) hours, or as soon as a Member's health condition requires, after the receipt of the request.

    d. The plan may extend the Appeal timeframe for either standard or expedited Appeals by up to fourteen (14) calendar days if either of these two (2) conditions apply:

        i. The Member requests the extension.

        ii. CalOptima demonstrates to the satisfaction of DHCS, upon request, that there is a need for additional information and the delay is in the Member's best interest.

    e. For any extension not requested by the Member, CalOptima shall provide the Member with written notice of the reason for the delay within two (2) calendar days and notify the Member of the right to file a Grievance if the Member disagrees with the extension.

    f. CalOptima shall make reasonable efforts to provide the Member with oral notice of the extension.

    g. CalOptima shall resolve the Appeal as expeditiously as the Member's health condition requires, but in no event may extend resolution beyond the initial fourteen (14) calendar day extension.

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h. In the event that CalOptima fails to adhere to the notice and timing requirements of an Appeal, the Member is deemed to have exhausted the CalOptima internal Appeal process and may initiate a State Hearing request.

9. Members shall be notified of the Appeal decision by mail, unless the request is an expedited Appeal, then CalOptima shall make reasonable efforts to provide oral notification to the Member of the resolution. Prescribing Practitioners shall be notified of the Appeal decision by fax and mail based on the notification standards as specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

B. Pharmacy Appeal Processing

1. Upon receipt of a Pharmacy Appeal from a Member, the Member's Authorized Representative, or Prescribing Practitioner, CalOptima's Pharmacy Management Department shall:

a. Acknowledge the receipt of a standard Appeal request to the Member, dated and postmarked within five (5) calendar days of the receipt of the Appeal. The Acknowledgement notice shall advise the Member that the Appeal has been received, include the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the Appeal. The acknowledgement letter shall include the nondiscrimination notice and the language assistance taglines.

b. Oral Appeals from Members, excluding expedited Appeals, shall be followed by a written, signed Appeal. The date of the oral Appeal shall establish the filing date for the Appeal. CalOptima shall provide the Member with an Appeal form along with the Member's written acknowledgement notification. In the event that CalOptima does not receive a written, signed Appeal from the member, CalOptima shall neither dismiss or delay the resolution of the Appeal.

c. Review the initial Pharmacy decision and all documents related to the determination of Medical Necessity of the service requested, including any additional information supplied by the Member, the Member's Authorized Representative, or the Prescribing Practitioner.

d. Prepare the case file for review by a new health care professional reviewer who was not involved in the initial decision, except if the decision is found fully in favor of the Member, in which case the person making the initial decision may reverse the prior decision.

e. A CalOptima Clinical Pharmacist shall:

i. Fully investigate the content of the Appeal without giving deference to the previous denial decision;

ii. Document the substance of the Appeal, including any aspects of clinical care involved;

iii. Document the findings of their Appeal review; and

iv. Document the reasons for the Appeal decision if upheld or overturned.

f. A CalOptima Clinical Pharmacist, or Medical Director, may reverse a denial decision and overturn an Appeal. For Appeal requests that do not meet the CalOptima Clinical

Guidelines, the CalOptima Clinical Pharmacist shall send a recommendation to a Medical Director to review for a potential appeal upheld decision.

g. CalOptima may utilize a specialist health care professional consultant in the same or similar specialty that typically treats the Medical Condition, as appropriate.

2. CalOptima Pharmacy Management Department shall process an expedited Appeal as standard Appeal timeframe, if the Appeal request does not meet the criteria for expedited review.

a. An exepedited Appeal may be granted, if a standard Appeal timeframe:

i. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or

ii. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

b. CalOptima's Pharmacy Management Department shall document and notify the Prescribing Practitioner of the appeal status change to standard appeal.

3. Pharmacy Notice of Appeal Resolution (NAR)

a. The CalOptima Pharmacy Management Department shall mail the Member and the Prescribing Practitioner a Notice of Appeal Resolution (NAR) for all Pharmaceutical Services Appeal requests.

b. The NAR shall include information as described in this Section.

c. If CalOptima upholds a pharmacy decision for a Pharmaceutical Service based in whole or in part on findings that the Pharmaceutical Service is not Medically Necessary or not a Covered Service, the NAR shall clearly specify the applicable reference that excludes that service along with the member's right to request for a State Hearing within one hundred twenty (120) calendar days from the date of on the NAR.

d. The NAR shall include the following information:

i. The results of the resolution and the date it was completed.

ii. For denial determination based in whole or in part on medical necessity, CalOptima shall include clear and concise reason reasons for the determination and clearly reference the criteria, clinical guidelines, or medical policies on which the Appeal decision is based.

iii. For determination in which the requested service is not a covered benefit, CalOptima shall include the provision in the DHCS contract or Member Handbook that excludes the service with the page where the provision is found and direct the Member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applied to the requested services.

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iv. The titles and qualifications, specialty (for appeal upheld decision), and contact information of the individual healthcare practitioners participating in the appeal review and in the decision of the appeal;

v. Information explaining that the Member may obtain, upon request to CalOptima's Customer Service Department, using the phone number provided on the notice, copies of their Appeal file documentation and a copy of the actual guideline used to make the Appeal decision free of charge;

vi. A nondiscrimination notice and the language assistance taglines, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

vii. The notification for an upheld Appeal decision shall also include the "Your Rights" Attachment. The Your Rights attachment shall contain the following:

1) The Member's right to request a State Hearing within one hundred twenty (120) calendar days from the date on the NAR, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures;

2) The Member's right to have a representative act on his or her behalf for the State Hearing; and

3) The Member's right to request and receive continuation of benefits within 10 days calendar days of when the NOA was sent.

IV. ATTACHMENTS

A. Notice of Appeal Resolution (NAR) - Decision Uphold (MCAL MM-17-35)
B. Notice of Appeal Resolution (NAR) - Decision Overturn (MCAL MM-17-33)
C. Centers for Medicare and Medicaid Appointment of Representative Form
D. Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy DD.2002: Cultural and Linguistic Services
E. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
G. CalOptima Policy HH.1101: CalOptima Provider Complaint
H. CalOptima Policy HH.1102: CalOptima Member Complaint
I. CalOptima Policy HH.1108: State Hearings Process and Procedures
J. Title 22, California Code of Regulations, §§51003 and 51303
K. Title 28, California Code of Regulations, §1300.68
L. Title 42, Code of Federal Regulations, §§438.402(b)(2), 438.406, 438.420(a) – (c)
M. All plan letter, 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.
N. Welfare & Institutions Code, § 14094.13 (d).
O. All plan letter, 18-011: California Children's Services Whole Child Model Program

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VI. REGULATORY AGENCY APPROVALS

A. 08/09/16: Department of Health Care Services
B. 04/26/16: Department of Health Care Services
C. 08/11/14: Department of Health Care Services

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

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[CalOptima logo]

"Uphold"

[Health Plan or PPG Tracking Number – optional]

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You or *[Name of requesting provider or authorized representative]*, on your behalf, appealed the *[denial, delay, modification, or termination]* of *[Service requested].* Our Clinical Pharmacist and our Medical Director, who is a physician and board certified in <<Specialty>>, have reviewed the appeal and have decided to uphold the decision. This request is still denied. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. To ask for this, please call *[CalOptima]* at *[telephone number]*.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged to send in any information that could help your case. The "Your Rights" notice tells you the cut off dates to ask for an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at *[CalOptima Customer Services telephone number]*.

This notice does not affect any of your other Medi-Cal services.

[Medical Director name]

Enclosed: “Your Rights under Medi-Cal Managed Care”

(Enclose notice with each letter)

[CalOptima logo]

"Overturn"

[Health Plan or PPG Tracking Number – optional]

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You or *[Name of requesting provider or authorized representative]*, on your behalf, appealed the *[denial, delay, modification, or termination]* of *[Service requested]. [CalOptima]* has reviewed the appeal and has decided to overturn the original decision. This request is now approved. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

[CalOptima] has 72 hours to give you the service.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at *[CalOptima Customer Services telephone number]*.

This notice does not affect any of your other Medi-Cal services.

[Medical Director name for medical services or Clinical Pharmacist name for pharmaceutical services]

Form Approved
OMB No. 0938-0950

APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier Number (provider as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (DHHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of DHHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

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Charging of Fees for Representing Beneficiaries before the Secretary of DHHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of DHHS (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council review, or a proceeding before an ALJ or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance if you are filing a grievance, initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227). TTY users please call 1-877-486-2048.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: **AltFormatRequest@cms.hhs.gov**.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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Attachment D (for GG.1410):
Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Prior Authorization		Notification Timeframe
Type of Request	**Decision**	**NOA: Practitioner and Member**
Standard (Non-urgent) Preservice - All necessary information received at time of initial request	A decision to approve, modify, or deny is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1].	- **Practitioner:** Within 2 business days of making the decision[2] (electronic and written notification) - **Member:** Within 2 business days of making the decision[2] (written notification)
Standard (Non-urgent) Preservice - Extension Needed - Additional clinical information required - Requires consultation by an Expert Reviewer - Additional examination or tests to be performed - [AKA: Deferral or Request for Information (RFI)]	- A response to defer is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 5 working days of receiving the additional information but no longer than 14 calendar days, upon receipt of the information reasonably necessary to render a decision. - The Member or the Member's provider may request for an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. - Notice of deferral should include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. - Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such[2].	- **Practitioner:** Within 2 business days of making the decision[2], not to exceed 14 calendar days from the receipt of the request for service[3] (electronic and written notification) - **Member:** Within 2 business days of making the decision[2], not to exceed 14 calendar days from the receipt of the request for service[3] (written notification)
Expedited (Urgent) Pre-Service - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. - All necessary information received at time of initial request	- A decision to approve, modify, or deny is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1]. - **Expedited (Urgent) Pre-Service** may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[4].	- **Practitioner:** Within 2 business days of making the decision[2] (electronic and written notification) - **Member:** Within 2 business days of making the decision[2] (written notification)

Attachment D (for GG.1410):
Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Prior Authorization		Notification Timeframe
Type of Request	**Decision**	**NABD Notification: Practitioner and Member**
Expedited (Urgent) Pre-Service - Extension Needed - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function[2,4]. - Additional clinical information required - [AKA: Deferral or Request for Information (RFI)]	- A response to defer is required within 24 hours for all drugs that require prior authorization, in accordance to Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 72 hours of initial receipt of the request[2,4]. - **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[2,4]. - The Member or the Member's provider may request for an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. - Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. - Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such[2].	- **Practitioner and Member:** Within 2 business days of making the decision[2] (electronic and written notification) - **Member:** Within 2 business days of making the decision[2] (written notification)
Concurrent review of treatment regimen already in place - A request for coverage of pharmaceutical services made while a member is in the process of receiving the requested pharmaceutical services, even if the organization did not previously approve the earlier care.	- A response to defer is required within 24 hours for all drugs that require prior authorization in accordance to Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 72 hours, or as soon as a Member's health condition requires, after the receipt of the request, in accordance to UM 5: Timeliness of UM decision, Element E: Timeliness of Pharmacy UM Decisions, 2016 HP Accreditation UM Standards[2,4]. - If the plan is unable to request for an extension of an urgent concurrent care within 24 hours **before the expiration of the prescribed period of time or number of treatments**, then the organization may treat the request as urgent preservice and make a decision within 72 hours[2]. - The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny[2].	- **Practitioner:** Within 24 hours of making the decision[2] (electronic and written notification) - **Member:** Within 24 hours of making the decision[2] (written notification)
Post-Services / Retrospective Review	A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request[2,4].	- **Practitioner:** Within 30 days of the receipt of the request[2,3] (written notification) - **Member:** Within 30 days of the receipt of the request[2,3] (written notification)

Attachment D (for GG.1410):
Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Appeals Time period to file an appeal: within 60 days of the initial denial decision[5]		**Notification Timeframe**
Type of Request	**Decision**	**Practitioner and Member**
Routine (Standard) Preservice Appeal	A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request[5].	- **Practitioner:** Within 30 days of making the decision[5] (electronic & written notification) - **Member:** Within 30 days of making the decision[5] (written notification)
Expedited (Urgent) Pre-Service Appeal - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function[2,4].	- A decision to approve, modify, or deny is required within 72 hour, or as soon as a Member's health condition requires, after receipt of the request[5]. - **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[2,4].	- **Practitioner:** Within 72 hours of making the decision[5] (electronic & written notification) - **Member:** Within 72 hours of making the decision[5] (oral and written notification)
Postservice Appeal -	A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request[5].	- **Practitioner:** Within 30 days of making the decision[5] (electronic & written notification) - **Member:** Within 30 days of making the decision[5] (written notification).

References:

1. Welfare and Institutions Code section 14185(a)(1) accessed at: http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=7.&article=5.6.
2. Health and Safety Code Sections 1367.01(h)
3. UM 5: Timeliness of UM decision, Element F: Notification of Pharmacy Decisions, 2016 HP Accreditation UM Standards.
4. UM 5: Timeliness of UM decision, Element E: Timeliness of Pharmacy UM Decisions, 2016 HP Accreditation UM Standards.
5. UM 8: Polices for Appeals, Element A: Factor 1.
6. All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

Policy #: GG.1600
Title: **Access and Availability Standards**
Department: Medical Affairs
Section: Quality Analytics

CEO Approval: Michael Schrader_____

Effective Date: 12/01/99
Last Review Date: 09/06/18~~12/01/17~~
Last Revised Date: 09/06/18~~12/01/17~~

I. PURPOSE

This policy establishes required access and availability standards for Members~~.~~ to obtain

~~II. POLICY~~

~~A. CalOptima and its Health Networks shall ensure that Members have~~ effective ~~and~~, appropriate, and timely access to ~~Covered Services in a timely manner, in accordance with~~care and describes the ~~standards of this policy~~process used by CalOptima for annual Network Certification.

II. POLICY

~~B.~~A. CalOptima shall evaluate ~~a~~CalOptima's and a Health Network's compliance with the standards outlined in this ~~Policy~~policy. Unless otherwise stated, each access and availability standard outlined herein shall have a minimum performance threshold of ninety percent (90%).

~~C.~~B. CalOptima and its Health Networks shall not discriminate against Members, ~~because~~on the basis of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, ~~or physical or mental handicap.~~language, gender identity, identification with any other persons or groups defined in Penal Code section 422.56, health status, or physical or mental disability.

~~D.~~C. CalOptima and its Health Networks shall ensure access for disabled Members which includes, but is not limited to ramps, elevators, restrooms, designated parking spaces, and drinking water provisions.

1. If a Provider cannot meet the minimum access standards for disabled Members, CalOptima and its Health Networks shall coordinate a referral to a Provider with the appropriate access standards.

~~E. Providers shall offer flexibility in scheduling to accommodate the needs of Members with disabilities.~~

~~1.~~D. CalOptima and its Health Networks shall ensure that Providers offer flexibility in scheduling Covered Services for Members with disabilities.

~~F. CalOptima and its Health Networks shall maintain sufficient numbers and types of contracted Specialist Physicians to ensure access and availability of specialty care to Members.~~

~~G.~~E. If a Provider has a moral or ethical objection to providing a Covered Service to a Member, CalOptima or a Health Network shall refer the Member to a different Provider.

DRAFT

~~H.~~F. If a Health Network refers a Member to a different Provider pursuant to Section II.G of this policy, CalOptima shall not incur any additional expense as a result of such referral.

~~I.~~G. If Covered Services are unavailable to the Member within the provider network, CalOptima or a Health Network shall arrange for the provision of specialty services from ~~specialists~~specialty care providers outside of the provider network in a timely manner, and in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

~~J.~~H. CalOptima and its Health Networks shall ensure that contracting Providers offer CalOptima Members hours of operation ~~similar~~that are no less than the hours of operation offered to commercial members or comparable to Medi-Cal Fee-For-Service, if the Provider services only Medi-Cal Members.

~~K.~~I. Emergency Services: Emergency services shall be available immediately to a Member twenty-four (24) hours a day, seven (7) days a week.

1. CalOptima and its Health Networks shall cover emergency medical services without prior authorization ~~in accordance with CalOptima policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Care Network Providers, and CalOptima Policy GG.1508: Authorization and Processing of Referrals~~s.

2. CalOptima shall have a designated emergency service facility within the ~~service area~~Service Area, providing care twenty-four (24) ~~-~~hours a day, seven (7) ~~-~~days a week. This designated emergency service facility will have one (1) or more physicians and one (1) nurse on duty in the facility at all times.

3. CalOptima and its Health Networks shall provide adequate follow-up care for those Members who have been screened in the Emergency Room in accordance with CalOptima Policy GG.1122: Follow-up for Emergency Department Care.

4. CalOptima and its Health ~~Network~~Networks shall ensure that a Physician is available twenty-four (24) hours a day, seven (7) days a week, to authorize Medically Necessary post-stabilization care, to coordinate the transfer of stabilized Members in an emergency department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

~~L. Appointment Access~~

J. CalOptima and its Health Networks shall ensure that Members have effective and appropriate access to Covered Services in a timely manner, in accordance with the standards of this policy. CalOptima shall evaluate CalOptima's and Health Network's compliance with the appointment access standards against a minimum performance threshold of ninety percent (90%), unless otherwise indicated.

1. Urgent Care Services: Available within twenty-four (24) hours of the request for an appointment.

2. Primary Care Appointments:

   a. Monitoring of primary care appointments shall include the monitoring of all primary care practitioners (PCPs) in CalOptima's provider network.

~~URGENT APPOINTMENTS~~PRIMARY CARE APPOINTMENTS		
Description	**Standard**	**Minimum Performance Level**
~~Urgent care services~~	~~Available within twenty-four (24) hours of the request for appointment~~	~~90%~~
Urgent appointment for services that ~~do not~~DO NOT require prior authorization	Available within forty-eight (48) hours of the request for appointment	90%
~~Urgent appointments for services that do require Prior Authorization~~Non-Urgent Primary Care (including Obstetrics/Gynecology Primary Care): Appointments	Available within ~~ninety-six (96) hours~~ten (10) business day of ~~the~~ request for appointment	90%

~~2. Non-Urgent Appointments:~~

~~NON-URGENT AND ROUTINE APPOINTMENTS~~		
~~**Description**~~	~~**Standard**~~	~~**Minimum Performance Level**~~
~~Primary Care: Appointments for non-urgent primary care~~	~~Available within ten (10) business day of request for appointment~~	~~90%~~
Routine Physical Exams and Health Assessments: Appointments for routine physical exams and health assessments	Available within thirty (30) calendar days of request for appointment	90%
~~Specialty Care: Appointments for non-urgent specialty care~~	~~Available within fifteen (15) business days of request for appointment~~	~~90%~~
~~Ancillary Services: Appointments for non-urgent ancillary services for the diagnosis or treatment of illness, injury, or other health conditions~~	~~Available within fifteen (15) business days of request for appointment~~	~~90%~~
Initial Health Assessment (IHA) or Individual Health Education Behavioral Assessment (IHEBA): Appointments for IHA or IHEBA	Available within one-hundred-twenty (120) calendar days of Medi-Cal enrollment	90%

3. Specialty and Ancillary Care Appointments:

a. Monitoring of specialty care appointments shall, at minimum, include the monitoring of the following specialty care providers: Cardiology/Interventional Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology, HIV/AIDS Specialist/Infectious Diseases, Nephrology, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Physical Medicine and Rehabilitation, Psychiatry, and Pulmonology.

b. Monitoring of ancillary appointments shall, at minimum, include the monitoring of the following: laboratories, occupational therapy, physical therapy, radiology centers, and speech therapy.

SPECIALTY AND ANCILLARY APPOINTMENTS		
Description	**Standard**	**Minimum Performance Level**
Urgent appointments for services that DO require Prior Authorization	Available within ninety-six (96) hours of the request for appointment	90%
Non-Urgent Specialty Care (including Obstetrics/Gynecology Specialty Care): Appointments	Available within fifteen (15) business days of request for appointment	90%
First Prenatal Visit: Appointments for the first prenatal visit	Available within two (2) weeks of request for appointment	90%
Non-Urgent Ancillary Services: Appointments for non-urgent ancillary services for the diagnosis or treatment of illness, injury, or other health conditions	Available within fifteen (15) business days of request for appointment	90%

~~3.~~4. Routine Behavioral Health Services:

a. Monitoring of timeliness of Behavioral Health Services shall, at minimum, include the following:

i. Non-Physician Behavioral health Providers: Psychologist, Licensed Clinical Social Worker, and Marriage and Family Therapist

ii. Physician Behavioral Health Provider: Psychiatrist

ROUTINE BEHAVIORAL HEALTH SERVICES		
Description	**Standard**	**Minimum Performance Level**
Appointment for routine care with a non-physician behavioral health care provider ~~(i.e. psychologists, Licensed Clinical Social Workers (LCSW), Marriage and Family Therapists (MFT)~~	Available to a Member within ten (10) business days after the date of the request	90%
Appointment for follow-up routine care with a non-physician behavioral health care provider (i.e. psychologists, Licensed Clinical Social Workers (LCSW), Marriage and Family Therapists (MFT)	~~Available to a Member within clinically reasonable timeframes. Behavioral health providers will assess the clinically appropriate treatment and provide follow-up services within the scope of their practice.~~ Members have a follow-up visit with a non-physician behavioral health care provider within twenty (20) calendar days of initial visit for a specific condition	~~N/A~~ 60%
Appointment for follow-up routine care with a physician behavioral health care provider	Members have a follow-up visit with a physician behavioral health care provider within thirty (30) calendar	60%

	days of initial visit for a specific condition	

~~4.~~5. Exceptions to Timeframes for Appointments

a. The timeframe to obtain an appointment for the services described in Sections II.~~L~~J.1 through II.~~L.3~~ J.4 of this policy may be extended if the referring or treating Provider, or the health care professional providing Triage or Screening Services, acting within the scope of his or her practice, and consistent with professionally recognized standards of practice, has determined and documented in the Member's record that a longer waiting time will not have a detrimental impact on the Member's health.

b. A Provider may offer an appointment for non-urgent Primary Care within the same or next business day from the time the Member requests the appointment, and advance scheduling of an appointment at a later date if the Member prefers not to accept the appointment offered within the same or next business day.

c. Preventive care services and periodic follow-up care for the services described in Sections II.~~L~~J.1 through II.~~L.3~~ J.4 of this policy may be scheduled in advance, consistent with professionally recognized standards of practice, as determined by the treating Provider acting within the scope of his or her practice.

d. Subsequent routine appointments: Appointments for subsequent routine appointments for prenatal visits shall be available to a Member and shall be scheduled in advance in accordance with applicable Department of Managed Health Care (DMHC) regulations governing timely access to non-emergency health care services. All Medically Necessary services for pregnant Members will be covered. The most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) will be utilized as the minimum measure of quality for perinatal services by CalOptima and its Health Networks.

6. Rescheduling of Appointments: When it is necessary for a Provider or a Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner appropriate for the Member's health care needs, and ensures continuity of care consistent with good professional practice.

K. In-office wait times shall not exceed forty-five (45) minutes before a Member is seen by a Provider.

~~M.~~L. Certified Nurse-Midwife and Certified Nurse Practitioner Services: If Certified Nurse-Midwife services, as described in CalOptima Policy GG.1713: Nurse-Midwife Practice Guidelines, ~~CalOptima Direct,~~ or Certified Nurse Practitioner services are not available to a Member; a Member may self-refer to an out-of-network Certified Nurse-Midwife or Certified Nurse Practitioner to receive such services.

~~N.~~M. Sensitive Services: Sensitive Services shall be available to a Member within the CalOptima Plan. A Member may self-refer to an out-of-network Provider to receive Sensitive Services, without Prior Authorization, pursuant to CalOptima Policy GG.1508: Authorization and Processing of Referrals.

~~O.~~N. Minor Consent Services: Minor Consent Services shall be available to a Member under the age of eighteen (18) in a confidential manner without parental consent, pursuant to CalOptima Policy GG.1508: Authorization and Processing of Referrals.

~~P.~~O. Family Planning Services: Family Planning Services shall be available to a Member, pursuant to CalOptima Policy GG.1118: Family Planning Services, Out-of-Network. A Member may self-refer to any Qualified Family Planning Practitioner, including an out-of-network practitioner to receive Family Planning Services.

~~Q.~~P. Behavioral Health Care: Behavioral Health Care Services shall be available to a Member, pursuant to CalOptima Policy GG.1900: Behavioral Health Services.

~~R.~~Q. Behavioral Health Treatment (BHT): BHT services shall be available to a Member pursuant to guidance provided by the Department of Health Care Services (DHCS), by a State Plan-approved provider, and in accordance with the requirements for access to specialty care services as indicated in CalOptima Policy GG.1548:Authorization for Applied Behavioral Health Analysis for Autism Spectrum Disorder.

~~S. Provider Availability:~~

R. Provider Availability: CalOptima and its Health Networks shall maintain a provider network adequate to serve one hundred percent (100%) of all eligible Members in the Service Area.

1. CalOptima shall take into consideration the geographic location of Providers and Members accounting for distance, travel time, and mode of transportation when evaluating adequate access to Covered Services.

2. CalOptima shall take into consideration Members and Providers language and gender when evaluating adequate access to Covered Services.

3. CalOptima shall take into consideration the number of Providers who are not accepting new patients when evaluating adequate access to Covered Services.

4. CalOptima shall take into consideration the anticipated Member enrollment numbers when evaluating adequate access to Covered Services.

5. CalOptima total physician availability standard: Ratio of total physicians to Members shall not be less than 1:1,200.

   a. If Non-Phyisican Medical Practitioners are included in CalOptima's provider network, each individual Non-Physician Medical Practitioners shall not exceed a full-time equivalent network provider/patient caseload of one (1) network provider per one thousand (1,000) patients.

6. CalOptima ~~and Health Network Mid Level~~shall ensure full-time equivalent Physician Supervisor to Non-Physician Medical Practitioner ~~availability standard: Ratio of total Mid Level~~ratios do not exceed the following:

   a. Nurse Practitioners 1:4

   b. Physician Assistants 1:4

   ~~6.~~c. Four (4) Non-Physician Medical Practitioner ~~to Members shall not exceed 1:1,000.~~ in any combination that does not include more than three (3) Certified Nurse Midwives or two (2) Physician Assistants.

~~a. Mid-Level Practitioners shall have a maximum Member case load of 1,000 members.~~

~~b. A Primary Care Provider can employ a maximum of four (4) Mid-Level Practitioners to comply with the PCP availability standards. A locum tenen in a PCP office will not be considered a Physician or Physician extender and shall be excluded from this policy.~~

7. CalOptima ~~and Health Network~~ Facilities Standards~~:~~: CalOptima shall maintain sufficient numbers and types of contracted facilities to ensure access and availability of care to Members.

~~a. Hospitals:~~

~~i.~~a. Hospitals: At least one (1) hospital shall be within fifteen (15) miles or thirty (30) minutes from the Member's residence.

b. Pharmacy: At least one (1) pharmacy shall be within ten (10) miles or thirty (30) minutes from the Member's residence.

~~b.~~ Long Term Support Services (LTSS):

~~i.~~c. CalOptima shall contract with Long Term Care Facilities in accordance with CalOptima Policy EE.1135: Long Term Care Facility Contracting.

i. Long Term Services and Supports (LTSS): CalOptima shall contract with a sufficient number of LTSS facilities to ensure that Member access meets the following criteria:

LTSS SERVICES		
Provider Type	**Standard**	**Minimum Performance Level**
Skilled Nursing Facility (SNF)	Available to a Member within five (5) business days after the date of the request	90%
Intermediate Care Facility / Developmentally Disabled (ICF-DD)	Available to a Member within five (5) business days after the date of the request	90%

~~c.~~d. Community-Based Adult Services (CBAS) Centers:

i. CalOptima shall ensure that every CBAS provider within the Service Area that has been approved by the California Department of Aging (CDA) as a CBAS provider as of July 1, 2012, is included in the provider network, to the extent that the CBAS provider remains licensed, certified, operating, and is willing to enter into a subcontract with CalOptima on mutually agreeable terms and meets CalOptima's credential and quality standards.

ii. If CalOptima determines that the additional CBAS providers are necessary to meet the needs of its Members, CalOptima may extend a contract to any CBAS Provider certified by the CDA after July 1, 2012. CalOptima shall consider a Member's relationship with previous CBAS Providers when ensuring access to CBAS. CalOptima shall not be required to include CBAS providers that were certified by the CDA after July 1, 2012 in the provider network.

iii. If CalOptima has assessed a Member and determines that the Member is eligible for CBAS services and there is insufficient CBAS center capacity in the area, CalOptima may authorize unbundled services and facilitate utilization through care coordination in accordance with CalOptima Policy GG.1130: Community-Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes.

~~8. Primary Care Practitioners:~~

~~a. Primary Care Practitioner (PCP) availability standards by geographic distribution:~~

~~GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS~~		
~~Practitioner Type~~	~~Measure~~	~~Minimum Performance Level~~
~~Total Primary Care Practitioners~~	~~One practitioner within ten (10) miles or thirty (30) minutes of the Member's residence~~	~~95%~~
~~General Practice/Family Practice~~	~~One General Practitioner/Family Practitioner within ten (10) miles or thirty (30) minutes of the Member's residence~~	~~95%~~
~~Internal Medicine~~	~~One Internist within ten (10) miles or thirty (30) minutes of the Member's residence~~	~~95%~~
~~Pediatrics~~	~~One Pediatrician within ten (10) miles or thirty (30) minutes of the Member's residence~~	~~95%~~
~~Obstetrics/Gynecology (OB/GYN)~~	~~One practitioner within ten (10) miles or thirty (30) minutes of the Member's residence~~	~~95%~~

e. Federally Qualified Health Center (FQHC): CalOptima shall contract with at least one (1) FQHC in the Service Area.

f. Rural Health Clinic (RHC): CalOptima shall contract with at least one (1) RHC to the extent licensed and recognized in the Service Area

g. Free Standing Birth Center (FBC): CalOptima shall contract with at least one (1) FBC to the extent licensed and recognized in the Service Area.

h. Indian Health Facility (IHF): CalOptima shall contract with at least one (1) IHF to the extent licensed and recognized in the Service Area.

8. Primary Care Practitioners Availability Standards: CalOptima and its Health Networks shall maintain sufficient numbers and types of contracted Primary Care Providers to ensure access and availability of primary care to Members.

~~b.~~a. PCP availability standards by the ratio of ~~practitioner~~Practitioner to Members:

NUMBER OF PRACTITIONERS		
Practitioner Type	**Measure**	**Minimum Performance Level**
Total Primary Care Practitioners	Primary Care Practitioners to Members	1:2,000

NUMBER OF PRACTITIONERS		
Practitioner Type	**Measure**	**Minimum Performance Level**
General Practice/Family Practice	General Practitioners/Family Practitioners to Members	1:2,000
Internal Medicine	Internists to Members	1:2,000
Pediatrics	Pediatricians to Members	1:2,000
Obstetrics/Gynecology Primary Care (OB/GYN)	Obstetrics/Gynecologists to Members	1:2,000

b. Primary Care Practitioner (PCP) availability standards by geographic distribution:

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS		
Practitioner Type	**Measure**	**Minimum Performance Level**
Total Primary Care Practitioners (Adult and Pediatric)	For each practitioner type, there shall be one practitioner within ten (10) miles or thirty (30) minutes of the Member's residence	100%
General Practice/Family Practice		
Internal Medicine		
Pediatrics		
Obstetrics/Gynecology Primary Care (OB/GYN)		

9. Specialty Care Providers: CalOptima and its Health Networks shall maintain sufficient numbers and types of contracted Specialty Care Providers to ensure access and availability of specialty care to Members.

~~9.~~ High Volume ~~Specialists:~~

a. ~~Identifying high-volume specialists annually~~Specialty Care Providers: CalOptima shall identify high-volume ~~specialists~~specialty providers by assessing the volume of claims and encounters by specialty type in a previous calendar year. ~~Specialties~~Specialty care providers with the highest utilization shall be determined as a high-volume ~~specialist.~~specialty care provider. (Obstetrics/gynecology ~~specialists~~specialty care providers shall be categorized as a PCP and a high-volume ~~specialist~~specialty care providers, in accordance with industry standards.)

~~b. High-volume specialists availability standards by geographic distribution:~~

~~GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS~~		
~~**Practitioner Type**~~	~~**Standard**~~	~~**Minimum Performance Level**~~
~~Obstetrics/Gynecology (OB/GYN):~~	~~One Obstetrics/Gynecologist within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~
~~Cardiology~~	~~One Cardiologist within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~
~~Hematology/Oncology~~	~~One Hematologist/Oncologist within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~

~~GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS~~		
~~Gastroenterology~~	~~One Gastroenterologist within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~
~~General Surgery~~	~~One General surgeon within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~
~~Nephrology~~	~~One Nephrologist within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~
~~Neurology~~	~~One Neurologist within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~
~~Ophthalmology~~	~~One Ophthalmologist within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~
~~Orthopedic Surgery~~	~~One Orthopedic surgeon within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~
~~Pulmonology~~	~~One Pulmonologist within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~

b. ~~High-volume specialists availability standards by the~~ High Impact Specialty Care Providers: CalOptima shall identify high-impact specialty care providers by identifying practitioner types who treat conditions that have high mortality and morbidity rates, and/or identifying practitioner types where treatment requires significant resources.

c. DHCS Adult and Pediatric Core Specialists: As part of the annual network certification, CalOptima shall maintain and monitor access to adult and pediatric core specialists as identified by DHCS.

d. Standards

~~c.~~i. High Volume Specialty Care Providers availability standards ratio ~~of practitioner~~ (Practitioner to Members~~:~~):

~~NUMBER OF PRACTITIONERS~~		
NUMBER OF HIGH VOLUME PRACTITIONERS		
Practitioner Type	**Standard**	**Minimum Performance Level**
Obstetrics/Gynecology Specialty Care (OB/GYN)	Ratio of practitioner to Members	1:2,000
Cardiology	Cardiologists to Members	1:5,000
Hematology/Oncology	Hematologists/Oncologists to Members	1:5,000
Gastroenterology	Gastroenterologists to Members	1:5,000
General Surgery	General surgeons to Members	1:5,000
Nephrology	Nephrologists to Members	1:10,000
Neurology	Neurologists to Members	1:5,000

Ophthalmology	Ophthalmologists to Members	1:5,000
Orthopedic Surgery	Orthopedic surgeons to Members	1:5,000
Psychiatry	Psychiatrists to Members	1:10,000
Pulmonology	Pulmonologists to Members	1:10,000

~~10. High Impact Specialists:~~

~~a. Identifying~~ Specialty care (high- volume, high impact, ~~specialists annually: CalOptima shall identify high impact specialists by a) identifying practitioner types who treat conditions that have high mortality~~ and ~~morbidity rates and/or b) identifying practitioner types where treatment requires significant resources.~~

~~b.~~ii. ~~High impact specialists~~DHCS core) availability standards by geographic distribution:

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS

~~**GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS**~~

Practitioner Type	High Volume	High Impact	DHCS Core	Standard	Minimum Performance Level
Obstetrics/Gynecology Specialty Care (OB/GYN):	X		X	For each practitioner type, there shall be one Practitioner within fifteen (15) miles or thirty (30) minutes of the Member's residence	100%
Cardiology/Interventional Cardiology	X		X		
Dermatology			X		
Endocrinology		X	X		
ENT/Otolaryngology			X		
Gastroenterology	X		X		
General Surgery	X		X		
Hematology		X	X		
HIV/AIDS Specialist/Infectious Diseases			X		
Nephrology	X	X	X		
Neurology	X		X		
Oncology	X	X	X		
Ophthalmology	X		X		
Orthopedic Surgery	X		X		
Physical Medicine and Rehabilitation			X		
Psychiatry	X		X		
Pulmonology	X		X		

~~Practitioner Type~~	~~Measure~~	~~Minimum Performance Level~~
~~Hematology/Oncology~~	~~One (1) Hematologist/Oncologist within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~

~~Practitioner Type~~	~~Measure~~	~~Minimum Performance Level~~
~~Nephrology~~	~~One (1) Nephrologist within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~

~~11.~~ Behavioral Health ~~Specialists~~Care Providers: CalOptima shall ~~identity behavioral healthcare practitioners based on the types of practitioners most likely to provide office-based behavioral health services to the largest segment of the membership.~~

~~a.~~10. maintain sufficient numbers and types of contracted Behavioral ~~health specialists~~Health Care Providers to ensure access and availability ~~standards by geographic distribution:~~of behavioral health care to Members.

~~GEOGRAPHIC DISTRIBUTION OF BEHAVIORAL HEALTH PRACTITIONERS~~		
~~Practitioner Type~~	~~Measure~~	~~Minimum Performance Level~~
~~Psychiatrist~~	~~One (1) Psychiatrist within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~
~~Psychologist~~	~~One (1) Psychologist within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~
~~Licensed Clinical Social Worker~~	~~One (1) Licensed Clinical Social Worker within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~
~~Marriage and Family Therapist~~	~~One (1) Marriage and Family Therapist within thirty (30) miles or forty-five (45) minutes of the Member's residence~~	~~90%~~

a. High Volume Behavioral Health Provider: CalOptima has identified the following provider types as high volume behavioral health providers: psychologists, licensed clinical social workers and marriage and family therapists.

b. Behavioral health ~~specialists~~providers' standards by ratio of Practitioners to Members:

~~NUMBER OF BEHAVIORAL HEALTH PRACTITIONERS~~		
NUMBER OF BEHAVIORAL HEALTH PROVIDERS		
Practitioner Type	**Measure**	**Minimum Performance Level**
~~Psychiatrist~~	~~Psychiatrists to Members~~	~~1:10,000~~
Psychologist	Psychologists to Members	1:15,000
Licensed Clinical Social Worker	Licensed Clinical Social Workers to Members	1:10,000
Marriage and Family Therapist	Marriage and Family Therapists to Members	1:3,000

11. Behavioral Health Care Providers' availability standards by geographic distribution:

GEOGRAPHIC DISTRIBUTION OF BEHAVIORAL HEALTH PROVIDERS		
Practitioner Type	**Measure**	**Minimum Performance Level**
Psychologist Licensed Clinical Social Worker Marriage and Family Therapist	For each provider type, there shall be one provider within fifteen (15) miles or thirty (30) minutes of the Member's residence	100%

12. California Children's Services (CCS) Program/Whole Child Model

    a. As required by DHCS, CalOptima shall demonstrate an adequate provider network that includes but may not be limited to the following:

        i. Pediatricians, pediatric specialty care providers, and pediatric subspecialty care providers; professional, allied and medical supportive personnel; as well as licensed acute care hospitals, special care centers, and specialized durable medical equipment providers.

        ii. An adequate number of hospitals and/or facilities that include neonatal intensive care, CCS-approved pediatric intensive care units, and CCS-approved inpatient facilities.

        iii. Licensed acute care hospitals and special care centers approved by the CCS program to treat a CCS-eligible condition.

        iv. An adequate provider overlap with CCS paneled providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty.

    b. Effective no sooner than January 1, 2019, CalOptima and Health Networks shall ensure that Members have access to all Medically Necessary CCS-paneled providers within the entire provider network.

~~T.~~S. Telephone Access:

1. Telephone Triage or Screening Services:

    a. Telephone Triage or Screening Services shall be available twenty-four (24) hours a day, seven (7) days a week. Telephone Triage or Screening waiting time shall not exceed thirty (30) minutes.

    b. CalOptima or a Health Network may provide telephone Triage or Screening Services through:

        i. CalOptima or Health Network-operated telephone Triage and Screening Services;

        ii. A telephone medical advice service consistent with Section 1348.8 of the Health and Safety Code;

        iii. CalOptima or the Health Network's contracted Primary Care or Behavioral health care provider office; or

        iv. Other method that provides Triage or Screening Services.

c. If CalOptima or a Health Network contracts with a primary care or mental health care Provider for the provision of telephone Triage or Screening Services, such Providers shall maintain a procedure for Triaging or Screening Member telephone calls twenty-four (24) hours a day, seven (7) days a week, with a telephone answering machine and/or answering service, and/or office staff, that informs the Member:

i. Regarding the length of wait for a return call from the Provider; and

ii. How the caller may obtain urgent or emergency care including, when applicable, how to contact another Provider who has agreed to be on-call, Triage, or Screen by phone, or, if needed, deliver urgent or emergency care.

d. An unlicensed staff member may perform Triage or Screening on behalf of a licensed staff member in order to assist in determining the Member's condition~~,~~ and refer the Member to a licensed staff member. Such unlicensed staff member shall not use this information obtained from Triage or Screening in an attempt to assess, evaluate, advise, or make any decision regarding the Member's condition, or determine when the Member should see a licensed Provider.

2. Telephone wait time during business hours:

a. The total waiting time for a Member to reach a non-recorded voice shall not exceed thirty (30) seconds.

b. The call abandonment rate for CalOptima or a Health Network shall not exceed five percent (5%).

c. Non-urgent and non-emergency messages during business hours: A Practitioner shall return the call within twenty-four (24) hours after the time of message.

d. Urgent message during business hours: A Practitioner shall return the call within thirty (30) minutes after the time of message.

e. Emergency message during business hours: All members shall be referred to the nearest emergency room. CalOptima shall have in its recorded message to include the following: "If you feel that this is an emergency, hang up and dial nine-one-one (911) or go to the nearest emergency room."

f. Telephone access after business hours:

i. After-hours access: A Primary Care Practitioner (PCP) or his or her designee, an appropriate licensed professional under his or her supervision, shall be available twenty-four (24) hours a day, seven (7) days a week, to respond to after-hours Member calls or to a hospital emergency room Practitioner.

ii. If live after-hours attendant answers and the call is an emergency, the attendant shall refer the Member to nine-one-one (911) emergency services or instruct the Member to go to the nearest emergency room.

iii. If a recorded message answers, it shall include the following: "If you feel that this is an emergency, hang up and dial nine-one-one (911) or go to the nearest emergency room."

~~U.~~T. Cultural and Linguistic Services: Shall be provided, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services:

1. Interpreter services:

   a. Oral interpreter services shall be made available to a Member in person, upon the Member's request, or by telephone at key points of contact, twenty-four (24) hours a day, seven (7) days a week, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

   b. Interpreter services shall be coordinated with scheduled appointments for health care services, whenever possible, to ensure the provision of interpreter services at the time of appointment.

2. Written Materials: All written materials shall be made available to Members in Threshold Languages, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

3. Alternative Forms of Communication:

   a. For a Member with a visual impairment, CalOptima and its Health Networks shall make informational or educational materials available at no cost in Threshold Languages in at least fourteen (14) point size font, audio format, or Braille upon request or as needed within twenty-one (21) days upon receipt of request or within a timely manner that is appropriate for the format requested. CalOptima and its Health Networks shall inform Members of the availability of these materials through the Member Handbook/EOC booklet and other mechanisms, including, but not limited to, posters and flyers distributed at sites where Members receive Covered Services and at Member orientation sessions.

   b. Telecommunication Device for the Deaf (TDD): TDD shall be made available to a Member, upon request, at no cost to the Member.

~~4.~~A. ~~In-office wait times shall not exceed forty-five (45) minutes before a Member is seen by a Provider.~~

~~5. Rescheduling of Appointments: When it is necessary for a Provider or a Member to reschedule an appointment, the Provider shall promptly reschedule the appointment in a manner appropriate to the Member's health care needs, and that ensures continuity of care consistent with good professional practice.~~

III. PROCEDURE

A. CalOptima shall analyze performance of CalOptima's and Health Networks' access and availability against the standards set forth in this policy.

1. CalOptima shall annually conduct the following:

   a. Provider Access Survey (appointment availability and access during and after business hours);

b. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys; and

c. Primary Care Physician Satisfaction Survey.

2. CalOptima shall monitor and/or run reports quarterly for the following:

a. Grievances and appeals data;

b. Availability (provider/member ratio and Geoaccess) data;

c. Encounter/claims data; and

d. Potential Quality Issues (PQI).

3. CalOptima shall monitor a ~~CalOptima~~ CalOptima's and Health ~~Network's~~Networks' access and availability as follows:

a. Track and review access and availability, in accordance with this policy;

b. Monitor a Health Network's quarterly reporting of Initial Health Assessment (IHA) and Individual Health Education Behavioral Assessment (IHEBA) activity;

c. Monitor and analyze telephone wait times through quarterly reports from the call center;

d. Monitor telephone access for call abandonment rates;

e. Monitor Behavioral Health reports on access and availability of contracted Behavioral Health providers.

f. Review quarterly reports on Grievances and Complaints related to access;

g. Review information obtained through Member and Provider surveys conducted on an annual basis related to access;

h. Review and monitor Triage and Screening Services;

i. Report access and availability performance against the standards set forth in this policy to the Member Experience Sub-Committee on an annual basis

j. Analyze and report results of audit and review activities in order to:

i. Prioritize opportunities for improvement identified from analyses.

ii. Implement interventions on at least one (1) area of opportunity (if applicable) for the following areas:

(a) Non-behavioral health care services and;

(b) Behavioral health care services.

k. Evaluate the effectiveness of interventions for improving access to non-behavioral and behavioral health care services.

4. CalOptima shall annually develop the following:

a. Accessibility analysis (appointment availability and access during and after business hours) report;

b. Availability analysis (provider/member ratio and GeoAccess) report;

B. CalOptima shall submit a complete and accurate Annual Network Certification using the reporting template provided by DHCS that reflects the entire contracted provider network, including providers who serve the needs of children and youth with CCS-Eligible Conditions as part of the CCS Program/Whole Child Model, and all required supporting documentation to DHCS no later than one hundred five (105) calendar days before the contract year begins (or the next business day if the due date occurs on a weekend or holiday), in accordance with DHCS All Plan Letter (APL) 18-005: Network Certification Requirements.

1. CCS/Whole Child Model Network Certification: In addition to the Annual Network Certification as described in Section III.B, CalOptima shall submit:

a. Updated policies and procedures, as required by DHCS.

b. An updated provider network template to ensure the network of providers meets network adequacy standards.

2. If CalOptima is unable to meet time and distance standards, an Alternative Access Standard (AAS) request shall be submitted to DHCS no later than one hundred five (105) calendar days prior to the beginning of every contract year and a Corrective Action Plan (CAP) may be issued.

3. If a Corrective Action Plan is issued to CalOptima by DHCS, CalOptima shall allow Members to access Medi-Cal services out-of-network if the services are not available in-network.

~~B.~~C. CalOptima shall provide the Health Networks and the Member Experience Sub-Committee with access and availability reports of CalOptima and Health Networks' performance. These reports shall include CalOptima's assessment results against the access and availability standards set forth in this policy.

~~C.~~D. If the Member Experience Sub-committee identifies deficiencies or non-compliance, the Chair of the Member Experience Sub-Committee, or Designee, may take the following steps:

1. Request that a Health Network submit a Quality Improvement Plan or Plan-Do-Study-Act (PDSA) cycle(s) for performance measures that are deemed deficient or non-compliant.

2. Submit a Request for Compliance Action (RCA) to the Office of Compliance to request corrective action. Such corrective action may include the issuance of a request for a Corrective Action Plan (CAP) and/or the imposition of Sanctions, in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions, respectively; and

3. Report the deficiencies or non-compliance to the Audit and Oversight Committee (AOC) and Compliance Committee, as appropriate.

E. Health Networks shall submit a Quality Improvement Plan or PDSA, if requested. If a CAP is issued~~, the~~:

~~D.~~1. The Health Network shall submit a CAP to CalOptima's Compliance department. A Health Network shall take all necessary and appropriate action to identify the causes underlying identified timely access deficiencies, including but not limited to a review of whether provider hours of operation and/or providers' scheduling practices contributed to the deficiencies, and resolve such deficiencies, to comply with the standards of this policy and CalOptima Policy HH.2005Δ: Corrective Action Plan.

2. CalOptima shall report, within three (3) business days, to the DHCS contract manager any significant instances of non-compliance or the imposition of CAPs or financial sanctions on a Health Network when it results in CalOptima's non-compliance with contractual requirements, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

~~E.~~F. The Quality Analytics Department shall coordinate performance reviews to assess adherence to access and availability standards, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

~~F.~~ The Quality Analytics Department shall annually update CalOptima's Access and Availability desktop procedures to assess adherence to access and availability standards, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

G.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. Age Discrimination Act of 1975
B. California Civil Code, §51
C. California Government Code, §11135
D. CalOptima Authorization Required List
E. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Contract for Health Care Services
G. CalOptima Policy DD.2002: Cultural and Linguistic Services
H. CalOptima Policy EE.1135: Long Term Care Facility Contracting
I. CalOptima Policy GG.1103: Specialty Mental Health Services
J. CalOptima Policy GG.1122: Follow-up for Emergency Department Care
K. CalOptima Policy GG.1130: Community-Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes
L. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Care Network Providers
M. CalOptima Policy GG.1508: Authorization and Processing of Referrals
N. CalOptima Policy GG.1713: Nurse-Midwife Practice Guidelines, CalOptima Direct
O. CalOptima Policy GG.1118: Family Planning Services, Out-of-Network

P. CalOptima Policy GG.1619: Delegation Oversight
Q. CalOptima Policy HH.2002Δ: Sanctions
R. CalOptima Policy HH.2003: Health Network Reporting
S. CalOptima Policy HH.2005Δ: Corrective Action Plan
T. CalOptima Operational Audit Tool
U. CalOptima Quality Improvement Plan
V. DHCS Medi-Cal Managed Care Division (MMCD) Policy Letter 99-007: Individual Health Education Behavior Assessment
W. DHCS MMCD Policy Letter 08-003: Initial Comprehensive Health Assessment
X. DHCS All Plan Letter (APL) 18-005: Network Certification Requirements
Y. DCHS All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program
~~X.~~Z. National Committee of Quality Assurance (NCQA) standards
~~Y.~~AA. Health and Safety Code §1374.73
~~Z.~~BB. Title 28, California Code of Regulations, §§1300.51(H), 1300.67.2, 1300.67.2.2
~~AA.~~CC. Title 28, Code of Federal Regulations, Part 36
~~BB.~~DD. Title 29, United States Code, §794 (Section 504 of the Rehabilitation Act of 1973)
~~CC.~~EE. Title 42, United States Code, §2000d
~~DD.~~FF. Title 45, Code of Federal Regulations, Part 80, Part 84, and Part 91
~~EE.~~GG. Title VI of the Civil Rights Act of 1964
~~FF.~~HH. Title IX of the Education Amendments of 1973

VI. REGULATORY AGENCY APPROVALS

A. 11/13/15: Department of Health Care Services
B. 06/03/15: Department of Health Care Services
C. 08/28/14: Department of Health Care Services
D. 03/21/11: Department of Health Care Services
E. 12/24/09: Department of Health Care Services

VII. BOARD ACTIONS

A. ~~None to Date~~09/06/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/01/1999	GG.1600	Access to Health Care	Medi-Cal
Revised	10/01/2003	GG.1600	Access and Availability Standards	Medi-Cal
Revised	06/01/2007	GG.1600	Access and Availability Standards	Medi-Cal
Revised	10/01/2008	GG.1600	Access and Availability Standards	Medi-Cal
Revised	08/01/2009	GG.1600	Access and Availability Standards	Medi-Cal
Revised	07/01/2010	GG.1600	Access and Availability Standards	Medi-Cal
Revised	03/01/2011	GG.1600	Access and Availability Standards	Medi-Cal
Revised	07/01/2011	GG.1600	Access and Availability Standards	Medi-Cal
Revised	01/01/2013	GG.1600	Access and Availability Standards	Medi-Cal
Revised	01/01/2014	GG.1600	Access and Availability Standards	Medi-Cal
Revised	09/01/2014	GG.1600	Access and Availability Standards	Medi-Cal
Revised	01/01/2015	GG.1600	Access and Availability Standards	Medi-Cal
Revised	07/01/2015	GG.1600	Access and Availability Standards	Medi-Cal
Revised	05/01/2016	GG.1600	Access and Availability Standards	Medi-Cal
Revised	08/01/2017	GG.1600	Access and Availability Standards	Medi-Cal
Revised	12/01/2017	GG.1600	Access and Availability Standards	Medi-Cal
Revised	09/06/2018	GG.1600	Access and Availability Standards	Medi-Cal

IX. GLOSSARY

Term	Definition
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
Alternative Access Standard (AAS)	An alternative to the existing access standard approved by DHCS when a managed care plan has exhausted all other reasonable options for obtaining providers in order to meet the applicable standards, or if DHCS determines that the requesting managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
Behavioral Health Care	Evaluation and treatment of psychological and substance abuse disorders including specialty mental health services. Specialty mental health services may include, but are not limited to, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facilities services.
Behavioral Health Treatment (BHT)	~~Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other~~ Medically Necessary, evidence-based ~~behavior intervention programs that develop and restore~~behavioral health interventions to promote, to the maximum extent practicable, the functioning of ~~an individual with ASD.~~a Member. These services are interventions designed to treat behavioral health conditions as determined by a licensed physician, surgeon, or psychologist. BHT ~~is the design, implementation, and evaluation~~includes a variety of ~~environmental modification using behavioral stimuli and consequences to produce socially significant improvement~~evidence-based behavioral interventions identified by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence that are designed to be delivered primarily in ~~human behavior~~the home and in other community settings.
Behavioral Health Treatment (BHT) Providers	~~Providers that are State Plan approved to render Behavioral Health Treatment services, including Qualified Autism Service Providers, Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals. For purposes of this policy, BHT providers are considered Specialty Care Providers.~~A Qualified Autism Services (QAS) Provider, Professional, or Paraprofessional, as defined with the State Plan Amendment.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.

Term	Definition
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
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.
Cultural and Linguistic (C&L) Services	Services that promote equal access to health care services and are responsive to a Member's cultural and linguistic needs. These services include, but are not limited to: 1. Recruiting bilingual employees for appropriate positions whenever possible, and enhancing employees' bilingual skills and cultural sensitivity through employee development programs; 2. Providing twenty-four (24)-hour access to interpreter services at Key Points of Contact for all Members; 3. Providing translations of informational materials in Threshold Languages, providing oral translation for other languages upon request or as needed, and providing information and materials to meet the needs of Members with sensory impairments; and 4. Referring Members to culturally and linguistically appropriate community services, as needed.
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.
Emergency Medical Condition	A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.

Term	Definition
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Free Standing Birth Center	Defined by Title 42, United States Code, Section 1396d(I)(3)(B) as a health facility- 1. That is not a hospital; 2. Where childbirth is planned to occur away from a pregnant woman's residence; 3. That is licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and 4. That complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the state shall establish.
Grievance	An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.
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. For purposes of this policy, a Health Network shall also include the CalOptima Community ~~Health~~ Network.
Individual Health Education Behavioral Assessment (IHEBA)	An assessment designed to identify high-risk behaviors of a Member to assist a Primary Care Physician (PCP) in prioritizing the Member's individual health education needs related to lifestyle, behavior, environment and cultural linguistic background, and to document focused health education interventions, referrals and follow up.
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.
Mid-Level Practitioner	A non-physician practitioner who has a professional license and certification. They include but are not limited to Certified Nurse Midwives, Certified Nurse Practitioners, and Physician Assistants.
Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some routine care of woman.

Term	Definition
Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Title 16 CCR section 1484.
Prenatal Care	Health care that a pregnant woman receives from a licensed practitioner. Services needed may include physical examinations, dietary and lifestyle advice.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any ~~Specialist Physician~~Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a ~~specialist~~specialty care provider or clinic ~~in accordance with W & I Code 14182(b)(11).~~ .
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Provider Network	For purposes of this Policy, the providers with which an organization contracts or makes arrangements to furnish covered health care services to their members.
Qualified Autism Service Paraprofessional	An ~~unlicensed and uncertified~~ individual who is employed and supervised by a ~~Qualified Autism Service~~QAS Provider ~~(QASP), who has adequate education, training, and experience, as certified by a QASP, and provides treatment and implements~~to provide Medically Necessary BHT services ~~pursuant to a treatment plan developed and approved and supervised by a QASP.~~to Members..
~~Qualified Autism Service Professional~~	~~An individual who provides behavioral health treatment, is employed and supervised by a Qualified Autism Service Provider (QASP), provides treatment pursuant to a treatment plan developed and approved by the QASP, and has training and experience in providing services for pervasive developmental disorder or autism.~~

Term	Definition
Qualified Autism Service ~~Provider~~Professional	~~Either of the following:~~ ~~1. A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.~~ ~~2. A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.~~An Associate Behavioral Analyst, Behavior Analyst, Behavior Management Assistant, or Behavior Management Consultant, as defined in the State Plan Amendment, who provides Medically Necessary BHT services to Members.
Qualified Autism Service Provider	A licensed practitioner or Board Certified Behavior Analyst (BCBA).
Qualified Family Planning Practitioner	A qualified provider licensed to furnish family planning services within their scope of practice within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish Family Planning Services to a Member as specified in title 22, Code of California Regulations, Section 51200.
Routine Care	Covered Services that are not urgent in nature and may be pre-planned or scheduled in advance.
Routine Physical Exams	A well-care visit that usually emphasizes priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.
Rural Health Clinic	An entity defined in Title 22 CCR Section 51115.5
Sanctions	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Service Area	The geographical area that DHCS authorizes CalOptima to operate in. A Service Area may include designated ZIP Codes within a county that CalOptima is approved to operate in.

Term	Definition
Skilled Nursing Facility (SNF)	Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program
~~Specialist Physician~~	~~A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.~~
Specialty Care Provider (SCP)	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider. Beginning February 2011, Specialty Care Provider will be used in place of Specialist Physician.
Triage or Screening	The evaluation of a Member's health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of the child's need for care.
Triage or Screening Services	Assessment of a Member's health concerns and symptoms via telephone or other means of communication with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to perform Triage or Screening Services.
Triage or Screening Waiting Time	The time waiting to speak by telephone with a doctor or nurse who is trained to screen a Member who may need care.
Urgent Authorization	"Urgent" is defined as when normal time frame for authorization will be detrimental to patient's life or health, jeopardize patient's ability to regain maximum function, or result in loss of life, limb or other major bodily function.
Urgent Care Service	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.

Policy #: GG.1600
Title: **Access and Availability Standards**
Department: Medical Affairs
Section: Quality Analytics

CEO Approval: Michael Schrader_____

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I. PURPOSE

This policy establishes required access and availability standards for Members to obtain effective, appropriate, and timely access to care and describes the process used by CalOptima for annual Network Certification.

II. POLICY

A. CalOptima shall evaluate CalOptima's and a Health Network's compliance with the standards outlined in this policy. Unless otherwise stated, each access and availability standard outlined herein shall have a minimum performance threshold of ninety percent (90%).

B. CalOptima and its Health Networks shall not discriminate against Members, on the basis of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, language, gender identity, identification with any other persons or groups defined in Penal Code section 422.56, health status, or physical or mental disability.

C. CalOptima and its Health Networks shall ensure access for disabled Members which includes, but is not limited to ramps, elevators, restrooms, designated parking spaces, and drinking water provisions.

1. If a Provider cannot meet the minimum access standards for disabled Members, CalOptima and its Health Networks shall coordinate a referral to a Provider with the appropriate access standards.

D. CalOptima and its Health Networks shall ensure that Providers offer flexibility in scheduling Covered Services for Members with disabilities.

E. If a Provider has a moral or ethical objection to providing a Covered Service to a Member, CalOptima or a Health Network shall refer the Member to a different Provider.

F. If a Health Network refers a Member to a different Provider pursuant to Section II.G of this policy, CalOptima shall not incur any additional expense as a result of such referral.

G. If Covered Services are unavailable to the Member within the provider network, CalOptima or a Health Network shall arrange for the provision of specialty services from specialty care providers outside of the provider network in a timely manner, and in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

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H. CalOptima and its Health Networks shall ensure that contracting Providers offer CalOptima Members hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medi-Cal Fee-For-Service, if the Provider services only Medi-Cal Members.

I. Emergency Services: Emergency services shall be available immediately to a Member twenty-four (24) hours a day, seven (7) days a week.

1. CalOptima and its Health Networks shall cover emergency medical services without prior authorizations.

2. CalOptima shall have a designated emergency service facility within the Service Area, providing care twenty-four (24) hours a day, seven (7) days a week. This designated emergency service facility will have one (1) or more physicians and one (1) nurse on duty in the facility at all times.

3. CalOptima and its Health Networks shall provide adequate follow-up care for those Members who have been screened in the Emergency Room in accordance with CalOptima Policy GG.1122: Follow-up for Emergency Department Care.

4. CalOptima and its Health Networks shall ensure that a Physician is available twenty-four (24) hours a day, seven (7) days a week, to authorize Medically Necessary post-stabilization care, to coordinate the transfer of stabilized Members in an emergency department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

J. CalOptima and its Health Networks shall ensure that Members have effective and appropriate access to Covered Services in a timely manner, in accordance with the standards of this policy. CalOptima shall evaluate CalOptima's and Health Network's compliance with the appointment access standards against a minimum performance threshold of ninety percent (90%), unless otherwise indicated.

1. Urgent Care Services: Available within twenty-four (24) hours of the request for an appointment.

2. Primary Care Appointments:

a. Monitoring of primary care appointments shall include the monitoring of all primary care practitioners (PCPs) in CalOptima's provider network.

PRIMARY CARE APPOINTMENTS		
Description	**Standard**	**Minimum Performance Level**
Urgent appointment for services that DO NOT require prior authorization	Available within forty-eight (48) hours of the request for appointment	90%
Non-Urgent Primary Care (including Obstetrics/Gynecology Primary Care): Appointments	Available within ten (10) business day of request for appointment	90%
Routine Physical Exams and Health Assessments: Appointments for routine physical exams and health assessments	Available within thirty (30) calendar days of request for appointment	90%

Initial Health Assessment (IHA) or Individual Health Education Behavioral Assessment (IHEBA): Appointments for IHA or IHEBA	Available within one-hundred-twenty (120) calendar days of Medi-Cal enrollment	90%

3. Specialty and Ancillary Care Appointments:

   a. Monitoring of specialty care appointments shall, at minimum, include the monitoring of the following specialty care providers: Cardiology/Interventional Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology, HIV/AIDS Specialist/Infectious Diseases, Nephrology, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Physical Medicine and Rehabilitation, Psychiatry, and Pulmonology.

   b. Monitoring of ancillary appointments shall, at minimum, include the monitoring of the following: laboratories, occupational therapy, physical therapy, radiology centers, and speech therapy.

SPECIALTY AND ANCILLARY APPOINTMENTS		
Description	**Standard**	**Minimum Performance Level**
Urgent appointments for services that DO require Prior Authorization	Available within ninety-six (96) hours of the request for appointment	90%
Non-Urgent Specialty Care (including Obstetrics/Gynecology Specialty Care): Appointments	Available within fifteen (15) business days of request for appointment	90%
First Prenatal Visit: Appointments for the first prenatal visit	Available within two (2) weeks of request for appointment	90%
Non-Urgent Ancillary Services: Appointments for non-urgent ancillary services for the diagnosis or treatment of illness, injury, or other health conditions	Available within fifteen (15) business days of request for appointment	90%

4. Routine Behavioral Health Services:

   a. Monitoring of timeliness of Behavioral Health Services shall, at minimum, include the following:

      i. Non-Physician Behavioral health Providers: Psychologist, Licensed Clinical Social Worker, and Marriage and Family Therapist

      ii. Physician Behavioral Health Provider: Psychiatrist

ROUTINE BEHAVIORAL HEALTH SERVICES		
Description	**Standard**	**Minimum Performance Level**

Appointment for routine care with a non-physician behavioral health care provider	Available to a Member within ten (10) business days after the date of the request	90%
Appointment for follow-up routine care with a non-physician behavioral health care provider (i.e. psychologists, Licensed Clinical Social Workers (LCSW), Marriage and Family Therapists (MFT)	Members have a follow-up visit with a non-physician behavioral health care provider within twenty (20) calendar days of initial visit for a specific condition	60%
Appointment for follow-up routine care with a physician behavioral health care provider	Members have a follow-up visit with a physician behavioral health care provider within thirty (30) calendar days of initial visit for a specific condition	60%

5. Exceptions to Timeframes for Appointments

   a. The timeframe to obtain an appointment for the services described in Sections II.J.1 through II.J.4 of this policy may be extended if the referring or treating Provider, or the health care professional providing Triage or Screening Services, acting within the scope of his or her practice, and consistent with professionally recognized standards of practice, has determined and documented in the Member's record that a longer waiting time will not have a detrimental impact on the Member's health.

   b. A Provider may offer an appointment for non-urgent Primary Care within the same or next business day from the time the Member requests the appointment, and advance scheduling of an appointment at a later date if the Member prefers not to accept the appointment offered within the same or next business day.

   c. Preventive care services and periodic follow-up care for the services described in Sections II.J.1 through II.J.4 of this policy may be scheduled in advance, consistent with professionally recognized standards of practice, as determined by the treating Provider acting within the scope of his or her practice.

   d. Subsequent routine appointments: Appointments for subsequent routine appointments for prenatal visits shall be available to a Member and shall be scheduled in advance in accordance with applicable Department of Managed Health Care (DMHC) regulations governing timely access to non-emergency health care services. All Medically Necessary services for pregnant Members will be covered. The most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) will be utilized as the minimum measure of quality for perinatal services by CalOptima and its Health Networks.

6. Rescheduling of Appointments: When it is necessary for a Provider or a Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner appropriate for the Member's health care needs, and ensures continuity of care consistent with good professional practice.

K. In-office wait times shall not exceed forty-five (45) minutes before a Member is seen by a Provider.

L. Certified Nurse-Midwife and Certified Nurse Practitioner Services: If Certified Nurse-Midwife services, as described in CalOptima Policy GG.1713: Nurse-Midwife Practice Guidelines, or Certified Nurse

Practitioner services are not available to a Member; a Member may self-refer to an out-of-network Certified Nurse-Midwife or Certified Nurse Practitioner to receive such services.

M. Sensitive Services: Sensitive Services shall be available to a Member within the CalOptima Plan. A Member may self-refer to an out-of-network Provider to receive Sensitive Services, without Prior Authorization, pursuant to CalOptima Policy GG.1508: Authorization and Processing of Referrals.

N. Minor Consent Services: Minor Consent Services shall be available to a Member under the age of eighteen (18) in a confidential manner without parental consent, pursuant to CalOptima Policy GG.1508: Authorization and Processing of Referrals.

O. Family Planning Services: Family Planning Services shall be available to a Member, pursuant to CalOptima Policy GG.1118: Family Planning Services, Out-of-Network. A Member may self-refer to any Qualified Family Planning Practitioner, including an out-of-network practitioner to receive Family Planning Services.

P. Behavioral Health Care: Behavioral Health Care Services shall be available to a Member, pursuant to CalOptima Policy GG.1900: Behavioral Health Services.

Q. Behavioral Health Treatment (BHT): BHT services shall be available to a Member pursuant to guidance provided by the Department of Health Care Services (DHCS), by a State Plan-approved provider, and in accordance with the requirements for access to specialty care services as indicated in CalOptima Policy GG.1548:Authorization for Applied Behavioral Health Analysis for Autism Spectrum Disorder.

R. Provider Availability: CalOptima and its Health Networks shall maintain a provider network adequate to serve one hundred percent (100%) of all eligible Members in the Service Area.

1. CalOptima shall take into consideration the geographic location of Providers and Members accounting for distance, travel time, and mode of transportation when evaluating adequate access to Covered Services.

2. CalOptima shall take into consideration Members and Providers language and gender when evaluating adequate access to Covered Services.

3. CalOptima shall take into consideration the number of Providers who are not accepting new patients when evaluating adequate access to Covered Services.

4. CalOptima shall take into consideration the anticipated Member enrollment numbers when evaluating adequate access to Covered Services.

5. CalOptima total physician availability standard: Ratio of total physicians to Members shall not be less than 1:1,200.

    a. If Non-Phyisican Medical Practitioners are included in CalOptima's provider network, each individual Non-Physician Medical Practitioners shall not exceed a full-time equivalent network provider/patient caseload of one (1) network provider per one thousand (1,000) patients.

6. CalOptima shall ensure full-time equivalent Physician Supervisor to Non-Physician Medical Practitioner ratios do not exceed the following:

a. Nurse Practitioners 1:4

b. Physician Assistants 1:4

c. Four (4) Non-Physician Medical Practitioner in any combination that does not include more than three (3) Certified Nurse Midwives or two (2) Physician Assistants.

7. CalOptima Facilities Standards: CalOptima shall maintain sufficient numbers and types of contracted facilities to ensure access and availability of care to Members.

a. Hospitals: At least one (1) hospital shall be within fifteen (15) miles or thirty (30) minutes from the Member's residence.

b. Pharmacy: At least one (1) pharmacy shall be within ten (10) miles or thirty (30) minutes from the Member's residence.

c. Long Term Support Services (LTSS): CalOptima shall contract with Long Term Care Facilities in accordance with CalOptima Policy EE.1135: Long Term Care Facility Contracting.

i. Long Term Services and Supports (LTSS): CalOptima shall contract with a sufficient number of LTSS facilities to ensure that Member access meets the following criteria:

LTSS SERVICES		
Provider Type	**Standard**	**Minimum Performance Level**
Skilled Nursing Facility (SNF)	Available to a Member within five (5) business days after the date of the request	90%
Intermediate Care Facility / Developmentally Disabled (ICF-DD)	Available to a Member within five (5) business days after the date of the request	90%

d. Community-Based Adult Services (CBAS) Centers:

i. CalOptima shall ensure that every CBAS provider within the Service Area that has been approved by the California Department of Aging (CDA) as a CBAS provider as of July 1, 2012, is included in the provider network, to the extent that the CBAS provider remains licensed, certified, operating, and is willing to enter into a subcontract with CalOptima on mutually agreeable terms and meets CalOptima's credential and quality standards.

ii. If CalOptima determines that the additional CBAS providers are necessary to meet the needs of its Members, CalOptima may extend a contract to any CBAS Provider certified by the CDA after July 1, 2012. CalOptima shall consider a Member's relationship with previous CBAS Providers when ensuring access to CBAS. CalOptima shall not be required to include CBAS providers that were certified by the CDA after July 1, 2012 in the provider network.

iii. If CalOptima has assessed a Member and determines that the Member is eligible for CBAS services and there is insufficient CBAS center capacity in the area, CalOptima may authorize unbundled services and facilitate utilization through care coordination in

accordance with CalOptima Policy GG.1130: Community-Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes.

e. Federally Qualified Health Center (FQHC): CalOptima shall contract with at least one (1) FQHC in the Service Area.

f. Rural Health Clinic (RHC): CalOptima shall contract with at least one (1) RHC to the extent licensed and recognized in the Service Area

g. Free Standing Birth Center (FBC): CalOptima shall contract with at least one (1) FBC to the extent licensed and recognized in the Service Area.

h. Indian Health Facility (IHF): CalOptima shall contract with at least one (1) IHF to the extent licensed and recognized in the Service Area.

8. Primary Care Practitioners Availability Standards: CalOptima and its Health Networks shall maintain sufficient numbers and types of contracted Primary Care Providers to ensure access and availability of primary care to Members.

a. PCP availability standards by the ratio of Practitioner to Members:

NUMBER OF PRACTITIONERS		
Practitioner Type	**Measure**	**Minimum Performance Level**
Total Primary Care Practitioners	Primary Care Practitioners to Members	1:2,000
General Practice/Family Practice	General Practitioners/Family Practitioners to Members	1:2,000
Internal Medicine	Internists to Members	1:2,000
Pediatrics	Pediatricians to Members	1:2,000
Obstetrics/Gynecology Primary Care (OB/GYN)	Obstetrics/Gynecologists to Members	1:2,000

b. Primary Care Practitioner (PCP) availability standards by geographic distribution:

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS		
Practitioner Type	**Measure**	**Minimum Performance Level**
Total Primary Care Practitioners (Adult and Pediatric)	For each practitioner type, there shall be one practitioner within ten (10) miles or thirty (30) minutes of the Member's residence	100%
General Practice/Family Practice		
Internal Medicine		
Pediatrics		

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS		
Practitioner Type	**Measure**	**Minimum Performance Level**
Obstetrics/Gynecology Primary Care (OB/GYN)		

9. Specialty Care Providers: CalOptima and its Health Networks shall maintain sufficient numbers and types of contracted Specialty Care Providers to ensure access and availability of specialty care to Members.

   a. High Volume Specialty Care Providers: CalOptima shall identify high-volume specialty providers by assessing the volume of claims and encounters by specialty type in a previous calendar year. Specialty care providers with the highest utilization shall be determined as a high-volume specialty care provider. (Obstetrics/gynecology specialty care providers shall be categorized as a PCP and a high-volume specialty care providers, in accordance with industry standards.)

   b. High Impact Specialty Care Providers: CalOptima shall identify high-impact specialty care providers by identifying practitioner types who treat conditions that have high mortality and morbidity rates, and/or identifying practitioner types where treatment requires significant resources.

   c. DHCS Adult and Pediatric Core Specialists: As part of the annual network certification, CalOptima shall maintain and monitor access to adult and pediatric core specialists as identified by DHCS.

   d. Standards

      i. High Volume Specialty Care Providers availability standards ratio (Practitioner to Members):

NUMBER OF HIGH VOLUME PRACTITIONERS		
Practitioner Type	**Standard**	**Minimum Performance Level**
Obstetrics/Gynecology Specialty Care (OB/GYN)	Ratio of practitioner to Members	1:2,000
Cardiology	Cardiologists to Members	1:5,000
Hematology/Oncology	Hematologists/Oncologists to Members	1:5,000
Gastroenterology	Gastroenterologists to Members	1:5,000
General Surgery	General surgeons to Members	1:5,000
Nephrology	Nephrologists to Members	1:10,000
Neurology	Neurologists to Members	1:5,000
Ophthalmology	Ophthalmologists to Members	1:5,000
Orthopedic Surgery	Orthopedic surgeons to Members	1:5,000
Psychiatry	Psychiatrists to Members	1:10,000
Pulmonology	Pulmonologists to Members	1:10,000

ii. Specialty care (high volume, high impact, and DHCS core) availability standards by geographic distribution:

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS					
Practitioner Type	**High Volume**	**High Impact**	**DHCS Core**	**Standard**	**Minimum Performance Level**
Obstetrics/Gynecology Specialty Care (OB/GYN):	X		X	For each practitioner type, there shall be one Practitioner within fifteen (15) miles or thirty (30) minutes of the Member's residence	100%
Cardiology/Interventional Cardiology	X		X		
Dermatology			X		
Endocrinology		X	X		
ENT/Otolaryngology			X		
Gastroenterology	X		X		
General Surgery	X		X		
Hematology		X	X		
HIV/AIDS Specialist/Infectious Diseases			X		
Nephrology	X	X	X		
Neurology	X		X		
Oncology	X	X	X		
Ophthalmology	X		X		
Orthopedic Surgery	X		X		
Physical Medicine and Rehabilitation			X		
Psychiatry	X		X		
Pulmonology	X		X		

10. Behavioral Health Care Providers: CalOptima shall maintain sufficient numbers and types of contracted Behavioral Health Care Providers to ensure access and availability of behavioral health care to Members.

a. High Volume Behavioral Health Provider: CalOptima has identified the following provider types as high volume behavioral health providers: psychologists, licensed clinical social workers and marriage and family therapists.

b. Behavioral health providers' standards by ratio of Practitioners to Members:

NUMBER OF BEHAVIORAL HEALTH PROVIDERS		
Practitioner Type	**Measure**	**Minimum Performance Level**
Psychologist	Psychologists to Members	1:15,000
Licensed Clinical Social Worker	Licensed Clinical Social Workers to Members	1:10,000
Marriage and Family Therapist	Marriage and Family Therapists to Members	1:3,000

11. Behavioral Health Care Providers' availability standards by geographic distribution:

GEOGRAPHIC DISTRIBUTION OF BEHAVIORAL HEALTH PROVIDERS		
Practitioner Type	**Measure**	**Minimum Performance Level**
Psychologist Licensed Clinical Social Worker Marriage and Family Therapist	For each provider type, there shall be one provider within fifteen (15) miles or thirty (30) minutes of the Member's residence	100%

12. California Children's Services (CCS) Program/Whole Child Model

    a. As required by DHCS, CalOptima shall demonstrate an adequate provider network that includes but may not be limited to the following:

        i. Pediatricians, pediatric specialty care providers, and pediatric subspecialty care providers; professional, allied and medical supportive personnel; as well as licensed acute care hospitals, special care centers, and specialized durable medical equipment providers.

        ii. An adequate number of hospitals and/or facilities that include neonatal intensive care, CCS-approved pediatric intensive care units, and CCS-approved inpatient facilities.

        iii. Licensed acute care hospitals and special care centers approved by the CCS program to treat a CCS-eligible condition.

        iv. An adequate provider overlap with CCS paneled providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty.

    b. Effective no sooner than January 1, 2019, CalOptima and Health Networks shall ensure that Members have access to all Medically Necessary CCS-paneled providers within the entire provider network.

S. Telephone Access:

1. Telephone Triage or Screening Services:

    a. Telephone Triage or Screening Services shall be available twenty-four (24) hours a day, seven (7) days a week. Telephone Triage or Screening waiting time shall not exceed thirty (30) minutes.

    b. CalOptima or a Health Network may provide telephone Triage or Screening Services through:

        i. CalOptima or Health Network-operated telephone Triage and Screening Services;

        ii. A telephone medical advice service consistent with Section 1348.8 of the Health and Safety Code;

        iii. CalOptima or the Health Network's contracted Primary Care or Behavioral health care provider office; or

iv. Other method that provides Triage or Screening Services.

c. If CalOptima or a Health Network contracts with a primary care or mental health care Provider for the provision of telephone Triage or Screening Services, such Providers shall maintain a procedure for Triaging or Screening Member telephone calls twenty-four (24) hours a day, seven (7) days a week, with a telephone answering machine and/or answering service, and/or office staff, that informs the Member:

i. Regarding the length of wait for a return call from the Provider; and

ii. How the caller may obtain urgent or emergency care including, when applicable, how to contact another Provider who has agreed to be on-call, Triage, or Screen by phone, or, if needed, deliver urgent or emergency care.

d. An unlicensed staff member may perform Triage or Screening on behalf of a licensed staff member in order to assist in determining the Member's condition and refer the Member to a licensed staff member. Such unlicensed staff member shall not use this information obtained from Triage or Screening in an attempt to assess, evaluate, advise, or make any decision regarding the Member's condition, or determine when the Member should see a licensed Provider.

2. Telephone wait time during business hours:

a. The total waiting time for a Member to reach a non-recorded voice shall not exceed thirty (30) seconds.

b. The call abandonment rate for CalOptima or a Health Network shall not exceed five percent (5%).

c. Non-urgent and non-emergency messages during business hours: A Practitioner shall return the call within twenty-four (24) hours after the time of message.

d. Urgent message during business hours: A Practitioner shall return the call within thirty (30) minutes after the time of message.

e. Emergency message during business hours: All members shall be referred to the nearest emergency room. CalOptima shall have in its recorded message to include the following: "If you feel that this is an emergency, hang up and dial nine-one-one (911) or go to the nearest emergency room."

f. Telephone access after business hours:

i. After-hours access: A Primary Care Practitioner (PCP) or his or her designee, an appropriate licensed professional under his or her supervision, shall be available twenty-four (24) hours a day, seven (7) days a week, to respond to after-hours Member calls or to a hospital emergency room Practitioner.

ii. If live after-hours attendant answers and the call is an emergency, the attendant shall refer the Member to nine-one-one (911) emergency services or instruct the Member to go to the nearest emergency room.

iii. If a recorded message answers, it shall include the following: "If you feel that this is an emergency, hang up and dial nine-one-one (911) or go to the nearest emergency room."

T. Cultural and Linguistic Services: Shall be provided, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services:

1. Interpreter services:

a. Oral interpreter services shall be made available to a Member in person, upon the Member's request, or by telephone at key points of contact, twenty-four (24) hours a day, seven (7) days a week, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

b. Interpreter services shall be coordinated with scheduled appointments for health care services, whenever possible, to ensure the provision of interpreter services at the time of appointment.

2. Written Materials: All written materials shall be made available to Members in Threshold Languages, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

3. Alternative Forms of Communication:

a. For a Member with a visual impairment, CalOptima and its Health Networks shall make informational or educational materials available at no cost in Threshold Languages in at least fourteen (14) point size font, audio format, or Braille upon request or as needed within twenty-one (21) days upon receipt of request or within a timely manner that is appropriate for the format requested. CalOptima and its Health Networks shall inform Members of the availability of these materials through the Member Handbook/EOC booklet and other mechanisms, including, but not limited to, posters and flyers distributed at sites where Members receive Covered Services and at Member orientation sessions.

b. Telecommunication Device for the Deaf (TDD): TDD shall be made available to a Member, upon request, at no cost to the Member.

III. PROCEDURE

A. CalOptima shall analyze performance of CalOptima's and Health Networks' access and availability against the standards set forth in this policy.

1. CalOptima shall annually conduct the following:

a. Provider Access Survey (appointment availability and access during and after business hours);

b. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys; and

c. Primary Care Physician Satisfaction Survey.

2. CalOptima shall monitor and/or run reports quarterly for the following:

    a. Grievances and appeals data;

    b. Availability (provider/member ratio and Geoaccess) data;

    c. Encounter/claims data; and

    d. Potential Quality Issues (PQI).

3. CalOptima shall monitor a CalOptima's and Health Networks' access and availability as follows:

    a. Track and review access and availability, in accordance with this policy;

    b. Monitor a Health Network's quarterly reporting of Initial Health Assessment (IHA) and Individual Health Education Behavioral Assessment (IHEBA) activity;

    c. Monitor and analyze telephone wait times through quarterly reports from the call center;

    d. Monitor telephone access for call abandonment rates;

    e. Monitor Behavioral Health reports on access and availability of contracted Behavioral Health providers.

    f. Review quarterly reports on Grievances and Complaints related to access;

    g. Review information obtained through Member and Provider surveys conducted on an annual basis related to access;

    h. Review and monitor Triage and Screening Services;

    i. Report access and availability performance against the standards set forth in this policy to the Member Experience Sub-Committee on an annual basis

    j. Analyze and report results of audit and review activities in order to:

        i. Prioritize opportunities for improvement identified from analyses.

        ii. Implement interventions on at least one (1) area of opportunity (if applicable) for the following areas:

            (a) Non-behavioral health care services and;

            (b) Behavioral health care services.

    k. Evaluate the effectiveness of interventions for improving access to non-behavioral and behavioral health care services.

4. CalOptima shall annually develop the following:

a. Accessibility analysis (appointment availability and access during and after business hours) report;

b. Availability analysis (provider/member ratio and GeoAccess) report;

B. CalOptima shall submit a complete and accurate Annual Network Certification using the reporting template provided by DHCS that reflects the entire contracted provider network, including providers who serve the needs of children and youth with CCS-Eligible Conditions as part of the CCS Program/Whole Child Model, and all required supporting documentation to DHCS no later than one hundred five (105) calendar days before the contract year begins (or the next business day if the due date occurs on a weekend or holiday), in accordance with DHCS All Plan Letter (APL) 18-005: Network Certification Requirements.

1. CCS/Whole Child Model Network Certification: In addition to the Annual Network Certification as described in Section III.B, CalOptima shall submit:

a. Updated policies and procedures, as required by DHCS.

b. An updated provider network template to ensure the network of providers meets network adequacy standards.

2. If CalOptima is unable to meet time and distance standards, an Alternative Access Standard (AAS) request shall be submitted to DHCS no later than one hundred five (105) calendar days prior to the beginning of every contract year and a Corrective Action Plan (CAP) may be issued.

3. If a Corrective Action Plan is issued to CalOptima by DHCS, CalOptima shall allow Members to access Medi-Cal services out-of-network if the services are not available in-network.

C. CalOptima shall provide the Health Networks and the Member Experience Sub-Committee with access and availability reports of CalOptima and Health Networks' performance. These reports shall include CalOptima's assessment results against the access and availability standards set forth in this policy.

D. If the Member Experience Sub-committee identifies deficiencies or non-compliance, the Chair of the Member Experience Sub-Committee, or Designee, may take the following steps:

1. Request that a Health Network submit a Quality Improvement Plan or Plan-Do-Study-Act (PDSA) cycle(s) for performance measures that are deemed deficient or non-compliant.

2. Submit a Request for Compliance Action (RCA) to the Office of Compliance to request corrective action. Such corrective action may include the issuance of a request for a Corrective Action Plan (CAP) and/or the imposition of Sanctions, in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions, respectively; and

3. Report the deficiencies or non-compliance to the Audit and Oversight Committee (AOC) and Compliance Committee, as appropriate.

E. Health Networks shall submit a Quality Improvement Plan or PDSA, if requested. If a CAP is issued:

1. The Health Network shall submit a CAP to CalOptima's Compliance department. A Health Network shall take all necessary and appropriate action to identify the causes underlying identified timely access deficiencies, including but not limited to a review of whether provider hours of operation and/or providers' scheduling practices contributed to the deficiencies, and resolve such deficiencies, to comply with the standards of this policy and CalOptima Policy HH.2005Δ: Corrective Action Plan.

2. CalOptima shall report, within three (3) business days, to the DHCS contract manager any significant instances of non-compliance or the imposition of CAPs or financial sanctions on a Health Network when it results in CalOptima's non-compliance with contractual requirements, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

F. The Quality Analytics Department shall coordinate performance reviews to assess adherence to access and availability standards, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

G. The Quality Analytics Department shall annually update CalOptima's Access and Availability desktop procedures to assess adherence to access and availability standards, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. Age Discrimination Act of 1975
B. California Civil Code, §51
C. California Government Code, §11135
D. CalOptima Authorization Required List
E. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Contract for Health Care Services
G. CalOptima Policy DD.2002: Cultural and Linguistic Services
H. CalOptima Policy EE.1135: Long Term Care Facility Contracting
I. CalOptima Policy GG.1103: Specialty Mental Health Services
J. CalOptima Policy GG.1122: Follow-up for Emergency Department Care
K. CalOptima Policy GG.1130: Community-Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes
L. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Care Network Providers
M. CalOptima Policy GG.1508: Authorization and Processing of Referrals
N. CalOptima Policy GG.1713: Nurse-Midwife Practice Guidelines, CalOptima Direct
O. CalOptima Policy GG.1118: Family Planning Services, Out-of-Network
P. CalOptima Policy GG.1619: Delegation Oversight
Q. CalOptima Policy HH.2002Δ: Sanctions
R. CalOptima Policy HH.2003: Health Network Reporting
S. CalOptima Policy HH.2005Δ: Corrective Action Plan
T. CalOptima Operational Audit Tool
U. CalOptima Quality Improvement Plan

V. DHCS Medi-Cal Managed Care Division (MMCD) Policy Letter 99-007: Individual Health Education Behavior Assessment
W. DHCS MMCD Policy Letter 08-003: Initial Comprehensive Health Assessment
X. DHCS All Plan Letter (APL) 18-005: Network Certification Requirements
Y. DCHS All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program
Z. National Committee of Quality Assurance (NCQA) standards
AA. Health and Safety Code §1374.73
BB. Title 28, California Code of Regulations, §§1300.51(H), 1300.67.2, 1300.67.2.2
CC. Title 28, Code of Federal Regulations, Part 36
DD. Title 29, United States Code, §794 (Section 504 of the Rehabilitation Act of 1973)
EE. Title 42, United States Code, §2000d
FF. Title 45, Code of Federal Regulations, Part 80, Part 84, and Part 91
GG. Title VI of the Civil Rights Act of 1964
HH. Title IX of the Education Amendments of 1973

VI. REGULATORY AGENCY APPROVALS

A. 11/13/15: Department of Health Care Services
B. 06/03/15: Department of Health Care Services
C. 08/28/14: Department of Health Care Services
D. 03/21/11: Department of Health Care Services
E. 12/24/09: Department of Health Care Services

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/01/1999	GG.1600	Access to Health Care	Medi-Cal
Revised	10/01/2003	GG.1600	Access and Availability Standards	Medi-Cal
Revised	06/01/2007	GG.1600	Access and Availability Standards	Medi-Cal
Revised	10/01/2008	GG.1600	Access and Availability Standards	Medi-Cal
Revised	08/01/2009	GG.1600	Access and Availability Standards	Medi-Cal
Revised	07/01/2010	GG.1600	Access and Availability Standards	Medi-Cal
Revised	03/01/2011	GG.1600	Access and Availability Standards	Medi-Cal
Revised	07/01/2011	GG.1600	Access and Availability Standards	Medi-Cal
Revised	01/01/2013	GG.1600	Access and Availability Standards	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	01/01/2014	GG.1600	Access and Availability Standards	Medi-Cal
Revised	09/01/2014	GG.1600	Access and Availability Standards	Medi-Cal
Revised	01/01/2015	GG.1600	Access and Availability Standards	Medi-Cal
Revised	07/01/2015	GG.1600	Access and Availability Standards	Medi-Cal
Revised	05/01/2016	GG.1600	Access and Availability Standards	Medi-Cal
Revised	08/01/2017	GG.1600	Access and Availability Standards	Medi-Cal
Revised	12/01/2017	GG.1600	Access and Availability Standards	Medi-Cal
Revised	09/06/2018	GG.1600	Access and Availability Standards	Medi-Cal

IX. GLOSSARY

Term	Definition
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
Alternative Access Standard (AAS)	An alternative to the existing access standard approved by DHCS when a managed care plan has exhausted all other reasonable options for obtaining providers in order to meet the applicable standards, or if DHCS determines that the requesting managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
Behavioral Health Care	Evaluation and treatment of psychological and substance abuse disorders including specialty mental health services. Specialty mental health services may include, but are not limited to, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facilities services.
Behavioral Health Treatment (BHT)	Medically Necessary, evidence-based behavioral health interventions to promote, to the maximum extent practicable, the functioning of a Member. These services are interventions designed to treat behavioral health conditions as determined by a licensed physician, surgeon, or psychologist. BHT includes a variety of evidence-based behavioral interventions identified by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence that are designed to be delivered primarily in the home and in other community settings.
Behavioral Health Treatment (BHT) Providers	A Qualified Autism Services (QAS) Provider, Professional, or Paraprofessional, as defined with the State Plan Amendment.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Term	Definition
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.
Cultural and Linguistic (C&L) Services	Services that promote equal access to health care services and are responsive to a Member's cultural and linguistic needs. These services include, but are not limited to: 1. Recruiting bilingual employees for appropriate positions whenever possible, and enhancing employees' bilingual skills and cultural sensitivity through employee development programs; 2. Providing twenty-four (24)-hour access to interpreter services at Key Points of Contact for all Members; 3. Providing translations of informational materials in Threshold Languages, providing oral translation for other languages upon request or as needed, and providing information and materials to meet the needs of Members with sensory impairments; and 4. Referring Members to culturally and linguistically appropriate community services, as needed.
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.
Emergency Medical Condition	A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.

Term	Definition
Free Standing Birth Center	Defined by Title 42, United States Code, Section 1396d(I)(3)(B) as a health facility- 1. That is not a hospital; 2. Where childbirth is planned to occur away from a pregnant woman's residence; 3. That is licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and 4. That complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the state shall establish.
Grievance	An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.
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. For purposes of this policy, a Health Network shall also include the CalOptima Community Network.
Individual Health Education Behavioral Assessment (IHEBA)	An assessment designed to identify high-risk behaviors of a Member to assist a Primary Care Physician (PCP) in prioritizing the Member's individual health education needs related to lifestyle, behavior, environment and cultural linguistic background, and to document focused health education interventions, referrals and follow up.
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.
Mid-Level Practitioner	A non-physician practitioner who has a professional license and certification. They include but are not limited to Certified Nurse Midwives, Certified Nurse Practitioners, and Physician Assistants.
Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some routine care of woman.
Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Title 16 CCR section 1484.
Prenatal Care	Health care that a pregnant woman receives from a licensed practitioner. Services needed may include physical examinations, dietary and lifestyle advice.

Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Provider Network	For purposes of this Policy, the providers with which an organization contracts or makes arrangements to furnish covered health care services to their members.
Qualified Autism Service Paraprofessional	An individual who is employed and supervised by a QAS Provider to provide Medically Necessary BHT services to Members..
Qualified Autism Service Professional	An Associate Behavioral Analyst, Behavior Analyst, Behavior Management Assistant, or Behavior Management Consultant, as defined in the State Plan Amendment, who provides Medically Necessary BHT services to Members.
Qualified Autism Service Provider	A licensed practitioner or Board Certified Behavior Analyst (BCBA).
Qualified Family Planning Practitioner	A qualified provider licensed to furnish family planning services within their scope of practice within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish Family Planning Services to a Member as specified in title 22, Code of California Regulations, Section 51200.
Routine Care	Covered Services that are not urgent in nature and may be pre-planned or scheduled in advance.
Routine Physical Exams	A well-care visit that usually emphasizes priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.
Rural Health Clinic	An entity defined in Title 22 CCR Section 51115.5
Sanctions	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.

Term	Definition
Service Area	The geographical area that DHCS authorizes CalOptima to operate in. A Service Area may include designated ZIP Codes within a county that CalOptima is approved to operate in.
Skilled Nursing Facility (SNF)	Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program
Specialty Care Provider (SCP)	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider. Beginning February 2011, Specialty Care Provider will be used in place of Specialist Physician.
Triage or Screening	The evaluation of a Member's health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of the child's need for care.
Triage or Screening Services	Assessment of a Member's health concerns and symptoms via telephone or other means of communication with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to perform Triage or Screening Services.
Triage or Screening Waiting Time	The time waiting to speak by telephone with a doctor or nurse who is trained to screen a Member who may need care.
Urgent Authorization	"Urgent" is defined as when normal time frame for authorization will be detrimental to patient's life or health, jeopardize patient's ability to regain maximum function, or result in loss of life, limb or other major bodily function.
Urgent Care Service	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.

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Policy #:	GG.1650Δ
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/17
Last Review Date:	~~01/01/18~~09/06/18
Last Revised Date:	~~01/01/18~~09/06/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy defines the process by which CalOptima evaluates and determines whether to approve or decline practitioners (as described in Section II. of this Policy ("Practitioners")) for participation in CalOptima programs.

II. POLICY

A. CalOptima shall establish guidelines by which CalOptima shall evaluate and select Practitioners to participate in CalOptima, in accordance with Title 42, Code of Federal Regulations, Section 422.204(a) and other applicable laws, regulations, and guidance.

B. CalOptima may delegate Credentialing and Recredentialing activities to a Health Network in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities. Delegated activities may include but are not limited to: Credentialing decisions, Credentialing verification, monitoring of sanctions, and processing of credentialing applications.

1. A Health Network shall establish policies and procedures to evaluate and approve Practitioners to participate in CalOptima programs that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO~~),~~) or his or her physician Designee~~,~~ shall have direct responsibility over and actively participate in the Credentialing program.

D. The CalOptima Credentialing Peer Review Committee (CPRC) shall be responsible for reviewing a Practitioner's Credentialing information and determining such Practitioner's participation in CalOptima.

E. CalOptima shall Credential and Recredential the following Practitioners as provided in this Policy: Physicians, Non-Physicians Medical Practitioners, Behavioral Health Practitioners, Substance Use Disorder (SUD) Practitioners, and Long Term Services and Supports (LTSS) Practitioners that provide care to CalOptima program Members, and are:

1. Licensed, certified, or registered by the state of California to practice independently and;

2. Contracted with CalOptima including physicians practicing at Federally Qualified Health Centers (FQHC) and community clinics that perform Primary and Specialty Care services.

F. CalOptima shall credential Non-Physician Medical Practitioners (NMP) who do not have an independent relationship with CalOptima, as follows:

1. For NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner who has executed a signed Delegation Services Agreement with the NMP; or

2. Under the employment agreement of a credentialed Provider.

G. An NMP shall notify CalOptima immediately if the supervising Physician Practitioner no longer meets the CalOptima Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or employment with the entity.

H. CalOptima does not Credential or Recredential:

1. Practitioners that practice exclusively within the inpatient setting (e.g., Hospitalist) and provide care for a Member only as a result of the Member being directed to the hospital, or inpatient, setting;

2. Practitioners that practice exclusively within freestanding facilities, and provide care for a Member only as a result of the Member being directed to the facility (e.g. Diagnostic Radiologists, Urgent Care, Emergency Medicine);

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima delegates utilization management (UM) functions (Credentialing of Pharmacies and its professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Policy GG.1406: Pharmacy Network Credentialing and Access);

4. Covering Practitioners (e.g., locum tenens) who do not have an independent relationship with CalOptima; and

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., External Physician Reviewer).

I. CalOptima shall categorize Practitioners into the three (3) Fraud, Waste, and Abuse risk levels established by the Centers for Medicare & Medicaid Services (CMS): limited, moderate, and high, and will screen Practitioners for the appropriate risk level in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 17-019: Provider Credentialing /Recredentialing and Screening / Enrollment, Title 42, CFR, Section 455, and as described Sections III.A. and III.B. of this Policy.

J. CalOptima shall Recredential a Practitioner at least every three (3) years, utilizing a thirty-six (36)-month cycle to the month, not to the day.

K. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles and shall provide evidence of monthly review of the Medical Board of

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California and Office of Inspector General (OIG) exclusion, or suspension, list in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Activities.

L. If CalOptima declines to include a Practitioner in the CalOptima network, CalOptima shall notify, in writing, such Practitioner within thirty (30) calendar days of the reason for its decision.

M. CalOptima shall not discriminate, in terms of participation, reimbursement, or indemnification, against any Practitioner who is acting within the scope of his or her license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima from:

1. Refusing to grant participation to a Practitioner in excess of the number necessary to meet the needs of Members;

2. Using different reimbursement amounts for different specialties, or for different Practitioners in the same specialty; and

3. Implementing measures designed to maintain quality and control costs consistent with CalOptima's responsibilities.

N. CalOptima shall not discriminate against a Practitioner that serves high-risk populations~~,~~ or specializes in the treatment of costly conditions.

O. CalOptima shall not make, or decline, Credentialing and Recredentialing decisions based on a Practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient, in which the Practitioner specializes.

P. CalOptima shall monitor and prevent discriminatory Credentialing decisions as follows:

1. Periodic audits of Credentialing files (in-process, denied, and approved files) to ensure Practitioners are not discriminated against at least annually;

2. Periodic audits of Practitioner complaints to determine if there are complaints alleging discrimination, including a review by the CPRC of quarterly reports of complaints, including discrimination at least annually;

3. Maintaining a heterogeneous Credentialing committee membership; and

4. Requiring those responsible for Credentialing and Recredentialing decisions to sign a statement affirming that they do not discriminate when making decisions.

Q. CalOptima shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

R. CalOptima shall maintain Credentialing files that include documentation of required elements, as described in this Policy.

S. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

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1. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing, or Recredentialing process, the application shall be considered expired.

T. Except as provided in CalOptima Policy GG.1608Δ: Full Scope Site Reviews, CalOptima does not delegate the Facility Site Review and Medical Record Review (MRR) processes to a Health Network. CalOptima assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

U. On an annual basis, the CalOptima Board of Directors shall review and approve this Policy.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. In conjunction with the CalOptima Provider Relations and Contracting Departments, a Practitioner shall initiate the Credentialing process with CalOptima.

a. Upon receipt of the request from the Practitioner, CalOptima shall send a notification electronically, explaining the expectations for completion and submission of the credentialing application and required documents.

b. Physician Practitioners shall meet the Minimum Physician Standards as outlined in CalOptima Policy GG.1643Δ: Minimum Physician Standards and CalOptima will verify that the Physician Practitioner meets the minimum standards as provided in this Policy.

c. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima that attests to:

i. Any work history gap that exceeds six (6) months, including written clarification;

ii. The essential functions of the position that the Practitioner cannot perform, with or without accommodation (i.e., health status);

iii. Lack of present illegal drug use that impairs current ability to practice;

iv. History of any loss of license and history of felony convictions;

v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

vi. Current malpractice insurance coverage; and

vii. The correctness and completeness of the application;

d. All credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

e. A Practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

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f. CalOptima shall return an incomplete application to a Practitioner, and such incomplete application will not be processed until the Practitioner submits all the required information.

g. An NMP who does not have an individual relationship with CalOptima, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed and credentialed by CalOptima; stating the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed provider.

2. Upon receipt of a complete Credentialing application, CalOptima shall verify the information provided through primary verification using industry-recognized verification sources or a Credentialing Verification Organization. This information includes, but is not limited to:

a. A current, valid California license to practice in effect at the time of the Credentialing decision;

b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians; and

~~c.~~ Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements and if applicable, completion of residency, and specialty training.

c.

3. CalOptima shall also collect and verify the following information from each Provider as applicable, but need not verify this information through a primary source. This information includes, but is not limited to:

a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The Practitioner shall provide, in writing, an explanation of any gaps of six (6) months, or more;

b. Written, or verbal, confirmation from the Practitioner's primary inpatient admitting facility that the Practitioner has privileges in good standing, or confirmation that the Practitioner refers patients to hospital-based Practitioners (Hospitalist), as applicable;

c. Any alternative admitting arrangements must be documented in the Credentialing file;

d. A valid DEA, or Controlled Dangerous Substances (CDS), certificate obtained through confirmation by National Technical Information Service (NTIS), if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

e. A valid National Provider Identifier (NPI) number;

f. Current malpractice insurance or self-insurance (e.g., trust, escrow accounts coverage) in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision;

g. Practitioner information entered into the National Practitioner Data Bank (NPDB), if applicable;

h. No exclusion, suspension, or ineligibility to participate in any state and federal health care program at the time of the Credentialing decision;

i. A review of any Grievances, or quality, cases filed against a Practitioner in the last five (5) years;

j. No exclusion from participation at any time in federal, or state, health care programs based on conduct within the last ten (10) years that supports a mandatory exclusion under the Medicare program, as set forth in Title 42, United States Code, Section 1320a-7(a), as follows:

i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

ii. A felony conviction related to neglect, or abuse, of patients in connection with the delivery of a health care item, or service;

iii. A felony conviction related to health care Fraud; or

iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

k. History of professional liability claims that resulted in settlements or judgments, paid by, or on behalf of, the Practitioner;

l. History of state sanctions, restrictions on licensure or limitations on scope of practice;

~~l.~~m. Human Immunodeficiency Virus (HIV) specialist attestation, if applicable;

n. Full or provisional California Children's Services (CCS)- paneled approval status, with a current active panel status;

~~m.~~o. Current IRS Form W-9;

~~n.~~p. Current (within last three (3) years) Full Scope FSR/MRR, and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews; and

~~o.~~q. Active enrollment status with Medi-Cal

~~i. The CMO, or his or her physician Designee, has the ability to make exceptions with respect to Medi-Cal enrollment status in order to satisfy access and continuity of care requirements; and~~

~~ii. The CMO, or his or her physician Designee, may also make exceptions to Providers outside of Orange, Los Angeles, San Bernardino, Riverside, and San Diego Counties, on a case-by-case basis.~~

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~~iii. When the CMO, or his or her physician Designee, makes an exception, CalOptima shall enroll and screen a Provider in a manner equivalent to the DHCS provider enrollment process, pursuant to APL 17-019: Provider Credentialing /Recredentialing and Screening / Enrollment.~~

~~p.~~r. Active enrollment status with Medicare for OneCare, or OneCare Connect, Practitioners.

B. Practitioner Recredentialing

1. CalOptima shall Recredential a Practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima shall:

   a. Collect and verify, at a minimum, all of the information required for initial credentialing, as set forth in Section III.A of this policy, including any change in work history, except historical data already verified at the time of the initial credentialing of the Practitioner; and

   b. Incorporate the following data in the decision-making process:

      i. Member Grievances and Appeals, including number and type during the past three (3) years;

      ii. Information from quality review activities;

      iii. Board Certification, if applicable;

      iv. Member satisfaction, if applicable;

      v. Medical Record Reviews, if applicable;

      vi. Facility Site Review (FSR) results and Physical Accessibility Review Survey (PARS) results, if applicable; and

      vii. Compliance with the terms of the Practitioner's contract.

   c. All Recredentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) Full Scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

3. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles.

4. If CalOptima terminates a Practitioner during the Recredentialing process for administrative reasons (i.e., the Practitioner failed to provide complete credentialing information) and not for quality reasons (i.e., medical disciplinary cause or reason), it may reinstate the Practitioner within thirty (30) calendar days of termination and is not required to perform initial credentialing. However, CalOptima must re-verify credentials that are no longer within the

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verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima must perform initial credentialing of such Practitioner.

C. Practitioner Rights

1. New applicants for Credentialing will receive Practitioner Rights attached to the CPPA as Addendum A, describing the following:

a. Right to review information

i. Practitioners will be notified of their right to review information CalOptima has obtained to evaluate their credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure.

b. Right to correct erroneous information

i. All Practitioners will be notified by certified mail when Credentialing information obtained from other sources varies substantially from that provided by the Practitioner;

ii. All Practitioners have the right to correct erroneous information, as follows:

a) The Practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

b) Requests for correction of erroneous information must be submitted by certified mail on the Practitioner's letterhead with a detailed explanation regarding erroneous information, as well as copy(ies) of corrected information; and

c) All submissions will be mailed to CalOptima's Quality Improvement Department using the following address:

Attention: Quality Improvement Department – Credentialing
CalOptima
505 City Parkway West
Orange, CA 92868

iii. CalOptima is not required to reveal the source of information, if the information is not obtained to meet CalOptima's Credentialing verification requirements, or if federal or state law prohibits disclosure.

2. Documentation of receipt of corrections

a. A Practitioner shall be notified within thirty (30) calendar days via a letter to document CalOptima's receipt of the identified erroneous information.

3. Right to be notified of application status

a. Practitioners may receive the status of their Credentialing, or Recredentialing, application, upon request.

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b. Practitioners may request to review non-privileged information obtained from outside sources (e.g., malpractice insurance carriers and licensing boards).

c. Practitioners can contact the Quality Improvement Department by phone, e-mail, or facsimile requesting the status of their application. The Quality Improvement Department will respond within one (1) business day of the status of the Practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing Peer Review Committee (CPRC)

1. CalOptima shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Such CPRC shall include representation from a range of Practitioners participating in the organization's network, and shall be responsible for reviewing a Practitioner's Credentialing and Recredentialing files, and determining the Practitioner's participation in CalOptima programs.

3. Completed Credentialing and Recredentialing files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no professional review or malpractice claim(s) that resulted in settlements or judgments paid by, or on behalf of, the Practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review

i. A clean file shall be considered approved and effective on the date that the CMO or his or her physician Designee review and approve a Practitioner's Credentialing, or Recredentialing, file, and deem the file clean.

ii. Approved, clean file lists shall be presented at the CPRC and reflected in the meeting minutes.

b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of malpractice claim(s) that resulted in settlements or judgments paid by, or on behalf of, the Practitioner, identification of Practitioner, or OIG exclusion list, Medi-Cal Suspended and Ineligible Provider List, or NPDB query identifying Medical Board investigations, or other actions.

i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

ii. CPRC minutes shall reflect thoughtful consideration of information presented in the credentialing file.

iii. CPRC meetings and decisions may take in real-time, as a virtual meeting, but may not be conducted through e-mail.

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4. The CPRC shall make recommendations based on the Practitioners' ability to deliver care based on the Credentialing information collected from the file review process, and shall be verified prior to making a Credentialing decision.

    a. The Quality Improvement Department shall send the Practitioner a decision letter, within thirty (30) calendar days of the decision:

        i. Acceptance;

        ii. Acceptance with Restrictions along with appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners; or

        iii. Denial of the application along with appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

    b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

        i. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing, or Recredentialing process, the application shall be considered expired.

E. CalOptima shall monitor and prevent discriminatory practices, to include, but not be limited to:

    a. Monitoring:

        i. CalOptima shall conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that Practitioners are not discriminated against; and

        ii. Review Practitioner complaints to determine if there are complaints alleging discrimination.

        iii. On a quarterly basis, the QI Department shall review grievances, appeals, and potential quality of care issues for complaints alleging discrimination, and will report outcomes to the CPRC for review and determination.

    b. Prevention:

        i. The QI Department shall maintain a heterogeneous Credentialing committee, and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

F. Upon acceptance of the Credentialing application, the CalOptima Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. This provider profile shall be generated from the credentialing database to ensure that the information is consistent with data verified during the Credentialing process (i.e. education, training, board certification and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima's core business system, which updates pertinent information into the online Provider directory.

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IV. ATTACHMENTS

A. California Participating Physician Application (CPPA)
B. CalOptima Primary Source Verification Table
~~C. Ongoing Monitoring Website Information Matrix~~

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima PACE Program Agreements
D. CalOptima Contract for Health Care Services
E. 2017 NCQA Standards and Guidelines
F. CalOptima Policy GG.1406: Pharmacy Network Credentialing and Access
G. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
H. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
I. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities
J. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
K. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
L. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
M. CalOptima Policy GG.1643Δ: Minimum Physician Standards
N. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of a Healthcare Delivery Organization (HDO)
O. CalOptima Policy HH.1101: CalOptima Provider Compliant
P. CalOptima Policy MA.9006: Provider Complaint Process
Q. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
R. Department of Health Care Services All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit
U. Department of Health Care Services All Plan Letter (APL) 17-019: Provider Credentialing / Recredentialing and Screening / Enrollment
V. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program
S. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 438.12, 438.214, 460.64 and 460.71
T. Title 45, Code of Federal Regulations, §455, Subpart E
U. Title 42, United States Code, §1320a-7(a)
V. Title XVIII and XIV of the Social Security Act
W. California Business and Professions Code, ~~Section~~ §805
X. California Evidence Code, ~~Section~~ §1157

VI. REGULATORY AGENCY APPROVALS

A. 04/28/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 06/01/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/1996	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	02/1998	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	01/1999	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	08/2000	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	02/2001	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	01/01/2006	MA.7009	Credentialing and Recredentialing	OneCare
Revised	07/01/2007	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	07/01/2009	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2011	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	03/01/2012	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2013	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	06/01/2014	GG.1609	Credentialing and Recredentialing	Medi-Cal
Retired	02/01/2015	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Retired	03/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Revised	03/01/2015	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Retired	06/01/2017	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Effective	06/01/2017	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE

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.
Appeal	A request by the Member or the Member's Authorized Representative for review of any decision to deny, modify, or discontinue a Covered Service.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services.
Credentialing Peer Review Committee	Peer review body who reviews all recommendations and decisions regarding Credentialing and Recredentialing
Credentialing Verification Organization	An organization that collects and verifies credentialing information.

Term	Definition
Delegation Services Agreement	Mutually agreed upon document, signed by both parties, which includes, without limit: 1. CalOptima responsibilities; 2. Duration of the agreement; 3. Termination of the agreement; 4. Delegated Entity responsibilities and Delegated Services; 5. Types and frequency of reporting to the Delegated Entity; 6. Process by which the CalOptima evaluates the Delegated Entity's performance (Performance Measurements); 7. Use of confidential CalOptima information including Member Protected Health Information (PHI) by the Delegated Entity; and 8. Remedies available to the CalOptima if the Delegated Entity does not fulfill its obligations.
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.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Full Scope Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a PCP Site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.
Grievance	An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.
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.
Long Term Support Services (LTSS) Provider	A licensed practitioner such as physicians, Non-Physician Medical Practitioners (NMP), social workers, and nurse managers.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An enrollee-beneficiary of a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.

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Term	Definition
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a Primary Care Provider (PCP).
Recredentialing	The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, Specialty Care given to Members by referral by other than a Primary Care Provider (PCP).
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one (1) of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.
Utilization Management (UM)	Requirements or limits on coverage. Utilization management may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy #:	GG.1650Δ
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/17
Last Review Date:	09/06/18
Last Revised Date:	09/06/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy defines the process by which CalOptima evaluates and determines whether to approve or decline practitioners (as described in Section II. of this Policy ("Practitioners")) for participation in CalOptima programs.

II. POLICY

A. CalOptima shall establish guidelines by which CalOptima shall evaluate and select Practitioners to participate in CalOptima, in accordance with Title 42, Code of Federal Regulations, Section 422.204(a) and other applicable laws, regulations, and guidance.

B. CalOptima may delegate Credentialing and Recredentialing activities to a Health Network in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities. Delegated activities may include but are not limited to: Credentialing decisions, Credentialing verification, monitoring of sanctions, and processing of credentialing applications.

1. A Health Network shall establish policies and procedures to evaluate and approve Practitioners to participate in CalOptima programs that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO) or his or her physician Designee shall have direct responsibility over and actively participate in the Credentialing program.

D. The CalOptima Credentialing Peer Review Committee (CPRC) shall be responsible for reviewing a Practitioner's Credentialing information and determining such Practitioner's participation in CalOptima.

E. CalOptima shall Credential and Recredential the following Practitioners as provided in this Policy: Physicians, Non-Physicians Medical Practitioners, Behavioral Health Practitioners, Substance Use Disorder (SUD) Practitioners, and Long Term Services and Supports (LTSS) Practitioners that provide care to CalOptima program Members, and are:

1. Licensed, certified, or registered by the state of California to practice independently and;

2. Contracted with CalOptima including physicians practicing at Federally Qualified Health Centers (FQHC) and community clinics that perform Primary and Specialty Care services.

F. CalOptima shall credential Non-Physician Medical Practitioners (NMP) who do not have an independent relationship with CalOptima, as follows:

1. For NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner who has executed a signed Delegation Services Agreement with the NMP; or

2. Under the employment agreement of a credentialed Provider.

G. An NMP shall notify CalOptima immediately if the supervising Physician Practitioner no longer meets the CalOptima Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or employment with the entity.

H. CalOptima does not Credential or Recredential:

1. Practitioners that practice exclusively within the inpatient setting (e.g., Hospitalist) and provide care for a Member only as a result of the Member being directed to the hospital, or inpatient, setting;

2. Practitioners that practice exclusively within freestanding facilities, and provide care for a Member only as a result of the Member being directed to the facility (e.g. Diagnostic Radiologists, Urgent Care, Emergency Medicine);

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima delegates utilization management (UM) functions (Credentialing of Pharmacies and its professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Policy GG.1406: Pharmacy Network Credentialing and Access);

4. Covering Practitioners (e.g., locum tenens) who do not have an independent relationship with CalOptima; and

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., External Physician Reviewer).

I. CalOptima shall categorize Practitioners into the three (3) Fraud, Waste, and Abuse risk levels established by the Centers for Medicare & Medicaid Services (CMS): limited, moderate, and high, and will screen Practitioners for the appropriate risk level in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 17-019: Provider Credentialing /Recredentialing and Screening / Enrollment, Title 42, CFR, Section 455, and as described Sections III.A. and III.B. of this Policy.

J. CalOptima shall Recredential a Practitioner at least every three (3) years, utilizing a thirty-six (36)-month cycle to the month, not to the day.

K. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles and shall provide evidence of monthly review of the Medical Board of

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California and Office of Inspector General (OIG) exclusion, or suspension, list in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Activities.

L. If CalOptima declines to include a Practitioner in the CalOptima network, CalOptima shall notify, in writing, such Practitioner within thirty (30) calendar days of the reason for its decision.

M. CalOptima shall not discriminate, in terms of participation, reimbursement, or indemnification, against any Practitioner who is acting within the scope of his or her license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima from:

1. Refusing to grant participation to a Practitioner in excess of the number necessary to meet the needs of Members;

2. Using different reimbursement amounts for different specialties, or for different Practitioners in the same specialty; and

3. Implementing measures designed to maintain quality and control costs consistent with CalOptima's responsibilities.

N. CalOptima shall not discriminate against a Practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

O. CalOptima shall not make, or decline, Credentialing and Recredentialing decisions based on a Practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient, in which the Practitioner specializes.

P. CalOptima shall monitor and prevent discriminatory Credentialing decisions as follows:

1. Periodic audits of Credentialing files (in-process, denied, and approved files) to ensure Practitioners are not discriminated against at least annually;

2. Periodic audits of Practitioner complaints to determine if there are complaints alleging discrimination, including a review by the CPRC of quarterly reports of complaints, including discrimination at least annually;

3. Maintaining a heterogeneous Credentialing committee membership; and

4. Requiring those responsible for Credentialing and Recredentialing decisions to sign a statement affirming that they do not discriminate when making decisions.

Q. CalOptima shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

R. CalOptima shall maintain Credentialing files that include documentation of required elements, as described in this Policy.

S. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

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1. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing, or Recredentialing process, the application shall be considered expired.

T. Except as provided in CalOptima Policy GG.1608Δ: Full Scope Site Reviews, CalOptima does not delegate the Facility Site Review and Medical Record Review (MRR) processes to a Health Network. CalOptima assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

U. On an annual basis, the CalOptima Board of Directors shall review and approve this Policy.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. In conjunction with the CalOptima Provider Relations and Contracting Departments, a Practitioner shall initiate the Credentialing process with CalOptima.

a. Upon receipt of the request from the Practitioner, CalOptima shall send a notification electronically, explaining the expectations for completion and submission of the credentialing application and required documents.

b. Physician Practitioners shall meet the Minimum Physician Standards as outlined in CalOptima Policy GG.1643Δ: Minimum Physician Standards and CalOptima will verify that the Physician Practitioner meets the minimum standards as provided in this Policy.

c. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima that attests to:

i. Any work history gap that exceeds six (6) months, including written clarification;

ii. The essential functions of the position that the Practitioner cannot perform, with or without accommodation (i.e., health status);

iii. Lack of present illegal drug use that impairs current ability to practice;

iv. History of any loss of license and history of felony convictions;

v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

vi. Current malpractice insurance coverage; and

vii. The correctness and completeness of the application;

d. All credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

e. A Practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

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f. CalOptima shall return an incomplete application to a Practitioner, and such incomplete application will not be processed until the Practitioner submits all the required information.

g. An NMP who does not have an individual relationship with CalOptima, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed and credentialed by CalOptima; stating the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed provider.

2. Upon receipt of a complete Credentialing application, CalOptima shall verify the information provided through primary verification using industry-recognized verification sources or a Credentialing Verification Organization. This information includes, but is not limited to:

   a. A current, valid California license to practice in effect at the time of the Credentialing decision;

   b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians; and

   c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements and if applicable, completion of residency, and specialty training.

3. CalOptima shall also collect and verify the following information from each Provider as applicable, but need not verify this information through a primary source. This information includes, but is not limited to:

   a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The Practitioner shall provide, in writing, an explanation of any gaps of six (6) months, or more;

   b. Written, or verbal, confirmation from the Practitioner's primary inpatient admitting facility that the Practitioner has privileges in good standing, or confirmation that the Practitioner refers patients to hospital-based Practitioners (Hospitalist), as applicable;

   c. Any alternative admitting arrangements must be documented in the Credentialing file;

   d. A valid DEA, or Controlled Dangerous Substances (CDS), certificate obtained through confirmation by National Technical Information Service (NTIS), if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

   e. A valid National Provider Identifier (NPI) number;

   f. Current malpractice insurance or self-insurance (e.g., trust, escrow accounts coverage) in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision;

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g. Practitioner information entered into the National Practitioner Data Bank (NPDB), if applicable;

h. No exclusion, suspension, or ineligibility to participate in any state and federal health care program at the time of the Credentialing decision;

i. A review of any Grievances, or quality, cases filed against a Practitioner in the last five (5) years;

j. No exclusion from participation at any time in federal, or state, health care programs based on conduct within the last ten (10) years that supports a mandatory exclusion under the Medicare program, as set forth in Title 42, United States Code, Section 1320a-7(a), as follows:

i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

ii. A felony conviction related to neglect, or abuse, of patients in connection with the delivery of a health care item, or service;

iii. A felony conviction related to health care Fraud; or

iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

k. History of professional liability claims that resulted in settlements or judgments, paid by, or on behalf of, the Practitioner;

l. History of state sanctions, restrictions on licensure or limitations on scope of practice;

m. Human Immunodeficiency Virus (HIV) specialist attestation, if applicable;

n. Full or provisional California Children's Services (CCS)- paneled approval status, with a current active panel status;

o. Current IRS Form W-9;

p. Current (within last three (3) years) Full Scope FSR/MRR, and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews; and

q. Active enrollment status with Medi-Cal

r. Active enrollment status with Medicare for OneCare, or OneCare Connect, Practitioners.

B. Practitioner Recredentialing

1. CalOptima shall Recredential a Practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima shall:

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a. Collect and verify, at a minimum, all of the information required for initial credentialing, as set forth in Section III.A of this policy, including any change in work history, except historical data already verified at the time of the initial credentialing of the Practitioner; and

b. Incorporate the following data in the decision-making process:

i. Member Grievances and Appeals, including number and type during the past three (3) years;

ii. Information from quality review activities;

iii. Board Certification, if applicable;

iv. Member satisfaction, if applicable;

v. Medical Record Reviews, if applicable;

vi. Facility Site Review (FSR) results and Physical Accessibility Review Survey (PARS) results, if applicable; and

vii. Compliance with the terms of the Practitioner's contract.

c. All Recredentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) Full Scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

3. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles.

4. If CalOptima terminates a Practitioner during the Recredentialing process for administrative reasons (i.e., the Practitioner failed to provide complete credentialing information) and not for quality reasons (i.e., medical disciplinary cause or reason), it may reinstate the Practitioner within thirty (30) calendar days of termination and is not required to perform initial credentialing. However, CalOptima must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima must perform initial credentialing of such Practitioner.

C. Practitioner Rights

1. New applicants for Credentialing will receive Practitioner Rights attached to the CPPA as Addendum A, describing the following:

a. Right to review information

i. Practitioners will be notified of their right to review information CalOptima has obtained to evaluate their credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (e.g.,

malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure.

b. Right to correct erroneous information

i. All Practitioners will be notified by certified mail when Credentialing information obtained from other sources varies substantially from that provided by the Practitioner;

ii. All Practitioners have the right to correct erroneous information, as follows:

a) The Practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

b) Requests for correction of erroneous information must be submitted by certified mail on the Practitioner's letterhead with a detailed explanation regarding erroneous information, as well as copy(ies) of corrected information; and

c) All submissions will be mailed to CalOptima's Quality Improvement Department using the following address:

Attention: Quality Improvement Department – Credentialing
CalOptima
505 City Parkway West
Orange, CA 92868

iii. CalOptima is not required to reveal the source of information, if the information is not obtained to meet CalOptima's Credentialing verification requirements, or if federal or state law prohibits disclosure.

2. Documentation of receipt of corrections

a. A Practitioner shall be notified within thirty (30) calendar days via a letter to document CalOptima's receipt of the identified erroneous information.

3. Right to be notified of application status

a. Practitioners may receive the status of their Credentialing, or Recredentialing, application, upon request.

b. Practitioners may request to review non-privileged information obtained from outside sources (e.g., malpractice insurance carriers and licensing boards).

c. Practitioners can contact the Quality Improvement Department by phone, e-mail, or facsimile requesting the status of their application. The Quality Improvement Department will respond within one (1) business day of the status of the Practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing Peer Review Committee (CPRC)

1. CalOptima shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Such CPRC shall include representation from a range of Practitioners participating in the organization's network, and shall be responsible for reviewing a Practitioner's Credentialing and Recredentialing files, and determining the Practitioner's participation in CalOptima programs.

3. Completed Credentialing and Recredentialing files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

    a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no professional review or malpractice claim(s) that resulted in settlements or judgments paid by, or on behalf of, the Practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review

        i. A clean file shall be considered approved and effective on the date that the CMO or his or her physician Designee review and approve a Practitioner's Credentialing, or Recredentialing, file, and deem the file clean.

        ii. Approved, clean file lists shall be presented at the CPRC and reflected in the meeting minutes.

    b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of malpractice claim(s) that resulted in settlements or judgments paid by, or on behalf of, the Practitioner, identification of Practitioner, or OIG exclusion list, Medi-Cal Suspended and Ineligible Provider List, or NPDB query identifying Medical Board investigations, or other actions.

        i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

        ii. CPRC minutes shall reflect thoughtful consideration of information presented in the credentialing file.

        iii. CPRC meetings and decisions may take in real-time, as a virtual meeting, but may not be conducted through e-mail.

4. The CPRC shall make recommendations based on the Practitioners' ability to deliver care based on the Credentialing information collected from the file review process, and shall be verified prior to making a Credentialing decision.

    a. The Quality Improvement Department shall send the Practitioner a decision letter, within thirty (30) calendar days of the decision:

        i. Acceptance;

        ii. Acceptance with Restrictions along with appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners; or

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iii. Denial of the application along with appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

i. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing, or Recredentialing process, the application shall be considered expired.

E. CalOptima shall monitor and prevent discriminatory practices, to include, but not be limited to:

a. Monitoring:

i. CalOptima shall conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that Practitioners are not discriminated against; and

ii. Review Practitioner complaints to determine if there are complaints alleging discrimination.

iii. On a quarterly basis, the QI Department shall review grievances, appeals, and potential quality of care issues for complaints alleging discrimination, and will report outcomes to the CPRC for review and determination.

b. Prevention:

i. The QI Department shall maintain a heterogeneous Credentialing committee, and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

F. Upon acceptance of the Credentialing application, the CalOptima Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. This provider profile shall be generated from the credentialing database to ensure that the information is consistent with data verified during the Credentialing process (i.e. education, training, board certification and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima's core business system, which updates pertinent information into the online Provider directory.

IV. ATTACHMENTS

A. California Participating Physician Application (CPPA)
B. CalOptima Primary Source Verification Table

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima PACE Program Agreements

D. CalOptima Contract for Health Care Services
E. 2017 NCQA Standards and Guidelines
F. CalOptima Policy GG.1406: Pharmacy Network Credentialing and Access
G. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
H. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
I. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities
J. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
K. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
L. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
M. CalOptima Policy GG.1643Δ: Minimum Physician Standards
N. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of a Healthcare Delivery Organization (HDO)
O. CalOptima Policy HH.1101: CalOptima Provider Compliant
P. CalOptima Policy MA.9006: Provider Complaint Process
Q. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
R. Department of Health Care Services All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit
U. Department of Health Care Services All Plan Letter (APL) 17-019: Provider Credentialing / Recredentialing and Screening / Enrollment
V. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program
S. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 438.12, 438.214, 460.64 and 460.71
T. Title 45, Code of Federal Regulations, §455, Subpart E
U. Title 42, United States Code, §1320a-7(a)
V. Title XVIII and XIV of the Social Security Act
W. California Business and Professions Code, §805
X. California Evidence Code, §1157

VI. REGULATORY AGENCY APPROVALS

A. 04/28/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
B. 06/01/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/1996	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	02/1998	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	01/1999	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	08/2000	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	02/2001	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	01/01/2006	MA.7009	Credentialing and Recredentialing	OneCare
Revised	07/01/2007	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	07/01/2009	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2011	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	03/01/2012	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2013	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	06/01/2014	GG.1609	Credentialing and Recredentialing	Medi-Cal
Retired	02/01/2015	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Retired	03/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Revised	03/01/2015	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Retired	06/01/2017	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Effective	06/01/2017	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE

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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.
Appeal	A request by the Member or the Member's Authorized Representative for review of any decision to deny, modify, or discontinue a Covered Service.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services.
Credentialing Peer Review Committee	Peer review body who reviews all recommendations and decisions regarding Credentialing and Recredentialing
Credentialing Verification Organization	An organization that collects and verifies credentialing information.

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Term	Definition
Delegation Services Agreement	Mutually agreed upon document, signed by both parties, which includes, without limit: 1. CalOptima responsibilities; 2. Duration of the agreement; 3. Termination of the agreement; 4. Delegated Entity responsibilities and Delegated Services; 5. Types and frequency of reporting to the Delegated Entity; 6. Process by which the CalOptima evaluates the Delegated Entity's performance (Performance Measurements); 7. Use of confidential CalOptima information including Member Protected Health Information (PHI) by the Delegated Entity; and 8. Remedies available to the CalOptima if the Delegated Entity does not fulfill its obligations.
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.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Full Scope Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a PCP Site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.
Grievance	An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.
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.
Long Term Support Services (LTSS) Provider	A licensed practitioner such as physicians, Non-Physician Medical Practitioners (NMP), social workers, and nurse managers.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An enrollee-beneficiary of a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.

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Term	Definition
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a Primary Care Provider (PCP).
Recredentialing	The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, Specialty Care given to Members by referral by other than a Primary Care Provider (PCP).
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one (1) of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.
Utilization Management (UM)	Requirements or limits on coverage. Utilization management may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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California Participating Practitioner Application

I. Instructions

This form should be typed. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please refer to cover page for a list of the required documents to be submitted with this application.

II. Identifying Information

Last Name: First Name: Middle:

Is there any other name under which you have been known? Name(s):

Home Mailing Address:

City: State: Zip Code:

Home Phone Number: Fax Number: Cell Number: Pager Number:

Practitioner Email: Citizenship (If not a U.S. citizen, please provide a copy of Alien Registration Card):

Birth Date: Social Security Number:

Birth Place: Gender ○ Male ○ Female

Driver's License State/Number: Race/Ethnicity (optional):

Your intent is to serve as a(n):

☐ Primary Care Provider ☐ Specialist ☐ Urgent Care ☐ Hospitalist ☐ Hospital Based

Specialty:

Subspecialties:

III. Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Primary Office Address:

City: State: Zip Code:

Telephone Number: Fax Number: Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number:

Office Administrator/Manager Email: Office Administrator/Manager Fax Number:

Federal Tax ID Number: Name Associated with Tax ID:

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III. Practice Information (Continued)

Please identify the physical accessibility of this office. ◯ Basic ◯ Limited ◯ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Primary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #: Group NPI #:

Secondary Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Secondary Office Address:

City: State: Zip Code:

Telephone Number: Fax Number: Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number:

Office Administrator/Manager Email: Office Administrator/Manager Fax Number:

Federal Tax ID Number: Name Associated with Tax ID:

Please identify the physical accessibility of this office. ◯ Basic ◯ Limited ◯ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Secondary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #: Group NPI #:

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Tertiary Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Tertiary Office Address:

City: State: Zip Code:

Telephone Number: Fax Number: Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number:

Office Administrator/Manager Email: Office Administrator/Manager Fax Number:

Federal Tax ID Number: Name Associated with Tax ID:

Please identify the physical accessibility of this office. ◯ Basic ◯ Limited ◯ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Tertiary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #: Group NPI #:

Mailing Address

Which of your practices is your primary mailing address? ◯ Primary ◯ Secondary ◯ Tertiary ◯ Other

If your mailing address is different from your practice address, please provide it:

IV. Billing Information

Which of your practices handles your billing? ◯ Primary ◯ Secondary ◯ Tertiary If none, please provide billing information:

Billing Company

Billing Company Mailing Address:

City: State: Zip Code:

Contact Person: Telephone Number:

Federal Tax ID Number: Name Associated with Tax ID:

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V. Practice Description

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologist, etc.)? ◯ Yes ◯ No
If so, please list:

Name	Type of Provider	License Number

Physician Assistant Supervisor Name: License Number:

Do you personally employ any physicians (do not include physicians who are employed by the medical group)? ◯ Yes ◯ No
If so, please list:

Name	**California Medical License Number**	**Primary/Secondary/Tertiary Practice**
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary

Please list any clinical services you perform that are not typically associated with your specialty:

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Please list any clinical services you do **not** perform that are typically associated with your specialty:

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Is your practice limited to certain ages? ◯ Yes ◯ No If yes, specify limitation:

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Coverage of Practice

List your answering service and covering physicians by name. Attach additional sheets if necessary.

Answering Service Company

Answering Service Mailing Address:

City: State: Zip Code: Email:

Covering Physician's Name(s) / Phone Number / Which practices does their coverage apply (Primary, Secondary, Tertiary):

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VI. Education, Training and Experience

Medical/Professional Education NOT REQUIRED FOR RE-CREDENTIALING

Medical School/Professional: | Degree Received: | Graduation Date:

Mailing Address: | Website (if applicable):

City: | State: | Zip Code: | Registrar's Phone Number:

Internship/PGY-1 NOT REQUIRED FOR RE-CREDENTIALING

Institution: | Program Director:

Address | City | State | Zip

Telephone Number: | Fax Number: | Website (if applicable):

Type of Internship: | From (mm/yyyy): | To (mm/yyyy):

Did you successfully complete the program? ◯ Yes ◯ No (If No, please explain on a separate sheet.)

Residencies/Fellowships For Re-Credentialing, please add any new Residencies or Fellowships in the last three (3) years.

Institution: | Program Director:

Address | City | State | Zip

Telephone Number: | Fax Number: | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) | To(mm/yy):

Institution: | Program Director:

Address | City | State | Zip

Telephone Number: | Fax Number: | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) | To(mm/yy):

Institution: | Program Director:

Address | City | State | Zip

Telephone Number: | Fax Number: | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) | To(mm/yy):

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VII. Medical Licensure & Certifications

California State Medical License Number	Issue Date	Expiration Date

Drug Enforcement Agency (DEA) Registration Number	Schedules	Expiration Date

Controlled Dangerous Substances Certificate (CDS) (if applicable)	Expiration Date

ECFMG Number (applicable to foreign medical graduates)	Issue Date

Individual National Physician Identifier (NPI)	Medi-Cal/Medicaid Number	Individual Medicare PTAN Number

All Other State Medical Licenses

State	License Number	Issue Date	Expiration Date

Other Certifications (e.g., Fluoroscopy, Radiography, ACLS/BLS/PALS, etc.)

Type of Certification	License Number	Expiration Date

Board Certification(s)

Include certifications by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with equivalent requirements approved by the Medical Board of California
- a board or association with an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board	Certificate Number	Date Certified/Recertified	Expiration Date (if any)

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Board Certification(s) (Continued)

Have you applied for board certification other than those indicated on the prior page? ◯ Yes ◯ No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification below or in a separate sheet.

Specialty:

Board Name:

Exam Date:

Describe here:

VIII. Current Hospital and Other Institutional Affiliations

Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B). This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

A. Current Affiliations

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Primary Hospital Address:

City: State: Zip Code: From (mm/yy):

Medical Staff Phone: Medical Staff Fax: To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Secondary Hospital Address:

City: State: Zip Code: From (mm/yy):

Medical Staff Phone: Medical Staff Fax: To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Other Institution Address:

City: State: Zip Code: From (mm/yy):

Medical Staff Phone: Medical Staff Fax: To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Other Institution Address:

City: State: Zip Code: From (mm/yy):

Medical Staff Phone: Medical Staff Fax: To (mm/yy):

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A. Current Affiliations (continued)

If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):

B. Previous Hospital and Other Institution Affiliations

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

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IX. Peer References

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations. **At least one reference must be from someone with the same credentials, for example, a MD must list a reference from another MD or a DPM must list one reference from another DPM.**

Name of Reference: Specialty:

Address City State Zip

Telephone Number: Fax Number: Email Address:

Name of Reference: Specialty:

Address City State Zip

Telephone Number: Fax Number: Email Address:

Name of Reference: Specialty:

Address City State Zip

Telephone Number: Fax Number: Email Address:

X. Work History

For Re-Credentialing, check box if no changes in the last three (3) years.

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. Curriculum vitae are <u>not</u> sufficient. Please explain any gaps on a separate page.

Current Practice: Contact Name:

Address City State Zip

Telephone Number: Fax Number: From (mm/yy): To (mm/yy):

Name of Practice/Employer: Contact Name:

Address City State Zip

Telephone Number: Fax Number: From (mm/yy): To (mm/yy):

Name of Practice/Employer: Contact Name:

Address City State Zip

Telephone Number: Fax Number: From (mm/yy): To (mm/yy):

XI. Professional Liability

Please list all of your professional liability carriers for the past five years, listing the most recent first. If more space is needed, attach additional sheet(s).

Name of Current Insurance Carrier: Policy Number:

Address City State Zip

Telephone Number: Fax Number: Website (if applicable):

Email Address: Tail Coverage? ◯ Yes ◯ No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

Name of Carrier: Policy Number:

Address City State Zip

Telephone Number: Fax Number: Website (if applicable):

Email Address: Tail Coverage? ◯ Yes ◯ No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

Name of Carrier: Policy Number:

Address City State Zip

Telephone Number: Fax Number: Website (if applicable):

Email Address: Tail Coverage? ◯ Yes ◯ No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

XII. Professional and Practice Services

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? ◯ Yes ◯ No

What type of anesthesia do you provide in your group/office?

☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify)

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver.

Federal Tax ID: Type of Service Provided: Do you have a CLIA certificate? ◯ Yes ◯ No

Billing Name: Do you have a CLIA waiver? ◯ Yes ◯ No

CLIA Certificate Number: CLIA Certificate Expiration Date:

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XII. Professional and Practice Services (continued)

Have you or your office received any of the following accreditations, certificates or licensures?

- ☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- ☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
- ☐ Medicare Certification
- ☐ The Medical Quality Commission (TMQC)
- ☐ Child Health and Disability Prevention Program (CHDP)
- ☐ Comprehensive Perinatal Services Program (CPSP)
- ☐ California Children Services (CCS)
- ☐ Family Planning
- ☐ Other

Please list international, state and/or national medical societies or other professional organizations or societies of which you are a member or applicant. Use the drop-down list to select your membership status.

Organization Name	Membership Status

Do you participate in electronic data interchange (EDI)? ○ Yes ○ No If so, which Network?

Do you use a practice management system/software? ○ Yes ○ No If so, which one?

Continue to the Next Page for HIV/AIDS Specialist Designation

HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine. **OR**

☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties. **OR**

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**

2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**

☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; **OR**

2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; **OR**

3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Continue to the Next Page for Attestation

ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending? ◯ Yes ◯ No

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending? ◯ Yes ◯ No

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs), or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? ◯ Yes ◯ No

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ◯ Yes ◯ No

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? ◯ Yes ◯ No

6. Have you ever been denied certification/recertification by a specialty board? ◯ Yes ◯ No

7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation? ◯ Yes ◯ No

8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense? ◯ Yes ◯ No
   b. Are any such actions pending? ◯ Yes ◯ No

9. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases? If **YES**, please complete Addendum B. ◯ Yes ◯ No

10. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending? If **YES**, please complete Addendum B. ◯ Yes ◯ No

11. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? ◯ Yes ◯ No

12. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If **YES**, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. ◯ Yes ◯ No

Continue to the Next Page for Additional Attestation

ATTESTATION QUESTIONS (Continued)

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

13. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. ○ Yes ○ No

    If **YES**, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? ○ Yes ○ No

14. Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs? ○ Yes ○ No

15. Within the last two (2) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? ○ Yes ○ No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

APPLICANT SIGNATURE (Stamp is Not Acceptable)	PRINTED NAME	DATE

Continue to the Next Page for Information Release/

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health care service plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents - collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including, but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, within fourteen (14) days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me, by the Medical Board of California taken or pending, including, but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding any minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I pledge to provide continuous care for my patients.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

APPLICANT SIGNATURE (Stamp is Not Acceptable)	**PRINTED NAME**	**DATE**

Addenda Submitting :

☐ Addendum B: Professional Liability Action Explanation

This application and Addenda A and B were created and are endorsed by:
- California Association of Health Plans (916) 552-2910
- California Association of Physician Groups (916) 443-2274

The CPPA has been completed. Please be sure you have signed the last two pages (pages 15 and 16) before submission.

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.

The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of your application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correct will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address:					
City:		ST:		Zip:	

APPLICANT SIGNATURE **PRINTED NAME** **DATE**

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California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to _____ herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise conclude professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

☐ *Please check here if there are no pending/settled claims to report (and sign below to attest).*

I. Practioner Identifying Information

Last Name: _____ First Name: _____ Middle: _____

II. Case Information

Patient's Name: _____ Patient Gender ○ Male ○ Female Patient DOB: _____

City, County, State where lawsuit filed: _____ Court Case number, if known: _____ Date of alleged incident serving as basis for the lawsuit/ arbitration: _____ Date suit filed: _____

Location of incident:
☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center ☐ Other (specify) _____

Relationship to patient (Attending physician, Surgeon, Assistant, Consultant, etc.) _____

Allegation

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ○ Yes ○ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization.

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name: _____ Telephone Number: _____ Fax Number: _____

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III. Status of Lawsuit/Arbitration (check one)

- ☐ Lawsuit/arbitration still ongoing, unresolved.
- ☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: $
- ☐ Judgment rendered and I was found not liable.
- ☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: $
- ☐ Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:
1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

APPLICANT SIGNATURE | **PRINTED NAME** | **DATE**

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CalOptima Primary Source Verification Table

Primary Source Verification – Licensure

Licensure	Source of Verification	Method of Documentation
MD – Medical Board of California	www.mbc.ca.gov AIM screen with Facility log-in	Full print out indicating "data current as of" and the accessed date at bottom of the print out
DO- Osteopathic Board of California	www.ombc.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
DC- California Board of Chiropractic	www.chiro.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
DDS- Dental Board of California	www.dbc.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
DPM- California Board of Podiatric Medicine	www.bpm.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
California Board of Psychology	http://www.psychology.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
California Board of Behavioral Sciences	http://www.bbs.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
Department of Consumer Affairs Acupuncture Board	http://www.acupuncture.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
Department of Consumer Affairs CA State Board of Optometry	http://www.optometry.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out

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CalOptima Primary Source Verification Table

Primary Source Verification- DEA

DEA	Source of Verification	Method of Documentation
DEA	NTIS https://www.deanumber.com	Full print out indicating "data current as of"
	https://www.deadiversion.usdoj.gov	Print out
	(or)	
	AMA Physician Master File	Visual inspection/ print out
	Copy of current DEA certificate	

Primary Source Verification – Board Certification

Board Certification	www.Boardcertifieddocs.com (or)	Print out
	https://www.doprofiles.org/	Print out
	American Board of Podiatric Surgery	Print out
	http://www.abps.org/	

Primary Source Verification- Education & Training

Education & Training	Source of Verification	Method of Documentation
Education & Training	Board certification by ABMS or AOA in practicing specialty	Print out certificate
	AMA Physician Master File http://profiles.ama-assn.org	Print out of AMA with education "verified" not "being verified" or "being re-verified" ; Print out
	(or)	
	AOA Official Osteopathic Physician Profile Report https://www.doprofiles.org/	AOA Profile
	(or)	
	Contact the training institution to verify the highest level of training.	Letter from institution stating that practitioner successfully completed the training in good standing or provide an explanation if the practitioner was ever disciplined.
	State Licensing Agency, as applicable	

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CalOptima Primary Source Verification Table

Primary Source Verification – Malpractice History

Malpractice History	NPDB-HIPDB Http://www.npdb-hippdb.hrsa.gov	Print out of report

Primary Source Verification- Medicare/Medicaid Sanctions

Sanction Information	Source of Verification	Method of Documentation
State & Federal Sanctions	NPDB-HIPDB Http://www.npdb-hippdb.hrsa.gov (and)	Print out of report
	System for Award Management http://www.sam.gov (and)	Information entered in Credentialing Data Base and print out included in the credentialing packet
	Office of Inspector General http://oig.hhs.gov (and)	Information entered in Credentialing Data Base and print out included in the credentialing packet
	Medi-Cal Suspended & Ineligible List http://files.medi-cal.ca.gov/	Information entered in Credentialing Data Base and print out included in the credentialing packet
	AMA Physician Master File AOA Physician Profile report	In credentialing file (if used for verification of another element) In Credentialing file
	State Licensing agencies	

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

JENNIER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: May 9, 2017

ALL PLAN LETTER 17-006
SUPERSEDES ALL PLAN LETTERS 04-006 AND 05-005
AND POLICY LETTER 09-006

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: GRIEVANCE AND APPEAL REQUIREMENTS AND REVISED NOTICE TEMPLATES AND "YOUR RIGHTS" ATTACHMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with clarification and guidance regarding the application of new federal and existing state regulations for processing Grievances and Appeals.

BACKGROUND:
On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule[1], which aimed to align Medicaid managed care regulations with requirements of other major sources of coverage. The final rule stipulated new requirements for the handling of Grievances and Appeals that become effective July 1, 2017.[2]

The Department of Health Care Services (DHCS) previously issued APLs 04-006 and 05-005, which provided MCPs with standardized templates for use when notifying beneficiaries of a denial, termination, delay, or modification in benefits. In addition, DHCS issued Policy Letter (PL) 09-006, which clarified federal and state timeframes for filing Grievances and Appeals and for requesting State Hearings and Independent Medical Reviews (IMR).

This APL supersedes APLs 04-006 and 05-005 and PL 09-006 and provides all-encompassing guidance to MCPs regarding Grievance and Appeal requirements. In addition to clarifying the application of new federal regulations and addressing discrepancies with existing state laws[3] and regulations[4], this APL also includes revised notice templates for each type of action that MCPs may decide, including revised "Your

[1] 81 FR 27497
[2] Title 42, Code of Federal Regulations (CFR), Part 438, Subpart F
[3] California Health & Safety Code (HSC) Section 1368
[4] Title 22, California Code of Regulations (CCR), Section 53858 and Title 28, CCR, Section 1300.68

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Rights" attachments that must be sent in conjunction with beneficiary notifications. Requirements pertaining to IMRs remain unchanged. Attachment A is included to provide MCPs with a summary table of all changes that become effective July 1, 2017.

REQUIREMENTS:

I. DEFINITIONS

A. Adverse Benefit Determination

The term "Action," which was used in prior APLs and PLs, has been replaced with "Adverse Benefit Determination."[5] The definition of an "Adverse Benefit Determination" encompasses all previously existing elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability. An "Adverse Benefit Determination" is defined to mean any of the following actions taken by an MCP:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner.
5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
6. For a resident of a rural area with only one MCP, the denial of the beneficiary's request to obtain services outside the network.
7. The denial of a beneficiary's request to dispute financial liability.

B. Notice of Action

Under new federal regulations, the term "Notice of Action" (NOA) has been replaced with "Notice of Adverse Benefit Determination."[6] However, because this new terminology may be confusing for beneficiaries, DHCS will retain use of "NOA" for ease of understanding. Therefore, a NOA shall be redefined as a formal letter informing a beneficiary of an Adverse Benefit Determination.

[5] Title 42, CFR, Section 438.400(b)
[6] Title 42, CFR, Section 438.404

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C. Grievance

While the state definition[7] does not specifically distinguish "Grievances" from "Appeals," federal regulations[8] have redefined "Grievance and Appeal System" to mean processes the MCP implements to handle Grievances and Appeals. The terms "Grievance" and "Appeal" are separately defined. Due to distinct processes delineated for the handling of each, MCPs shall adopt the federal definition but also incorporate applicable sections of the existing state definition that do not pose conflicts.

1. A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the MCP to make an authorization decision.[9]

2. A complaint is the same as a Grievance. Where the MCP is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.[10]

3. An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other MCP processes.

MCPs shall not discourage the filing of Grievances. A beneficiary need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a beneficiary expressly declines to file a Grievance, the complaint shall still be categorized as a Grievance and not an inquiry. While the MCP may protect the identity of the beneficiary, the complaint shall still be aggregated for tracking and trending purposes as with other Grievances.

D. Appeal

Under new federal regulations, an "Appeal" is defined as a review by the MCP of an Adverse Benefit Determination.[11] While state regulations[12] do not explicitly

[7] Title 28, CCR, Sections 1300.68(a)(1) and (2)
[8] Title 42, CFR, Section 438.400(b)
[9] Title 42, CFR, Section 438.400(b)
[10] Title 28, CCR, Sections 1300.68(a)(1) and (2)
[11] Title 42, CFR, Section 438.400(b)
[12] Title 28, CCR, Sections 1300.68(d)(4) and (5)

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define the term “Appeal”, they do delineate specific requirements for types of Grievances that would fall under the new federal definition of Appeal. These types of Grievances involve the delay, modification, or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit. The MCP shall treat these Grievances as Appeals under federal regulations.

MCPs shall adopt the formal definition of “Appeal” in accordance with new federal regulations, but still comply with all existing state regulations as it pertains to Appeal handling, as applicable. These requirements are further delineated in Section IV of this APL.

II. ADVERSE BENEFIT DETERMINATION

A. Authorization Timeframes

1. Standard Requests

Excluding pharmacy, MCPs must approve, modify, or deny a provider’s prospective or concurrent request for health care services in a timeframe that is appropriate for the nature of the beneficiary’s condition, but no longer than five business days from the MCP’s receipt of information reasonably necessary and requested by the MCP to make a determination.[13] The timeframe to make a decision may not exceed 14 calendar days following receipt of the request. An extension of 14 calendar days may be granted if either the beneficiary or provider requests the extension, or the MCP justifies a need for additional information and how the extension is in the beneficiary’s best interest.[14] If the MCP fails to render a decision within the required timeframe, it shall be considered a denial and therefore constitutes an Adverse Benefit Determination on the date that the timeframe expires.[15] The beneficiary would then have the right to request an Appeal with the MCP.

The MCP’s written response (NOA) to the beneficiary shall be dated and postmarked within two business days of the decision.[16]

[13] HSC Section 1367.01(h)(1)
[14] Title 42, CFR, Section 438.210(d)(1)
[15] Title 42, CFR, Section 438.404(c)(5)
[16] HSC Section 1367.01(h)(3)

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2. Retrospective Requests

MCPs must approve, modify, or deny a provider's retrospective request for health care services within 30 calendar days from receipt of information that is reasonably necessary to make a determination.[17]

3. Expedited Requests

In instances where a provider indicates, or the MCP determines, that the standard timeframe may seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MCP must approve, modify, or deny a provider's prior authorization or concurrent request for health care services, and send the appropriate NOA template, in a timeframe which is appropriate for the nature of the beneficiary's condition, but no longer than 72 hours from the receipt of the request. An extension of 14 calendar days may be granted if the beneficiary requests the extension, or the MCP justifies a need for additional information and how the extension is in the beneficiary's best interest. If the MCP fails to render a decision within the required timeframe, it shall be considered a denial and therefore constitutes an Adverse Benefit Determination on the date that the timeframe expires.[18] The beneficiary would then have the right to request an Appeal with the MCP.

4. Deferrals

In instances where the MCP cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, the MCP shall send out the NOA "delay" template to the provider and beneficiary within the required timeframe or as soon as the MCP becomes aware that it will not meet the timeframe.[19] A deferral notice is warranted if the MCP extends the timeframe an additional 14 calendar days because either the beneficiary or provider requests the extension, or the MCP justifies a need for additional information and how the extension is in the beneficiary's best interest.[20]

The NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The MCP shall also include the anticipated date when a decision will be rendered.[21]

[17] HSC Section 1367.01(h)(1)
[18] Title 42, CFR, Sections 438.210(d)(2) and 438.404(c)(5); HSC Section 1367.01(h)(2)
[19] HSC Section 1367.01(h)(5)
[20] Title 42, CFR, Section 438.210(d)(2)(ii)
[21] HSC Section 1367.01(h)(5)

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Upon receipt of all information reasonably necessary and requested by the MCP, the MCP shall approve, modify, or deny the request for authorization within five business days or 72 hours for standard and expedited requests, respectively.

5. Terminations, Suspensions, or Reductions

For terminations, suspensions, or reductions of previously authorized services, MCPs must notify beneficiaries at least ten days before the date of the action with the exception of circumstances permitted under Title 42, CFR, Sections 431.213 and 431.214.[22]

B. Notice of Action

Beneficiaries must receive written notice of an Adverse Benefit Determination. MCPs currently utilize DHCS-developed, standardized NOA templates for common scenarios (denial, delay, modification, termination) as directed by APLs 04-006 and 05-005. DHCS continues to provide standardized templates for use and has revised all existing NOA templates and corresponding "Your Rights" attachments to comply with new federal regulations. The following five distinct NOA templates accommodate actions that MCPs may commonly take:

1. Denial of a treatment or service
2. Delay of a treatment or service
3. Modification of a treatment or service
4. Termination, suspension, or reduction of the level of treatment or service currently underway
5. Carve-out of a treatment or service

Effective July 1, 2017, MCPs shall utilize the revised NOA templates and corresponding "Your Rights" attachments included in this APL. MCPs shall not make any changes to the NOA templates or "Your Rights" attachments without prior review and approval from DHCS, except to insert information specific to beneficiaries as required.

C. Contents of Notice

Content requirements of the NOA are delineated in federal regulations[23], state laws[24], and state regulations.[25] The DHCS standardized templates are comprised of two components: 1) the NOA and 2) "Your Rights" attachments.

[22] Title 42, CFR, Section 438.404(c)(1)
[23] Title 42, CFR, Section 438.404(b)
[24] HSC Section 1367.01
[25] Title 22, CCR, Sections 51014.1, 51014.2, and 53894

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These revised documents are viewed as a "packet" and must be sent in conjunction to comply with all requirements of the NOA.

1. NOA

New federal regulations necessitate minimal changes to the existing NOA template. DHCS has added a clarifying statement to indicate that beneficiaries may request, free of charge, copies of all documents and records relevant to the NOA, including criteria or guidelines used.[26]

MCPs shall comply with all other existing state laws and regulations in determining whether to approve, modify, or deny requests by providers prospectively, concurrently, or retrospectively. For decisions based in whole or in part on medical necessity, the written NOA shall contain all of the following:

a. A statement of the action the MCP intends to take.[27]
b. A clear and concise explanation of the reasons for the decision.[28]
c. A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guideline.[29]
d. The clinical reasons for the decision. The MCP shall explicitly state how the beneficiary's condition does not meet the criteria or guidelines.[30]
e. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions shall be communicated to the beneficiary in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing. Decisions rendered retrospectively only need to be communicated to providers in writing.[31]

   If the MCP can substantiate through documentation that effective processes are in place to allow the provider to easily contact the decision-maker through means other than a direct phone number (e.g., telephone number to the specific unit of the Utilization Management Department that handles provider Appeals directly), a direct telephone

[26] Title 42, CFR, Section 438.404(b)(2)
[27] Title 22, CCR, Sections 51014.1(c)(1) and 53894(d)(1)
[28] HSC Section 1367.01(h)(4); Title 22, CCR, Sections 51014.1(c)(2) and 53894(d)(2)
[29] HSC Section 1367.01(h)(4); Title 22, CCR, Sections 51014.1(c)(3) and 53894(d)(3)
[30] HSC Section 1367.01(h)(4)
[31] HSC Section 1367.01(h)(4)

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number or extension shall not be required. However, the MCP must conduct ongoing oversight to monitor the effectiveness of this process.

The above requirements shall only pertain to decisions based in whole or in part on medical necessity. For all other Adverse Benefit Determinations (e.g., denials based on a lack of information, or benefit denials, etc.) that are not based on medical necessity, MCPs shall ensure that the NOA still provides a clear and concise explanation of the reasons for the decision.

2. "Your Rights" Attachment

New federal regulations warrant substantial revision to the "Your Rights" attachment, which informs beneficiaries of critical Appeal rights. Currently, existing federal and state regulations permit a beneficiary to file an Appeal and request a State Hearing at the same time. New federal regulations require beneficiaries to exhaust the MCP's internal Appeal process and receive notice that the Adverse Benefit Determination has been upheld prior to proceeding to a State Hearing. If the MCP fails to adhere to the required timeframe when resolving the Appeal, the beneficiary is deemed to have exhausted the MCP's internal Appeal process and may request a State Hearing.

In accordance with both new and existing federal regulations, the written NOA shall, at a minimum, meet all language and accessibility standards set forth in Title 42, CFR, Section 438.10, Health & Safety Code (HSC) Section 1367.01, and Title 28, CCR, Section 1300.67.04, and include all of the following requirements:

a. The beneficiary's or provider's right to request an internal Appeal with the MCP within 60 calendar days[32] from the date on the NOA.[33]
b. The beneficiary's right to request a State Hearing only after filing an internal Appeal with the MCP and receiving notice that the Adverse Benefit Determination has been upheld.[34]
c. The beneficiary's right to request a State Hearing if the MCP fails to send a resolution notice in response to the Appeal within the required timeframe.[35]

[32] New federal regulations (Title 42, CFR, Section 438.402(c)(2)(ii)) revise the timeframe that beneficiaries have to request an Appeal from 90 to 60 calendar days.
[33] Title 42, CFR, Section 438.404(b)(3)
[34] Title 42, CFR, Section 438.404(b)(3)
[35] Title 42, CFR, Section 438.408(c)(3)

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d. Procedures for exercising the beneficiary's rights to request an Appeal.[36]
e. Circumstances under which an expedited review is available and how to request it.[37]
f. The beneficiary's right to have benefits continue pending resolution of the Appeal and how to request a continuation of benefits in accordance with Title 42, CFR, Section 438.420.[38]

Due to the significant impact that these new changes have on beneficiaries' Appeal rights, DHCS has deemed it necessary to create two distinct "Your Rights" attachments to accommodate the following scenarios: 1) beneficiaries who receive a NOA and 2) beneficiaries who receive a Notice of Appeal Resolution (NAR). A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld.

While the "Your Rights" attachment sent out to beneficiaries who receive a NOA will contain general information on State Hearing and IMR rights, the notice will primarily inform the beneficiary on how to request an Appeal with the MCP. A State Hearing form will not be attached, as the beneficiary would need to exhaust the MCP's Appeal process first. Similarly, an IMR form will not be attached, as the beneficiary would also need to exhaust the MCP's Appeal process prior to requesting an IMR unless the Department of Managed Health Care (DMHC) determines that an expedited review is warranted due to extraordinary and compelling circumstances.[39] Requirements pertaining to IMRs remain unchanged.

Conversely, the "Your Rights" attachment sent out to beneficiaries who receive a NAR that upholds the original Adverse Benefit Determination will not contain information on how to file a request for an Appeal as the beneficiary will have already exhausted the MCP's Appeal process. The notice will primarily inform the beneficiary on how to request a State Hearing and/or IMR. State Hearing and IMR application forms will be attached as appropriate.

Current versions of State Hearing[40] and IMR[41] forms shall be used when sending the NAR, and MCPs must check the DMHC and Department of

[36] Title 42, CFR, Section 438.404(b)(4)
[37] Title 42, CFR, Section 438.404(b)(5)
[38] Title 42, CFR, Section 438.404(b)(6)
[39] HSC Section 1368.03(a); Title 28, CCR, Section 1300.74.30(b)
[40] The SFH form can be accessed at the following link: www.cdss.ca.gov/cdssweb/entres/forms/English/NABACK9ACAMediCal.pdf
[41] The IMR form can be accessed at the following link: http://www.dmhc.ca.gov/

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Social Services (DSS) websites periodically to ensure use of the most updated forms. MCPs may include State Hearing and IMR forms that contain tracking numbers to more easily identify and administer beneficiary rights. Such tracking numbers should contain initials, acronyms, or names that identify the MCP.

MCPs shall use the revised NOA/NAR and "Your Rights" attachments contained in this APL, selecting the appropriate packet for use depending on whether the MCP is issuing a NOA or NAR. Furthermore, all County Organized Health System MCPs, except those that are Knox-Keene licensed, must use the "Your Rights" attachment for non-Knox-Keene licensed MCPs, whereas all Knox-Keene licensed MCPs must use the "Your Rights" attachment for Knox-Keene licensed plans. Knox-Keene licensed MCPs must comply with additional state laws[42] and include verbatim language required in all notices sent to beneficiaries. This required paragraph is already incorporated into the templates and requires no action by the MCP.

D. Translation of Notices

The DHCS Contract[43] additionally requires MCPs to fully translate beneficiary-informing materials into the required threshold languages. DHCS acknowledges the challenges associated with the timely translation of clinical rationale that must be inserted into the NOA. If translating the clinical rationale will jeopardize an MCP's ability to comply with the mailing timeframes, DHCS will accept NOAs where the rationale is written in English. However, the body of the NOA must be translated into required threshold languages and a sentence in the beneficiary's preferred language must be inserted to explain how the beneficiary can obtain a verbal translation of the clinical rationale. The body of the NOA constitutes the entire content of the NOA with the exception of the clinical rationale. MCPs must also provide a written translation of the clinical rationale if specifically requested by the beneficiary.

III. GRIEVANCES

A. Timeframes for Filing

Timeframes for filing Grievances are delineated in both federal[44] and state[45] regulations. While existing state regulations establish a timeframe of at least 180 calendar days from the date of the incident subject to the beneficiary's dissatisfaction, new federal regulations allow Grievances to be filed at any time.

[42] HSC Section 1368.02(b)
[43] Exh bit A, Attachment 13 (Member Services), Written Member Information
[44] Title 42, CFR, Section 438.402(c)(2)(i)
[45] Title 28, CCR, Section 1300.68(b)(9)

MCPs shall adopt the standard which is least restrictive to beneficiaries and allow Grievances to be filed at any time in accordance with new federal regulations.

B. Method of Filing

In accordance with both existing federal[46] and state[47] regulations, a Grievance may be filed by a beneficiary, a provider acting on behalf of the beneficiary, or an authorized representative either orally or in writing.

C. Standard Grievances

1. Acknowledgment

In accordance with existing state laws[48] and regulations[49], MCPs shall provide written acknowledgment to the beneficiary that is dated and postmarked within five calendar days of receipt of the Grievance. The acknowledgment letter shall advise the beneficiary that the Grievance has been received, the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the Grievance.

2. Resolution

Timeframes for resolving Grievances and sending written resolution to the beneficiary are delineated in both federal[50] and state[51] regulations. Federal regulations, which remain unchanged, allow the State to establish a timeframe for Grievance resolution that does not exceed 90 calendar days from the date of receipt of the Grievance. The State's established timeframe is 30 calendar days. MCPs shall continue to comply with the State's established timeframe of 30 calendar days for Grievance resolution.

a. "Resolved" means that the Grievance has reached a final conclusion with respect to the beneficiary's submitted Grievance as delineated in existing state regulations.[52]
b. The MCP's written resolution shall contain a clear and concise explanation of the MCP's decision.[53]
c. Federal regulations[54] allow for a 14-calendar day extension for standard and expedited Appeals. This allowance does not apply to Grievances.

[46] Title 42, CFR, Section 438.402(c)(3)(i)
[47] Title 28, CCR, Section 1300.68(a)(1)
[48] HSC Section 1368(a)(4)(A)
[49] Title 28, CCR, Section 1300.68(d)(1)
[50] Title 42, CFR, Section 438.408(b)(1)
[51] HSC Section 1368.01(a); Title 28, CCR, Sections 1300.68(a) and (d)(3)
[52] Title 28, CCR, Section 1300.68(a)(4)
[53] HSC Section 1368(a)(5); Title 28, CCR, Section 1300.68(d)(3)
[54] Title 42, CFR, Sections 438.408(b) and (c)

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However, in the event that resolution of a standard Grievance is not reached within 30 calendar days as required, the MCP shall notify the beneficiary in writing of the status of the Grievance and the estimated date of resolution, which shall not exceed 14 calendar days.

D. Exempt Grievances

MCPs shall continue to comply with all state laws[55] and regulations[56] pertaining to exempt Grievance handling as follows:

Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the close of the next business day are exempt from the requirement to send a written acknowledgment and response. MCPs shall maintain a log of all such Grievances containing the date of the call, the name of the complainant, beneficiary identification number, nature of the Grievance, nature of the resolution, and the representative's name who took the call and resolved the Grievance. The information contained in this log shall be periodically reviewed by the MCP.

MCPs shall ensure exempt Grievances are incorporated into the quarterly Grievance and Appeal report that is submitted to DHCS.

Under new federal regulations, coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment would qualify as Appeals and not Grievances. Therefore, Appeals are not exempt from written acknowledgment and resolution.

E. Expedited Grievances

State laws[57] and regulations[58] delineate processes for expedited Grievance handling and require resolution within three calendar days. Congruent with state regulations, DHCS acknowledges that there are instances that may involve an imminent and serious threat to the health of a beneficiary, including, but not limited to, severe pain or potential loss of life, limb or major bodily function that do not involve the appeal of an Adverse Benefit Determination, yet are “urgent” or “expedited” in nature. For consistency, MCPs shall apply the revised federal timeframe for resolving expedited Appeals (72 hours) to expedited Grievances. The 72-hour timeframe would require MCPs to additionally record the time of

[55] HSC Section 1368(a)(4)(B)
[56] Title 28, CCR Section 1300.68(d)(8)
[57] HSC Section 1368.01(b)
[58] Title 28, CCR, Section 1300.68.01

Grievance receipt, and not just the date, as the specific time of receipt would drive the timeframe for resolution.

Federal regulations[59] require the MCP to make reasonable efforts to provide oral notice to the beneficiary of the resolution. MCPs shall apply this requirement of oral notice for expedited Appeals to expedited Grievances.

MCPs shall comply with all other existing state regulations pertaining to expedited Grievance handling in accordance with HSC Section 1368.01(b) and Title 28, CCR, Section 1300.68.01.

IV. APPEALS

A. Timeframes for Filing

Timeframes for filing Appeals are delineated in the DHCS Contract[60], as well as in both state[61] and federal[62] regulations.

Existing federal regulations allow beneficiaries 90 days from the date on the NOA to file an Appeal. By contrast, existing state regulations, which do not distinguish Grievances from Appeals, allow at least 180 calendar days to file Grievances, which are inclusive of Appeals. Currently, MCPs comply with the 90-day timeframe in accordance with the DHCS Contract and existing federal regulations.

New federal regulations require beneficiaries to file an Appeal within 60 calendar days from the date of the NOA. MCPs shall adopt the 60-calendar day timeframe in accordance with the new federal regulations. Beneficiaries must also exhaust the MCP's Appeal process prior to requesting a State Hearing.

B. Method of Filing

In accordance with existing federal[63] and state[64] regulations, Appeals may be filed by a beneficiary, a provider acting on behalf of the beneficiary, or an authorized representative either orally or in writing. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.[65] MCPs

[59] Title 42, CFR, Section 438.408(d)(2)(ii)
[60] Exh bit A, Attachment 14 (Member Grievance and Appeal System), Member Appeal System
[61] Title 28, CCR, Section 1300.68(b)(9)
[62] Title 42, CFR, Section 438.402(c)(2)(ii)
[63] Title 42, CFR, Section 438.402(c)(3)(ii)
[64] Title 28, CCR, Section 1300.68(a)(1)
[65] Title 42, CFR, Sections 438.402(c)(1)(ii)

shall continue to comply with this existing requirement in accordance with the DHCS Contract[66] and federal regulations.

In addition, an oral Appeal (excluding expedited Appeals) shall be followed by a written, signed Appeal.[67] The date of the oral Appeal establishes the filing date for the Appeal. MCPs shall request that the beneficiary's oral request for a standard Appeal be followed by written confirmation in accordance with federal regulations. MCPs shall assist the beneficiary in preparing a written Appeal, including notifying the beneficiary of the location of the form on the MCP's website or providing the form to the beneficiary upon request. MCPs shall also advise and assist the beneficiary in requesting continuation of benefits during the Appeal of the Adverse Benefit Determination in accordance with federal regulations.[68] In the event that the MCP does not receive a written, signed Appeal from the beneficiary, the MCP shall neither dismiss nor delay resolution of the Appeal.

C. Standard Appeals

1. Acknowledgment

In accordance with existing state laws[69] and regulations[70], MCPs shall provide written acknowledgment to the beneficiary that is dated and postmarked within five calendar days of receipt of the Appeal. The acknowledgment letter shall advise the beneficiary that the Appeal has been received, the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the Appeal.

2. Resolution

Federal regulations revise the timeframe for resolving Appeals from 45 to 30 calendar days.[71] MCPs may extend the timeframe for Appeals resolution by 14 calendar days in accordance with federal regulations delineated under Section IV(E) below.

[66] Exh bit A, Attachment 14 (Member Grievance and Appeal System), Member Appeal System
[67] Title 42, CFR, Sections 438.402(c)(3)(ii) and 438.406(b)(3)
[68] Title 42, CFR, Section 438.420
[69] HSC Section 1368(a)(4)(A)
[70] Title 28, CCR, Section 1300.68(d)(1)
[71] Title 42, CFR, Section 438.408(b)(2)

D. Expedited Appeals

State laws[72] and regulations[73], which do not distinguish Grievances from Appeals, require expedited resolution of Grievances within three calendar days, which is inclusive of Appeals. Federal regulations[74] revise the timeframe for resolving Appeals from three working days to 72 hours. MCPs shall comply with the 72-hour timeframe in accordance with new federal regulations. The 72-hour timeframe would require MCPs to additionally record the time of Appeal receipt, and not just the date, as the specific time of receipt would drive the timeframe for resolution. MCPs may extend the timeframe for expedited Appeals resolution by 14 calendar days in accordance with federal regulations delineated under Section IV(E) below.

Additionally, MCPs are required to make reasonable efforts to provide oral notice to the beneficiary of the resolution.[75]

MCPs shall comply with all other existing state regulations pertaining to expedited Appeal handling in accordance with Title 28, CCR, Section 1300.68.01.

E. Extension of Timeframes

1. MCPs may extend the resolution timeframes for either standard or expedited Appeals by up to 14 calendar days if either of the following two conditions apply:

    a. The beneficiary requests the extension.[76]
    b. The MCP demonstrates, to the satisfaction of DHCS upon request, that there is a need for additional information and how the delay is in the beneficiary's best interest.[77]

2. For any extension not requested by the beneficiary, MCPs are required to provide the beneficiary with written notice of the reason for the delay. New federal regulations delineate the following additional requirements that MCPs must comply with:

[72] HSC Section 1368.01(b)
[73] Title 28, CCR, Section 1300.68.01
[74] Title 42, CFR, Section 438.408(b)(3)
[75] Title 42, CFR, Section 438.408(d)(2)(ii)
[76] Title 42, CFR, Section 438.408(c)(1)(i)
[77] Title 42, CFR, Section 438.408(c)(1)(ii)

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a. The MCP shall make reasonable efforts to provide the beneficiary with oral notice of the extension.[78]
b. The MCP shall provide written notice of the extension within two calendar days and notify the beneficiary of the right to file a Grievance if the beneficiary disagrees with the extension.[79]
c. The MCP shall resolve the Appeal as expeditiously as the beneficiary's health condition requires and in no event extend resolution beyond the initial 14-calendar day extension.[80]
d. In the event that the MCP fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted the MCP's internal Appeal process and may initiate a State Hearing.[81]

F. Upheld Decisions

Federal definitions separately define Notice of Adverse Benefit Determination (NOA) and NAR, which in turn trigger a separate set of Appeal rights, necessitating the need for unique notices for denials and Appeals. DHCS has therefore created distinct notice templates to inform beneficiaries of their Appeal rights depending on whether a NOA or NAR is issued.

For Appeals not resolved wholly in favor of the beneficiary, MCPs shall utilize the DHCS template packet for upheld decisions, which is comprised of two components: 1) the NAR and 2) "Your Rights" attachments. These revised documents are viewed as a "packet" and must be sent in conjunction to comply with all requirements of the NAR.

1. Notice of Appeal Resolution (NAR)

MCPs shall comply with federal and state regulations in sending written response to Appeals as follows:

a. The results of the resolution and the date it was completed.[82]
b. If the MCP's denial determination is based in whole or in part on medical necessity, the MCP shall include in its written response the reasons for its determination and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination.[83]
c. If the MCP's determination specifies the requested service is not a covered benefit, the MCP shall include in its written response the provision

[78] Title 42, CFR, Section 438.408(c)(2)(i)
[79] Title 42, CFR, Section 438.408(c)(2)(ii)
[80] Title 42, CFR, Section 438.408(c)(2)(iii)
[81] Title 42, CFR, Section 438.408(c)(3)
[82] Title 42, CFR, Section 438.408(e)(1)
[83] HSC Section 1367.01(b); Title 28, CCR, Sections 1300.68(d)(4)

in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the beneficiary to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested.[84]

2. "Your Rights" Attachment

In accordance with federal and state regulations, the written NAR shall, at a minimum, include all of the following required requirements:

a. The beneficiary's right to request a State Hearing no later than 120 calendar days from the date of the MCP's written Appeal resolution and instructions on how to request a State Hearing.[85]
b. The beneficiary's right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made in accordance with Title 42, CFR, Section 438.420.[86]
c. For Knox-Keene licensed MCPs, the beneficiary's right to request an IMR from the DMHC if the MCP's decision is based in whole or in part on a determination that the service is not medically necessary, is experimental/investigational, or is an emergency service.[87] The MCP shall include the IMR application, instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC.[88]

G. Overturned Decisions

For Appeals resolved in favor of the beneficiary, written notice to the beneficiary shall include the results of the resolution and the date it was completed. MCPs shall also ensure that the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.[89] MCPs shall utilize the DHCS template packet for Appeals, which contains the NAR for overturned decisions.

MCPs must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's condition requires if the MCP reverses the

[84] HSC Section 1367.01(b); Title 28, CCR, Sections 1300.68(d)(5)
[85] Title 42, CFR, Section 438.408(e)(2)(i); Title 22, CCR, Section 53858(e)(5)
[86] Title 42, CFR, Section 438.408(e)(2)(ii)
[87] HSC Sections 1370.4 and 1374.30(d); Title 28, CCR, Section 1300.74.30(a)
[88] Title 28, CCR, Section 1300.68(d)(4)
[89] HSC Section 1368(a)(5); Title 28, CCR, Section 1300.68(d)(3)

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decision to deny, limit, or delay services that were not furnished while the Appeal was pending. MCPs shall authorize or provide services no later than 72 hours from the date it reverses the determination.[90]

V. STATE HEARINGS

A beneficiary has the right to request a State Hearing when a claim for medical assistance is denied or is not acted upon with reasonable promptness.[91]

A. Timeframes for Filing

Existing federal regulations[92] and state laws[93] currently require beneficiaries to request a State Hearing within 90 days from the date of the NOA. However, new federal regulations[94] require beneficiaries to request a State Hearing within 120 calendar days from the date of the NAR, which informs the beneficiary that the Adverse Benefit Decision has been upheld. This presents a significant change for beneficiaries who previously did not have to exhaust the MCP's Appeal process prior to requesting a State Hearing. DHCS has updated all "Your Rights" attachment templates so that beneficiaries are informed of the revised 120-calendar day requirement in accordance with new federal regulations.

The parties to State Hearing include the MCP as well as the beneficiary and his or her representation or the representative of a deceased beneficiary's estate.

B. Standard Hearings

The MCP shall notify beneficiaries that the State must reach its decision within 90 calendar days of the date of the request.[95]

C. Expedited Hearings

The MCP shall notify beneficiaries that the State must reach its decision within three working days of the date of the request.[96]

D. Overturned Decisions

The MCP shall authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.[97]

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[90] Title 42, CFR, Section 438.424(a)
[91] Title 42, United States Code, Section 1396a(a)(3); Welfare & Institutions Code (WIC), Section 10950
[92] Title 42, CFR, Section 438.408(f)
[93] WIC, Section 10951
[94] Title 42, CFR, Sections 438.408(f)(1) and (2)
[95] Title 42, CFR, Section 431.244(f)(1)
[96] Title 42, CFR, Section 431.244(f)(2)
[97] Title 42, CFR, Section 438.424(a)

VI. NONDISCRIMINATION NOTICE AND LANGUAGE ASSISTANCE TAGLINES

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. On May 18, 2016, the United States Department of Health and Human Services (HHS), Office for Civil Rights (OCR) issued the Nondiscrimination in Health Program and Activities Final Rule[98] to implement Section 1557. Federal regulations[99] require MCPs to post nondiscrimination notice requirements and language assistance taglines in significant communications to beneficiaries. DHCS has thus created a sample "Nondiscrimination Notice" and "Language Assistance" taglines, which are available for MCP use. MCPs may utilize the templates provided by DHCS, make modifications to the templates, or create new templates. If modifications or new templates are created, DHCS review and approval must be obtained prior to use. These templates must be sent in conjunction with each of the following significant notices sent to beneficiaries: NOA, Grievance acknowledgment letter, Appeal acknowledgment letter, Grievance resolution letter, and NAR.

VII. GRIEVANCE AND APPEAL SYSTEM OVERSIGHT

MCPs shall establish, implement, and maintain a Grievance and Appeal System to ensure the receipt, review, and resolution of Grievances and Appeals. The Grievance and Appeal System shall operate in accordance with all applicable federal regulations[100], state laws[101], and state regulations.[102]

A. The MCP shall operate in accordance with its written procedures. These procedures shall be submitted to DHCS prior to use.[103]

B. The MCP shall designate an officer that has primary responsibility for overseeing the Grievance and Appeal System. The officer shall continuously review the operation of the Grievance and Appeal System to identify any emergent patterns of Grievances and Appeals. The Grievance and Appeal System shall include the reporting procedures in order to improve MCP policies and procedures.[104]

C. The MCP shall notify beneficiaries about its Grievance and Appeal System and

[98] 81 FR 31375
[99] Title 45, CFR, Section 92.8
[100] Title 42, CFR, Section 438
[101] HSC Section 1368
[102] Title 22, CCR, Section 53858; Title 28, CCR, Section 1300.68
[103] Title 22, CCR, Section 53858
[104] Title 28, CCR, Section 1300.68(b)(1)

shall include information on the MCP's procedures for filing and resolving Grievances and Appeals, a toll-free telephone number or a local telephone number in each service area, and the address for mailing Grievances and Appeals. The notice shall also include information regarding the DMHC's review process, the IMR system, and DMHC's toll-free telephone number and website address, as appropriate.[105]

D. The MCP shall notify beneficiaries of the process for obtaining Grievance and Appeals forms. A description of the procedure for filing Grievances and Appeals shall be readily available at each facility of the MCP, on the MCP's website, and at each contracting provider's office or facility. The MCP shall ensure that assistance in filing Grievances and Appeals will be provided at each location where Grievances and Appeals are submitted. Grievance and Appeal forms shall be provided promptly upon request.[106]

E. The MCP shall ensure adequate consideration of Grievances and Appeals and rectification when appropriate. If multiple issues are presented by the beneficiary, the MCP shall ensure that each issue is addressed and resolved.[107]

F. The MCP shall maintain a written record for each Grievance and Appeal received by the MCP. The record of each Grievance and Appeal shall be maintained in a log and include the following information:[108]

    1. The date and time of receipt of the Grievance or Appeal
    2. The name of the beneficiary filing the Grievance or Appeal
    3. The representative recording the Grievance or Appeal
    4. A description of the complaint or problem
    5. A description of the action taken by the MCP or provider to investigate and resolve the Grievance or Appeal
    6. The proposed resolution by the MCP or provider
    7. The name of the MCP provider or staff responsible for resolving the Grievance or Appeal
    8. The date of notification to the beneficiary of resolution.

G. The written record of Grievances and Appeals shall be submitted at least quarterly to the MCP's quality assurance committee for systematic aggregation and analysis for quality improvement. Grievances and Appeals reviewed shall

[105] Title 22, CCR, Section 53858(b); Title 28, CCR, Sections 1300.68(b)(2) and (4)
[106] Title 22, CCR, Sections 53858(c), (d), and (f); Title 28, CCR, Sections 1300.68(d)(6) and (7)
[107] HSC Section 1368(a)(1)
[108] Title 22, CCR, Section 53858(e)(1); Title 28, CCR, Section 1300.68(b)(5)

include, but not be limited to, those related to access to care, quality of care, and denial of services. Appropriate action shall be taken to remedy any problems identified.[109]

H. The written record of Grievances and Appeals shall be reviewed periodically by the governing body of the MCP, the public policy body, and by an officer of the MCP or designee. The review shall be thoroughly documented.[110]

I. The MCP shall ensure the participation of individuals with authority to require corrective action. All Grievances and Appeals related to medical quality of care issues shall be immediately submitted to the MCP's medical director for action.[111]

J. The MCP shall address the linguistic and cultural needs of its beneficiary population as well as the needs of beneficiaries with disabilities. The MCP shall ensure all beneficiaries have access to and can fully participate in the Grievance and Appeal System by assisting those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of Grievance and Appeal procedures, forms, and MCP responses to Grievances and Appeals, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.[112]

K. The MCP shall assure that there is no discrimination against a beneficiary on the grounds that the beneficiary filed a Grievance or Appeal.[113]

L. The MCP shall establish and maintain a system of aging of Grievances and Appeals that are pending and unresolved for 30 days or more and shall include a brief explanation of the reasons each Grievance and Appeal is pending and unresolved.[114]

M. The MCP shall ensure that the person making the final decision for the proposed resolution of a Grievance or Appeal has not participated in any prior decisions related to the Grievance or Appeal. Additionally, the decision-maker shall be a health care professional with clinical expertise in treating a beneficiary's condition or disease if any of the following apply[115]:

[109] Title 22, CCR, Sections 53858(e)(3) and (4)
[110] Title 28, CCR, Section 1300.68(b)(5)
[111] Title 22, CCR, Section 53858(e)(2)
[112] Title 22, CCR, Section 53858(e)(6); Title 28, CCR, Section 1300.68(b)(3)
[113] Title 28, CCR, Section 1300.68(b)(8)
[114] HSC Section 1368(b)(8)
[115] Title 42, CFR, Section 438.406(b)(2)

1. An Appeal of an Adverse Benefit Determination that is based on lack of medical necessity.
2. A Grievance regarding denial of an expedited resolution of an Appeal.
3. Any Grievance or Appeal involving clinical issues.

N. The MCP shall ensure that individuals making decisions on clinical Appeals take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's designated representative, regardless of whether such information was submitted or considered in the initial Adverse Benefit Determination.[116]

O. The MCP shall provide the beneficiary or beneficiary's designated representative the opportunity to review the beneficiary's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCP in connection with any standard or expedited Appeal of an Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe.[117]

P. The MCP shall provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony. The MCP must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals as specified and in the case of expedited resolution.[118]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Dual Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

All member notices and attachments referenced in this APL may be viewed in PDF format on the DHCS website. To obtain copies in Word format, please send a request via email to: Jeanette.Fong@dhcs.ca.gov.

[116] Title 42, CFR, Section 438.406(b)(2)(iii)
[117] Title 42, CFR, Section 438.406(b)(5)
[118] Title 42, CFR, Section 438.406(b)(4)

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Attachment(s)

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Attachment A

The summary table below outlines key Grievance and Appeal requirements, including a comparison of new and existing requirements. Where discrepancies between federal and state requirements exist, an asterisk (*) is indicated to denote the standard MCPs currently comply with.

SUMMARY OF GRIEVANCE & APPEAL REQUIREMENTS

TOPIC	EXISTING REQUIREMENT	NEW REQUIREMENT *(Effective 07/01/17)*
DEFINITIONS		
	"Action"	"Adverse Benefit Determination"
	"Grievance System"	"Grievance and Appeal System"
"Grievance"	• State: Definition is inclusive of Appeals • Federal: An expression of dissatisfaction about any matter other than an Action*	An expression of dissatisfaction about any matter other than an Adverse Benefit Determination
"Appeal"	• State: Not defined • Federal: A request for review of an Action*	A review by an MCP of an Adverse Benefit Determination
GRIEVANCES		
Filing	180 days	Any time
Acknowledgment	5 calendar days	5 calendar days
Standard Resolution	• 30 calendar days (State)* • 90 days but based on State-established standard (Federal)	30 calendar days
Exempt Resolution	24 hours	24 hours
Expedited Resolution	• 3 calendar days (State)* • Expedited Grievances not defined (Federal)	72 hours
APPEALS		
Filing	• 90 days (Federal)* • 180 days (State)	60 calendar days
Filing	Oral appeal followed by signed, written appeal (existing requirement not delineated in the Contract)	Oral appeal followed by signed, written appeal (no change)
Acknowledgment	5 calendar days	5 calendar days
Standard Resolution	• 30 calendar days (State)* • 45 days (Federal)	30 calendar days
Expedited Resolution	• 3 calendar days (State)* • 3 working days (Federal)	72 hours
Extension	14 calendar days	14 calendar days
Notification of Extension	No specified timeframe	• Reasonable efforts to provide prompt oral notice

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TOPIC	EXISTING REQUIREMENT	NEW REQUIREMENT *(Effective 07/01/17)*
		• Written notice within 2 calendar days
Effectuation of Overturned Decisions	As expeditiously as the health condition requires	72 hours
STATE HEARINGS		
Filing	90 days from NOA	120 calendar days from NAR
Standard Resolution	90 days	90 calendar days
Expedited Resolution	3 working days	3 working days
Effectuation of Overturned Decisions	As expeditiously as the health condition requires	72 hours
NOTICE OF ACTION (NOA)		
NOA	• Clear & Concise • Criteria/Guideline • Clinical Reason	• Clear & Concise • Criteria/Guideline • Clinical Reason
NOA	Must provide the reason for the decision	Must provide the reason for the decision, including the beneficiary's right to request free of charge copies of all documents and records relevant to the NOA, including criteria or guidelines used
"Your Rights" Attachment	Beneficiary informed of right to request an Appeal, State Hearing, and IMR at the same time	Beneficiary informed of requirement to exhaust the MCP's internal Appeal process prior to proceeding to a State Hearing or IMR
State Hearing & IMR Forms	Attached to NOA	Not attached to NOA
NOTICE OF APPEAL RESOLUTION (NAR)		
NAR (Uphold)	Same NOA template used as with initial denial	Distinct NAR template created for appeal resolution
"Your Rights" Attachment	Same "Your Rights" attachments used as with initial denial	Distinct "Your Rights" attachment created to inform beneficiary of only State Hearing and IMR rights
State Hearing & IMR Forms	Attached to NOA	Attached to NAR
NAR (Overturn)	No standard template required	Standard template created for consistency

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: November 14, 2017

ALL PLAN LETTER 17-019
SUPERSEDES ALL PLAN LETTER 16-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROVIDER CREDENTIALING / RECREDENTIALING AND SCREENING / ENROLLMENT

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their responsibilities related to the screening and enrollment of all network providers pursuant to the Centers for Medicare and Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule), CMS-2390-F,[1] dated May 6, 2016. Additionally, this APL clarifies MCPs' contractual obligations related to credentialing and recredentialing as required in Title 42 Code of Federal Regulations (CFR), Section 438.214.[2] This APL supersedes APL 16-012.[3] The screening and enrollment responsibilities are located in Part: 1 and the credentialing and recredentialing responsibilities are located in Part: 2 of this APL.

All MCP network providers must enroll in the Medi-Cal Program. MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through the Department of Health Care Services (DHCS). MCPs electing to establish their own enrollment process are expected to have their infrastructure in place by January 1, 2018.

BACKGROUND:
On February 2, 2011, CMS issued rulemaking CMS-6028-FC[4] to enhance fee-for-service (FFS) provider enrollment screening requirements pursuant to the Affordable Care Act. The intent of Title 42 CFR, Part 455, Subparts B and E[5] was to reduce the

[1] CMS-2390-F is available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[2] Title 42 CFR Section 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=755076fcbadfbe6a02197ec96e0f7e16&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_1214
[3] APL 16-012 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-012.pdf
[4] CMS-6028-FC is available at: https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf
[5] Title 42 CFR, Part 455, Subparts B and E are available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=3471319414e845a757a46ec42cde2b72&mc=true&node=pt42.4.455&rgn=div5

incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

In May 2016, CMS issued rulemaking CMS-2390-F, which extended the provider screening and enrollment requirements of 42 CFR, Part 455, Subparts B and E to MCP contracted providers (Title 42 CFR, Section 438.602(b)). These requirements are designed to reduce the number of providers who do not meet CMS provider enrollment requirements from participating in the MCPs' provider networks.

MCPs are required to maintain contracts with their network providers (Plan-Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. However, prior to the Final Rule, the MCPs' network providers were not required to enroll in the Medi-Cal Program. Title 42 CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, in accordance with the requirements of Title 42 CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting network providers[6] as well as prospective network providers.

The Medi-Cal FFS delivery system currently enforces a statewide set of enrollment standards that the Medi-Cal managed care program and MCPs must now implement.[7] Although the implementation date for Title 42 CFR Section 438.602(b) is not scheduled until July 1, 2018, Section 5005(b)(2) of the 21st Century Cures Act (Cures Act),[8] requires managed care network provider enrollment to be implemented by January 1, 2018.

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes. The credentialing and recredentialing process is one component of the comprehensive quality improvement system required in all MCP contracts.[9] Credentialing is defined as the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, and/or professional association membership. The credentialing process ensures that providers are properly licensed and certified as required by state and federal law.

[6] Exhibit E, Attachment 1 Definitions. The MCP Boilerplate contracts can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[7] State-specific Medi-Cal FFS provider enrollment requirements are contained in Title 22, CCR, Section 51000 through 51051, and Welfare & Institutions Code, Division 9, Part 3, Chapter 7 (commencing with Section 14043).
[8] 42 USC § 1396u-2 (d)(6)(A)
[9] Exhibit A, Attachment 4, Credentialing and Recredentialing.

POLICY:

Part 1: Medi-Cal Managed Care Screening and Enrollment Requirements

Available Enrollment Options

MCPs may screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, MCPs may also rely on the enrollment and screening results conducted by DHCS or other MCPs. MCPs can access the California Health and Human Services' (CHHS) Open Data Portal[10] to obtain a list of currently enrolled Medi-Cal FFS providers. MCPs are required to issue network providers a "verification of enrollment" that MCPs can rely on to prevent enrollment duplication. MCPs may collaborate with each other to share provider screening and enrollment results.

Providers who enroll through the DHCS enrollment process may participate in both the Medi-Cal FFS program as well as contract with an MCP (provided the MCP chooses to contract with the provider). However, providers who only enroll through an MCP may not also participate in the Medi-Cal FFS program. Although DHCS does not require that managed care providers enroll as FFS providers, if a provider wishes to participate in, or receive reimbursement from, the Medi-Cal FFS program, the provider must enroll as a Medi-Cal FFS provider through DHCS.

MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis.

MCP Enrollment Processes

If the MCP elects to enroll a provider, the MCP must comply with the following processes:

General Requirements:

A. MCP Provider Application and Application Fee

MCPs are not required to use DHCS' provider enrollment forms. However, MCPs must ensure that they collect all the appropriate information, data elements, and supporting documentation required for each provider type.[11] In addition, MCPs must ensure that every network provider application they process is reviewed for both accuracy and

[10] The CHHS Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017

[11] Applications packages by provider type can be found at the following: http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx. For associated definitions and provider types see Title 22 CCR 51000 – 51000.26 and 51051.

completeness. MCPs must ensure that all information specified in Title 22, California Code of Regulations (CCR), including but not limited to, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60, including all required submittals and attachments to the application package have been received. The MCP must obtain the provider's consent in order for DHCS and the MCP to share information relating to the provider's application and eligibility, including but not limited to issues related to program integrity.

MCPs may collect an application fee, established by CMS from unenrolled prospective network providers, to cover the administrative costs of processing a provider's screening and enrollment application. The MCP's application fee policy must be comparable to, and must not exceed, the state's application fee.[12] The application fee for calendar year 2017 is $560. Before collecting this fee, the MCP should be certain that the network provider is not already enrolled.

B. DHCS Provider Enrollment Agreement and Plan Provider Agreement

All Medi-Cal providers are required to enter into a provider enrollment agreement with the state (DHCS Provider Enrollment Agreement) as a condition of participating in the Medi-Cal Program pursuant to Section 1902(a)(27) of the Social Security Act and Section 14043.1 of the Welfare & Institutions Code. As part of the enrollment process, MCPs are responsible for ensuring that all successfully enrolled providers execute and sign the DHCS Provider Enrollment Agreement. This provider agreement is separate and distinct from the Plan Provider Agreement (see below). MCPs must maintain the original signed DHCS Provider Enrollment Agreement for each provider and must submit a copy to DHCS, CMS, and other appropriate agencies upon request. MCPs are responsible for maintaining all provider enrollment documentation in a secure manner and place that ensures the confidentiality of each provider's personal information. These enrollment records must be made available upon request to DHCS, CMS, or other authorized governmental agencies.

The agreement between the MCP and a provider (Plan Provider Agreement) is separate and distinct from the DHCS Provider Enrollment Agreement. Both the DHCS Provider Enrollment Agreement and the Plan Provider Agreement are required for MCP network providers. The DHCS Provider Enrollment Agreement does not expand or alter the MCP's existing rights or obligations relating to its Plan Provider Agreement.

C. Review of Ownership and Control Disclosure Information

As a requirement of enrollment, providers must disclose the information required by Title 42, CFR, Sections 455.104, 455.105, and 455.106, and Title 22, CCR, Section 51000.35. Providers who are unincorporated sole-proprietors are not required to

[12] Application Fee information is available at: http://www.dhcs.ca.gov/provgovpart/Pages/AppFeeChange2017.aspx

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disclose the ownership or control information described in Title 42, CFR, Section 455.104. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by Title 42, CFR, Section 455.104.

Full disclosure throughout the enrollment process is required for participation in the Medi-Cal Program. These disclosures must be provided when:

- A prospective provider submits the provider enrollment application.
- A provider executes the DHCS Provider Enrollment Agreement.
- A provider responds to an MCP's request during the enrollment re-validation process.
- Within 35 days of any change in ownership of the network provider.

Upon MCP request, a network provider must submit within 35 days:

- Full and complete information about the ownership of any subcontractor with whom the network provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and,
- Any significant business transactions between the network provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.[13]

Additionally, MCPs must comply with the requirements contained in Title 22, CCR, Section 51000.35, Disclosure Requirements. MCPs are not required to utilize the DHCS disclosure forms (DHCS 6207 and 6216[14]); however, MCPs must collect all information and documentation required by Title 22, CCR, Section 51000.35.

D. "Limited," "Moderate," "High" Risk Assignment

MCPs must screen initial provider applications, including applications for a new practice location, and any applications received in response to a network provider's reenrollment or revalidation request to determine the provider's categorical risk level as "limited," "moderate," or "high." If a provider fits within more than one risk level, the MCP must screen the provider at the highest risk level.

The federal requirements for screening requirements and for MCPs to stratify their network providers by risk level are set forth in Attachment 1 to this APL. These federal requirements list provider types considered as limited risk, moderate risk, and high risk, and define the screening requirements for each level of risk. A provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated provider lists, and criminal background checks. MCPs are

[13] 42 CFR 455.105(b)
[14] DHCS Forms 6207 and 6216 are available at: http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

not able to enroll a provider who fails to comply with the screening criteria for that provider's assigned level of risk.

Providers are subject to screening based on verification of the following requirements:

Limited-Risk Providers:

- Meet state and federal requirements.
- Hold a license certified for practice in the state and has no limitations from other states.
- Have no suspensions or terminations on state and federal databases.

Medium-Risk Providers:

- Screening requirements of limited-risk providers.
- Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to the MCP and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

High-Risk Providers:

- Screening requirements of medium-risk providers.
- Criminal background checks based in part on a set of fingerprints.

The MCP and DHCS will adjust the categorical risk level when any of the following circumstances occur:

- The state imposes a payment suspension on a provider based on a credible allegation(s) of fraud, waste, or abuse.
- The provider has an existing Medicaid overpayment based on fraud, waste, or abuse.
- The provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten years, or when a state or federal moratorium on a provider type has been lifted.

DHCS will provide the information necessary to determine provider risk level to MCPs on a regular basis. MCPs may also obtain this information upon request from their DHCS Managed Care Operations Division (MCOD) contract manager.

E. Additional Criteria for High Risk Providers - Fingerprinting and Criminal Background Check

High-risk providers are subject to criminal background checks, including fingerprinting and the screening requirements for medium-risk providers. Regardless of whether a high-risk provider has undergone fingerprinting in the past, the requirement to submit to a criminal background check and fingerprinting remains the same. Any person with a

5% or more direct or indirect ownership in a high-risk applicant must submit to a criminal background check.[15] In addition, information discovered in the process of onsite reviews or data analysis may lead to a request for fingerprinting and criminal background checks for applicants.

DHCS will coordinate all criminal background checks. DHCS will make a pre-filled Live Scan form available to all MCPs to distribute to providers. When fingerprinting is required, MCPs must furnish the provider with the Live Scan form and instructions on where to deliver the completed form. It is critical that MCPs distribute the designated Live Scan form as this ensures the criminal history check results are forwarded directly to DHCS. The provider is responsible for paying for any Live Scan processing fees. MCPs must notify DHCS upon initiation of each criminal background check for a provider that has been designated as high risk. DHCS will provide notification of the Live Scan results directly to the MCP. The MCP must maintain the security and confidentiality of all of the information it receives from DHCS relating to the provider's high-risk designation and the results of criminal background checks.

F. Site Visits

MCPs must conduct pre- and post-enrollment site visits of medium-risk and high-risk providers to verify that the information submitted to the MCP and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements, including but not limited to, Title 22, CCR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60. In addition, all providers enrolled in the Medi-Cal Program, including providers enrolled through MCPs,[16] are subject to unannounced onsite inspections at all provider locations.

Onsite visits may be conducted for many reasons including, but not limited to, the following:

- The provider was temporarily suspended from the Medi-Cal Program.
- The provider's license was previously suspended.
- There is conflicting information in the provider's enrollment application.
- There is conflicting information in the provider's supporting enrollment documentation.
- As part of the provider enrollment process, the MCP receives information that raises a suspicion of fraud.

[15] Welfare and Institutions Code 14043.38(c)(2)
[16] 42 CFR 455.432

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G. Federal and State Database Checks

During the provider enrollment process, MCPs are required to check the following databases to verify the identity and determine the exclusion status of all providers:

- Social Security Administration's Death Master File.[17]
- National Plan and Provider Enumeration System (NPPES).[18]
- List of Excluded Individuals/Entities (LEIE).[19]
- System for Award Management (SAM).[20]
- CMS' Medicare Exclusion Database (MED).[21]
- DHCS' Suspended and Ineligible Provider List.[22]

H. Denial or Termination of Enrollment/Appeal Process

MCPs may enroll providers to participate in the Medi-Cal Managed Care Program. However, if the MCP declines to enroll a provider, it must refer the provider to DHCS for further enrollment options. If the MCP acquires information, either before or after enrollment, that may impact the provider's eligibility to participate in the Medi-Cal Program, or a provider refuses to submit to the required screening activities,[23] the MCP may decline to accept that provider's application. However, only DHCS can deny or terminate a provider's enrollment in the Medi-Cal Program.

If at any time the MCP determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, the MCP must immediately suspend the enrollment process. The MCP must inform the prospective provider that he/she may seek enrollment through DHCS.[24]

MCPs are not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.[25]

I. Provider Enrollment Disclosure

At the time of application, MCPs must inform their network providers, as well as any providers seeking to enroll with an MCP, of the differences between the MCP's and

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[17] Social Security Administration's Death Master File is available at: https://www.ssdmf.com/
[18] NPPES is available at: https://nppes.cms.hhs.gov
[19] LEIE is available at: https://oig hhs.gov/exclusions/exclusions_list.asp
[20] SAM is available at: https://www.sam.gov
[21] MED is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html
[22] Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
[23] 42 CFR 455.416
[24] Provider Enrollment information can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx.
[25] 42 CFR 455.422

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DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

DHCS has provided a disclosure statement (Attachment 2), which MCPs may use to advise providers. MCPs are not required to use this exact form, but any disclosure used must contain, at a minimum, the same information contained in Attachment 2. DHCS may periodically require MCPs to provide additional disclosures to providers relating to differences in the enrollment processes.

The provider enrollment disclosure must include, but is not limited to, the following elements:

- A statement that certain enrollment functions will not be performed by the MCP, but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.
- Notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a provider chooses to enroll through an MCP, including provisional provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal an MCP's decision to suspend the enrollment process.
- A provision informing the provider that if the MCP receives any information that impacts the provider's eligibility for enrollment, the MCP will suspend processing of the provider's enrollment application and make the provider aware of the option to apply through the DHCS' Medi-Cal FFS provider enrollment process.
- A statement clarifying that in order for the provider to participate in the Medi-Cal FFS Program, the provider must enroll through DHCS, and that enrolling through DHCS will also make the provider eligible to contract with the MCP.

J. Post Enrollment Activities

Revalidation of Enrollment

To ensure that all enrollment information is accurate and up-to-date, all providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process. MCPs may align revalidation efforts with their recredentialing efforts to reduce duplication of activities. MCPs must revalidate the enrollment of each of their limited-risk and medium-risk network providers at least every five years,[26] and their high-risk network providers every three years. MCPs are not required to revalidate providers that were enrolled through DHCS or revalidated by another MCP.

[26] 42 CFR 455.414

Data Base Checks
MCPs must review the SAM and LEIE databases on a monthly basis. All other databases must be reviewed upon a provider's reenrollment to ensure that the provider continues to meet enrollment criteria. Each MCP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal Programs; any provider terminated from the Medicare or Medicaid/Medi-Cal Program may not participate in the MCP's provider network.

Retention of Documents
MCPs are required to retain all provider screening and enrollment materials and documents for ten years.[27] Additionally, MCPs must make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

K. Miscellaneous Requirements

Timeframes
Within 120 days of receipt of a provider application, the MCP must complete the enrollment process and provide the applicant with a written determination. MCPs may allow providers to participate in their network for up to 120 days, pending the outcome of the screening process, in accordance with Title 42, CFR, Section 438.602(b)(2).

Delegation of Screening and Enrollment
MCPs may delegate their authority to perform screening and enrollment activities to a subcontractor. When doing so, the MCP remains contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor's ability to perform these activities, including an initial review to ensure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the delegated functions.

Part 2: Medi-Cal Managed Care Credentialing and Recredentialing Requirements

MCPs must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, certified, or registered. MCPs must implement the provider credentialing and recredentialing policy described below by developing and maintaining written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of their network providers. Each MCP must ensure that its governing

[27] 42 CFR 438.3(u)

body, or the designee of its governing body, reviews and approves these policies and procedures, and must ensure that the responsibility for recommendations regarding credentialing decisions rest with a credentialing committee or other peer-review body.

Some screening and enrollment requirements overlap with credentialing and recredentialing requirements. Any such overlap does not require an MCP to duplicate any of the activities described in this APL. However, if an MCP relies on the screening and enrollment activities conducted by another MCP, or by DHCS, the MCP must comply with all credentialing and recredentialing requirements described in this APL.

Provider Credentialing

MCPs are required to verify the credentials of their contracted medical providers, and to verify the following items, as required for the particular provider type, through a primary source,[28] as applicable:[29]

- The appropriate license and/or board certification or registration.
- Evidence of graduation or completion of any required education.
- Proof of completion of any relevant medical residency and/or specialty training.
- Satisfaction of any applicable continuing education requirements.

MCPs must also receive the following information from every network provider, but do not need to verify this information through a primary source:

- Work history.
- Hospital and clinic privileges in good standing.
- History of any suspension or curtailment of hospital and clinic privileges.
- Current Drug Enforcement Administration identification number.
- National Provider Identifier number.
- Current malpractice insurance in an adequate amount, as required for the particular provider type.
- History of liability claims against the provider.
- Provider information, if any, entered in the National Practitioner Data Bank, when applicable.[30]

[28] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.
[29] The listed requirements are not applicable to all provider types. When applicable to the provider's designation, the information must be obtained.
[30] National Practitioner Data Bank is available at: https://www ncsbn.org/418.htm.

- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List may not participate in the MCP's provider network.[31]
- History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards.

Attestations

For all medical service provider types who deliver Medi-Cal-covered medical services, the provider's application to contract with the MCP must include a signed and dated statement attesting to all the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy and completeness.[32]

Provider Recredentialing

DHCS requires each MCP to verify every three years that each network provider delivering medical services continues to possess valid credentials. MCPs must review new applications from providers and verify the items listed under the Provider Credentialing section of this APL, in the same manner, as applicable. Recredentialing must include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews. The recredentialing application must include the same attestation as contained in the provider's initial application.

MCPs must maintain a system for reporting to the appropriate oversight entities serious quality deficiencies that result in suspension or termination of a network provider. MCPs must maintain policies and procedures for disciplinary actions, including reduction, suspension, or termination of a provider's privileges, and must implement and maintain a provider appeal process.

MCPs must also conduct onsite reviews of their network provider sites. For detailed guidance, see Policy Letter (PL) 14-004, Site Reviews, Facility Site Review and Medical

[31] The Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

[32] These limited statements comply with requirements of the Americans with Disabilities Act (ADA), as discussed in the attached PL 02-03. The ADA Attachment is available at (pg. 7): http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2002/MMCDPL02003.pdf.

Record Review,[33] and any subsequent revisions to this PL. MCPs must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to the MCP's provider network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review.

Delegation of Provider Credentialing and Recredentialing

MCPs may delegate their authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the MCP remains contractually responsible for the completeness and accuracy of these activities. If an MCP delegates credential verification activities, it should establish a formal and detailed agreement with the entity performing those activities. These agreements must be revised when the parties change the agreement's terms and conditions. To ensure accountability for these activities, the MCP must establish a system that:

- Evaluates the subcontractor's ability to perform delegated activities that includes an initial review to assure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.
- Ensures that the subcontractor meets MCP and DHCS standards.
- Continuously monitors, evaluates, and approves the delegated functions.

Entities such as medical groups or independent physician organizations may conduct delegated credentialing activities and may obtain a Provider Organization Certification (POC) from the National Committee on Quality Assurance (NCQA) at their discretion. The POC focuses on the entity's role as the agent performing the credentialing functions on behalf of an MCP. The MCP may accept evidence of NCQA POC in lieu of a monitoring site visit at delegated physician organizations. If an MCP delegates credential verification activities, it should establish a formal and detailed written agreement with that entity. Such agreements need not be revised until the parties to the agreement change the agreement's terms and conditions.

Health Plan Accreditation

MCPs that receive a rating of "excellent," "commendable," or "accredited" from the NCQA will be deemed to have met DHCS' requirements for credentialing. Such MCPs will be exempt from DHCS' medical review audit of credentialing practices. MCPs; however, retain overall responsibility for ensuring that credentialing requirements are met. Credentialing accreditation from entities other than the NCQA will be considered by DHCS upon request.

[33] Policy Letter 14-004 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-004.pdf

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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 applicable APLs, PLs and Dual Plan Letters. For questions regarding this APL, please contact your MCOD contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

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Attachment 1: Provider Types and Categories of Risk[34]/Screening Requirements

(1) Limited Risk Provider Types. Physician or non-physician practitioners and medical groups or clinics:

- Ambulatory Surgical Centers (ASCs)
- End-Stage Renal Disease (ESRD) facilities
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Hospitals, including Critical Access Hospitals (CAHs)
- Indian Health Service (IHS) facilities
- Mammography screening centers
- Mass immunization roster billers
- Organ Procurement Organizations (OPOs)
- Portable x-ray suppliers
- Providers or suppliers that are publicly traded on the New York Stock Exchange (NYSE) or NASDAQ
- Public or Government-Owned Ambulance Services Suppliers
- Religious Nonmedical Health Care Institutions (RNHCIs)
- Rural Health Clinics (RHCs)
- Radiation therapy centers
- Skilled Nursing Facilities (SNFs)

(2) Moderate Risk Provider Types. Provider and supplier categories:

- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Currently enrolled (re-validating) home health agencies
  - Exception: Any such provider that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Currently enrolled (re-validating) suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)
  - Exception: Any such supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities

[34] CMS-6028-FC Tables 1–3. Federal Register / Vol. 76, No. 22 / February 2, 2011 / Rules and Regulations

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- Non-public, non-government owned or affiliated ambulance services suppliers
    - Exception: Any such provider or supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.

(3) High Risk Provider Types. Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS.

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Attachment 2: Managed Care Provider Enrollment Disclosure

Background

Beginning January 1, 2018, federal law requires that all managed care network providers must enroll in the Medi-Cal Program if they wish to provide services to Medi-Cal managed care beneficiaries. Managed care providers have two options for enrolling with the Medi-Cal Program. Providers may enroll through (1) DHCS; or (2) an MCP. If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with MCPs. If the provider enrolls through an MCP, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to fee-for-service (FFS) providers will also apply to the enrollment process for managed care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements - the "Plan Provider Agreement" and the "DHCS Provider Enrollment Agreement." The Plan Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The DHCS Provider Enrollment Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. Enrollment through an MCP. The following provides an overview of the MCP enrollment process:

- The provider will submit a provider enrollment application to the MCP using a process developed by the MCP.
- As part of the application process, the provider will be required to agree that DHCS and the MCP may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The MCP will be responsible for gathering all necessary documents and information associated with the MCP application.
- The provider should direct any questions it has regarding its MCP application to the MCP.
- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with the MCP.
- While the MCP enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment

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application may differ. In addition, MCPs will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.

- Providers will not have the right to appeal an MCP's decision to cease the enrollment process.
- The MCP will complete the enrollment process within 120 days of the provider's submission of its application. During this time, the provider may participate in the MCP's network for up to 120 days, pending approval from the MCP.
- Once the enrolling MCP places a provider on the Enrolled Provider List, the provider is eligible to contract with all MCPs. However, an MCP is not required to contract with an enrolled provider.
- Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.
- Accordingly, if the MCP receives any information that impacts the provider's enrollment, the MCP will suspend processing the provider's enrollment application and refer the provider to DHCS' FFS Provider Enrollment Division (PED) for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

B. Enrollment through DHCS.

- The provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program. (See http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx)
- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for managed care providers.
- Upon successful enrollment through DHCS, the provider will be eligible to contract with MCPs and provide services to FFS beneficiaries.

There may be other important aspects of the enrollment process that are not set forth in this information bulletin. Please check the DHCS website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: February 16, 2018

ALL PLAN LETTER 18-005

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NETWORK CERTIFICATION REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding new Annual Network Certification, other network reporting requirements, and associated network adequacy standards. The requirement to certify MCP networks annually was issued on May 6, 2016 by the federal Centers for Medicare & Medicaid Services (CMS) in rulemaking CMS-2390-F (Final Rule).[2] This APL also provides clarifying guidance regarding federal and state provider network requirements.

BACKGROUND:
Historically, the Department of Health Care Services (DHCS) has conducted network certification when a new MCP enters into a contract with DHCS or when a significant change occurs (e.g., change in services or benefits, change in geographic service area, or enrollment of a new beneficiary group) in the MCP's operations that would affect the adequacy of the MCP's network and provision of services. [3]

MCP's will still be required to submit documentation to DHCS when a significant change occurs that affects network adequacy. However, pursuant to the Final Rule, DHCS will be required, beginning July 1, 2018, to certify each MCP's provider network on an annual basis.[4]

The Annual Network Certification includes verification of the following:[5]

- The network's ability to provide medically necessary services needed for the anticipated enrollment and utilization;

[1] This APL applies to all MCPs and SCAN.
[2] CMS-2390-F is available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See Title 42 of the Code of Federal Regulations (C.F.R.), sections 438.207(c)(1), 438.207(c)(3), and 438.207(c)(3)(i) and (ii). Part 438 Managed Care Regulations can be found at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fdf4e77a29e6327c6ff8475948c57df7&mc=true&node=pt42.4.438&rgn=div5
[4] 42 C.F.R. section 438.207(c)(2)
[5] 42 C.F.R. section 438.207(b)

- The number and types of network providers;
- The geographic location of providers to ensure compliance with time and distance standards;
- MCP internal operations analysis and review of service availability, physical accessibility, out-of-network access, timely access, continuity of care, and 24/7 language assistance.

The Final Rule also requires MCPs to submit documentation to DHCS any time there is a significant change in the MCP's network that impacts its adequacy or capacity to deliver services, or that affects payments to the MCP's provider network.[6,7]

POLICY:
MCPs are required to annually submit network certification documentation to DHCS.[8] The Annual Network Certification provides a prospective look at the MCP's upcoming contract year (CY).[9] Each MCP must provide DHCS with supporting documentation that demonstrates the MCP's capacity to serve the anticipated enrollment in its service area in accordance with federal regulations.[10,11] DHCS is required to review all MCP network submissions and provide an assurance of compliance to CMS before the CY begins.[12]

ANNUAL NETWORK CERTIFICATION STANDARDS AND COMPONENTS:
MCPs must submit a complete and accurate Annual Network Certification report/template that reflects the MCP's entire contracted provider network for each service area at the time of submission. MCPs must submit the Annual Network Certification and all supporting documentation to DHCS no later than 105 days before the CY begins (or the next business day if the due date occurs on a weekend or holiday). Each MCP must complete and submit all required reporting attachments of this APL to DHCS. The documentation must confirm the MCP's network will meet the anticipated needs of its service area(s) and show that the MCP's network includes an appropriate range of providers.[13] Documentation must be submitted through the DHCS Secure File Transfer Protocol (SFTP) site and labeled based on the instructions provided in Attachment B.

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[6] 42 C.F.R. section 438.207(c)(3)
[7] For additional information on significant changes, refer to APL 16-001.
[8] 42 C.F.R. section 438.207(c)(2)
[9] For purposes of this APL, the CY is the MCP's fiscal year of July 1- June 30, with the exception of Family Mosaic, AIDS Healthcare Foundation and SCAN Health Plan, for which the CY is the calendar year.
[10] For purposes of this APL, service area and reporting unit have the same meaning. Reporting units are outlined in Attachment C.
[11] 42 C.F.R. sections 438.207, 438.68, and 438.206(c)(1)
[12] 42 C.F.R. section 438.207(d)
[13] 42 C.F.R. section 438.207(b)

Network Capacity and Ratios

MCPs must maintain a provider network adequate to serve their service area. MCPs must meet or exceed network capacity requirements, as defined in the MCP contract, and proportionately adjust the number of network providers to support any anticipated changes in enrollment.[14] The MCP must maintain a network capacity adequate to serve the following percentages of all eligible beneficiaries, including SPD beneficiaries within its service area: County/Two-Plan plan models - 60%; Geographic Managed Care plan model - 60%; and County Organized Health Systems (COHS) plan model - 100%. In the event that an MCP's membership in a service area exceeds the above-mentioned network capacity percentages, the MCP must increase its network capacity to accommodate enrollment beyond these percentages.

Additionally, MCPs must meet full-time equivalent (FTE) provider-to-beneficiary ratios for Primary Care Physicians (PCPs) of one FTE PCP to every 2,000 beneficiaries and total network physicians of one FTE physician to every 1,200 beneficiaries.[15] MCPs are permitted to use non-physician medical practitioners, such as physician assistants, nurse practitioners, and certified nurse midwifes, to meet required beneficiary-to-provider ratios.[16] DHCS calculates full time equivalency based on the MCP's network capacity percentage by plan model, or their allotted beneficiary assignment, whichever is greater; however, per the MCP contract, MCPs can renegotiate their network capacity requirement in limited circumstances.[17] The MCP must complete Attachment C, Exhibit A-1 to meet the federal requirement for providing supporting documentation to demonstrate compliance with network capacity standards and provider-to-beneficiary ratios. DHCS will review each submission to confirm compliance with network adequacy standards and contractual requirements.

Network Composition

MCPs must maintain and monitor an appropriate provider network which includes FTE adult and pediatric PCPs, FTE adult and pediatric core specialists,[18] mental health providers,[19] hospitals, pharmacies, and ancillary services.[20] MCP provider networks must also have the capacity to provide all medically necessary services not covered by

[14] MCP Contract, Exhibit A, Attachment 6, Network Capacity. DHCS Boilerplate Managed Care Contracts are available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[15] MCP Contract, Exhibit A, Attachment 6, Provider to Member Ratios.
[16] Ibid.
[17] MCP Contract, Exhibit A, Attachment 6, Network Capacity.
[18] Core specialists are outlined in Attachment A of this APL.
[19] State Plan Amendment (SPA) 14-012 is available at: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/CASPA14-012ApprovedPackageOriginalADA.pdf
[20] MCP Contract, Exhibit A, Attachment 6, Network Composition.

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the core specialists. In addition, MCPs operating in COHS or Coordinated Care Initiative (CCI) counties must provide Managed Long-Term Services and Supports (MLTSS)[21] provider counts in accordance with the applicable MCP contract.

DHCS will utilize data sources including, but not limited to, MCP enrollment and encounter data in order to project CY utilization levels and MCP enrollment. DHCS will then project the number of providers needed to meet the anticipated enrollment and utilization. Data submitted by MCPs will be validated and verified by DHCS by comparing it with the MCPs' 274 provider network file submissions. MCPs must complete Attachment C, Exhibit A-1 to meet the federal requirement for providing supporting documentation to demonstrate that the provider network is appropriate to serve anticipated enrollment and utilization. DHCS will review the submitted documentation to determine compliance with requirements.

Mandatory Provider Types

MCPs must include at least one federally qualified health center (FQHC), one rural health clinic (RHC), and one freestanding birth center (FBC), where available, in their contracted service area, per CMS State Health Official letter (SHO) #16-006.[22] MCPs must also include Indian Health Facilities (IHF) in their provider network.

Additionally, MCPs must meet federal and contractual requirements for access to midwifery services, as outlined in APL 16-017 or any superseding letter.[23] MCPs must utilize Attachment C, Exhibit A-2 to document efforts to include midwifery service providers in the MCP's provider network.

California state regulations provide protections for American Indians and American Indian Health Services, as they are not required to contract with managed care plans. IHFs are not required to contract with MCPs; however, they retain the option to contract with an MCP at any time. MCPs are required to offer to contract with an IHF in each of their reporting units and must utilize Attachment C, Exhibit A-2 to document any and all efforts to contract with IHFs, especially in cases where the MCP is unable to contract with an IHF. [24]

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[21] MCP Contract, Exhibit A, Attachment 21, Managed Long-Term Services and Supports.
[22] SHO #16-006 is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf
[23] APL 16-017 can be found, along with other APLs, at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[24] Title 22 of the California Code of Regulations (CCR), section 55120. The CCR can be found at: https://govt.westlaw.com/calregs/Index?transitionType=Default&contextData=(sc.Default)

MCPs must complete Attachment C, Exhibit A-2 of this APL to demonstrate compliance with provider network requirements regarding FQHCs, RHCs, FBCs, IHFs and midwifery services. If the MCP does not have a contract with any of the mandatory provider types, the MCP must submit an explanation and supporting documentation to justify the absence of the provider type to DHCS. DHCS will review the submitted documentation to determine compliance with requirements.

Behavioral Health Treatment

On July 7, 2014, in response to CMS guidance,[25] DHCS included Behavioral Health Treatment (BHT) services as a covered Medi-Cal benefit for beneficiaries under 21 years of age when medically necessary, based upon recommendation from a licensed physician and surgeon, or licensed psychologist, after a diagnosis of Autism Spectrum Disorder (ASD). BHT services for children diagnosed with ASD are provided by MCP-credentialed qualified autism service providers as defined in the California State Plan.

To conform to the federal Early Period Screening, Diagnosis and Treatment (EPSDT) requirements, effective July 1, 2018, DHCS will include BHT services as a Medi-Cal managed care benefit for all beneficiaries under 21 years of age when medically necessary, based upon recommendation from a licensed physician and surgeon or a licensed psychologist. Each MCP must demonstrate an adequate provider network of State Plan-approved BHT providers[26] sufficient to serve the anticipated BHT-eligible beneficiaries, using Attachment C, Exhibit A-3.

Time and Distance Standards

To ensure adequate availability and accessibility of services to beneficiaries, the Final Rule requires DHCS to establish network adequacy standards that will be effective July 1, 2018. Assembly Bill (AB) 205 (Wood, Chapter 738, Statutes of 2017),[27] outlines California's state-specific standards.

These standards, set forth in Attachment A, include time and distance standards based on county population density, and are applicable to the following provider types: pediatric and adult PCPs, pediatric and adult core specialists, OB/GYN primary care and specialty care services, hospitals, mental health providers, and pharmacies. MCPs

[25] CMS Informational Bulletin, July 7, 2014 can be found at: http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf.
[26] See APL 15-025, regarding BHT coverage. APL 15-025 can be found, along with other APLs, at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[27] AB 205 (Wood, Chapter 738, Statutes of 2017) can be found at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB205

may use time or distance requirements to demonstrate compliance. Additionally, DHCS will allow MCPs to use telehealth as a means of determining compliance with time and distance standards.[28]

For each service area, MCPs must create and submit geographic access maps or accessibility analyses that cover the entire service area, following the instructions provided in Attachment B, to confirm compliance with time or distance standards. The MCP's analysis must either illustrate that it complies with applicable time or distance standards or demonstrate that it has requested approval of an alternative access standard by submitting Attachment F to DHCS for review and approval.

Whole Child Model

Each Whole Child Model (WCM) MCP[29] will be required, per Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016),[30] to demonstrate an adequate provider network that includes: pediatricians, pediatric specialists, and pediatric subspecialties; professional, allied, and medical supportive personnel; as well as licensed acute care hospitals and special care centers. Each WCM MCP must also show that its network contains adequate provider overlap with California Children's Services (CCS) paneled providers. WCM MCPs must submit documentation to DHCS by utilizing the checklist located in Attachment D and the reporting template located in Attachment E, to demonstrate compliance with both SB 586 and CCS requirements.

ALTERNATIVE ACCESS REQUESTS:
MCPs unable to meet time and distance standards for assigned beneficiaries must submit an Alternative Access Standard (AAS) request to DHCS.[31] DHCS will allow AAS requests when the MCP has exhausted all other reasonable options for obtaining providers in order to meet the applicable standards, or if DHCS determines that the requesting MCP has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.[32] AAS requests must be received by DHCS no later than 105 days prior to the beginning of every CY (or the next business day if the due date occurs on a weekend or holiday) to be considered for the Annual Network Certification.

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[28] Welfare and Institutions Code (WIC) section 14197(e)(4). WIC 14197 can be found at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14197.&lawCode=WIC
[29] A listing of the WCM MCPs can be found at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx
[30] SB 586, (Hernandez, Chapter 625, Statutes of 2016) can be found at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[31] WIC 14197(e)(2)
[32] WIC 14197(e)(1)

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DHCS will attempt to expedite any AAS requests received after the deadline but will not guarantee a decision prior to submission to CMS. The requirement to comply with the Annual Network Certification does not relieve MCPs of the ongoing requirement to submit an AAS request to DHCS when a significant change to their provider network occurs that affects the MCP's ability to meet all network adequacy standards, components set forth in this APL and state and federal law. Requests for AAS will be approved or denied on a zip code and provider type basis. All AAS requests must be submitted in Excel format, in accordance with Attachment F, and, if required, must include documentation of Department of Managed Health Care (DMHC) approval and/or pending AAS requests. Likewise, if an MCP requests approval of AAS from DMHC, the MCP must include the DHCS approval and/or pending AAS request with its DMHC request. Upon DHCS approval of an AAS request, the request will be valid for one contract year and must be renewed every year thereafter.

Telehealth and Mail Order Pharmacy

DHCS will allow MCPs to use telehealth to determine compliance with time and distance standards, and MCPs will be authorized to begin using telehealth as an alternative access to care for contractual provider-to-beneficiary ratios and/or time and distance standards, beginning July 1, 2018, [33] if the services provided via telehealth align with the telehealth policy in the Medi-Cal Provider Manual[34] and if the telehealth providers meet the following criteria:

- Licensed to practice medicine in the State of California
- Certified and enrolled as providers in the Medi-Cal program[35]
- Trained per contractual requirements[36]

In order to utilize telehealth to fulfill network adequacy requirements for time and distance standards in a defined service area, the MCP must make reasonable attempts to acquire an in-person provider.[37] The telehealth provider must be available to provide telehealth services to assigned beneficiaries in the defined service area regardless of beneficiary assignment in any Individual Physician Association (IPA) or physician group.

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[33] WIC 14197(e)(4)
[34] Medi-Cal Provider Manual. "Medicine: Telehealth." http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc.
[35] For information on provider enrollment and certification, see All Plan Letter 17-019, available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-019.pdf
[36] DHCS Boilerplate Managed Care Contracts are available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[37] WIC 14197(e)(1)(A)

MCPs may also utilize telehealth providers to meet physician and provider-to-beneficiary ratios. Current provider-to-beneficiary ratios for PCPs and Total Network Physicians can be found in the MCP contracts.[38] Network providers who provide both in-person and telehealth services can only be factored in once when calculating the MCP's available providers in any given specialty. Providers who are not otherwise a network provider for the purposes of providing in-person care can be counted as an additional provider to meet provider-to-beneficiary ratio requirements.

If using telehealth to meet either network adequacy standards or provider-to-beneficiary ratios, MCPs must submit information to DHCS about their telehealth providers using Attachment C, Exhibit A-4. The information must indicate the provider type and specialty, whether the provider is available for in-person services as well as telehealth services, and the service area the telehealth provider serves.

MCPs may also utilize mail order pharmacy to fulfill network adequacy requirements for time and distance standards as an alternative access to care in a defined service area. The MCP must make all reasonable attempts to acquire a pharmacy with a physical location within time and distance standards. MCPs must submit information to DHCS about their mail order pharmacy providers using Attachment C, Exhibit A-4. The MCP must have a procedure to ensure that any medications that cannot be sent through the mail are delivered to beneficiaries in a timely manner consistent with the beneficiary's medical need.

Though MCPs may utilize telehealth or mail order pharmacies to meet network adequacy standards, this does not authorize the MCP to require beneficiaries to utilize telehealth or pharmacy services in place of in-person services.

MCP INTERNAL OPERATIONS ANALYSIS:
DHCS' Audits and Investigations Division (A&I) routinely performs full medical audits of each MCP, including a review of the MCP's infrastructure to assess MCP compliance with timely access and availability of care requirements. A&I will communicate audit findings to the Network Certification team for coordination purposes if the medical audit contains findings of non-compliance, including findings in Category 3 (Access and Availability). Under these circumstances, the Medi-Cal Managed Care Quality and Monitoring Division (MCQMD) will monitor the progress of the corrective action plan (CAP) that has been assessed by A&I as a part of the Annual Network Certification process.

[38] DHCS Boilerplate Managed Care Contracts are available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

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SUBCONTRACTUAL RELATIONSHIPS AND DELEGATION:
MCPs are permitted to use subcontractors to fulfill their obligations under the MCP contract. If an MCP delegates the responsibility to deliver services covered by the MCP contract, whether under a capitated or fee-for-service payment arrangement, to a subcontractor, including, but not limited to, a health plan partner, IPA or clinic, the subcontractor must have an adequate provider network. If the subcontractor does not have an adequate provider network, it must allow assigned beneficiaries to access services out-of-network for any deficient network component(s), as required by state and federal law, the MCP contract, and DHCS guidance, including any applicable APLs.

The delegated subcontractor is not permitted to restrict an assigned beneficiary to only access Medi-Cal managed care services in its own provider network if network adequacy deficiencies exist. In these cases the MCP must authorize services through out-of-network providers. DHCS prohibits the use of an administrative subcontractor, including, but not limited to, an Administrative Services Organization, to restrict an assigned beneficiary to a subcontractor's network if that network does not meet network adequacy standards. DHCS will certify the aggregated MCP provider network.

MCPs must have policies and procedures for monitoring subcontractor network adequacy, including the use of administrative subcontractors that facilitate the referral and/or utilization management process. MCP policies and procedures must include an annual process to assess the network adequacy of all subcontractors that are delegated for the provision of Medi-Cal managed care covered services.

MCPs must also have policies and procedures in place for imposing CAPs and financial sanctions on subcontractors when there is non-compliance with the subcontract or other Medi-Cal requirements. Within three business days, MCPs must report to their contract manager any significant instances of non-compliance[39] or the imposition of CAPs or financial sanctions on a subcontractor when it results in the MCP's non-compliance with contractual requirements.

CERTIFICATION OF DOCUMENTS AND DATA CERTIFICATION:
MCPs are required to submit complete, accurate, reasonable, and timely Annual Network Certification attachments in compliance with this APL and 42 C.F.R. 438.207, 42 C.F.R. 438.68, and 42 C.F.R. 438.206 (c)(1). The Annual Network Certification falls within the scope of APL 17-005.[40]

[39] DHCS APL 16-001 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-001.pdf
[40] APL 17-005 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-005.pdf

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NETWORK CERTIFICATION NON-COMPLIANCE:
MCPs who fail to meet the Annual Network Certification reporting requirements or have submitted inaccurate or incomplete data, information or documentation may be placed under a CAP and may be subject to sanctions[41] or penalties for non-compliance. DHCS also reserves the right to halt a beneficiary transition, such as the WCM, if the MCP does not meet network certification requirements.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct all provider network deficiencies. During the CAP process, MCPs must allow Medi-Cal beneficiaries to access Medi-Cal services out-of-network if the services are not available in-network until DHCS finds that the deficiency(ies) has been corrected. If an MCP requests AAS due to a rate dispute with a provider, the MCP must continue to allow the beneficiary to see the provider during the CAP process. DHCS reserves the right to issue escalating measures for ongoing deficiencies for patterns of non-compliance with all network adequacy requirements.

POST NETWORK CERTIFICATION MONITORING ACTIVITIES:
MCPs will be subject to a quarterly monitoring process that includes, but is not limited to, timely access surveys; investigation of complaints, grievances, appeals and issues of non-compliance;[42] a random sample of MCP subcontractor annual network assessments; provider-to-beneficiary ratios; and out-of-network access requests. In addition, MCPs are subject to a mandatory network adequacy validation performed by the External Quality Review Organization (EQRO). The validation will evaluate the previous 12 months captured by the Annual Network Certification in accordance with 42 C.F.R. section 438.358 (b)(iv).

In conjunction with the quarterly monitoring processes, DHCS will continue its existing data quality review processes. Encounter and provider data quality will continue to be evaluated and verified by MCQMD. Encounter and provider data quality metrics may include, but are not limited to, primary source verification that is conducted by DHCS' EQRO through encounter data validation studies and provider surveys, respectively.

DHCS reserves the right to perform an ad hoc network certification if there is a significant change[43] in the MCP's provider network that would affect the adequacy and capacity of services. These significant changes include, but are not limited to, changes

[41] See APL 18-003, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-003.pdf
[42] WIC 14197(f)(2)
[43] See APL 16-001, available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-001.pdf

in services, benefits, or geographic service area, or an enrollment of a new beneficiary group.

DHCS will post all approved alternative access standards on its website.[44] Additionally, DHCS will post a report that includes the findings of its evaluation and identify any MCPs that are subject to a CAP due to non-compliance with network adequacy standards, along with the MCPs response to the CAP.[45] In addition, DHCS will post an annual report in accordance with 42 C.F.R. section 438.66(e)(1)(i).

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, Policy Letters, and Dual Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

[44] WIC 14197(e)(3)
[45] WIC 14197(f)(3)

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 7, 2018

ALL PLAN LETTER 18-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,[1] which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program.

BACKGROUND:
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[2] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[3, 4]

MCPs will authorize care that is consistent with CCS Program standards and provided by CCS-paneled providers, approved special care centers, and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as

[1] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[3] See Health and Safety Code (HSC) Section 123850(b)(1), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=123850.
[4] See Welfare and Institutions Code (WIC) Section 14094.11, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

continuity of care (COC), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning no sooner than July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

MCP	COHS Counties
Phase 1 – No sooner than July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – No sooner than January 1, 2019	
CalOptima	Orange
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo

POLICY:
Starting no sooner than July 1, 2018, MCPs in designated counties shall assume full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS will each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS Program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.[5] Independent CCS counties will maintain responsibility for CCS Program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS Program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS Program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical

[5] A link to the Division of Responsibility chart can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

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redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS Program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage (OHC), with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP) and Pediatric Palliative Care Waiver (PPCW). WCM counties participating with the MTP and PPCW will continue to receive a separate allocation for these programs. The MCP is responsible for care coordination of services that remain carved-out of the MCP's contractual responsibilities.

MCPs are required to use all current and applicable CCS Program guidelines, including CCS Program regulations, additional forthcoming regulations related to the WCM program, CCS Numbered Letters (N.L.s),[6] and county CCS program information notices, in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations and contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures, and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP will serve as the primary vehicle for ensuring

[6] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[7] A link to the MOU template can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP, consistent with the requirements of SB 586 and dependent upon DHCS approval. The MOU must include, at a minimum, all of the provisions specified in the MOU template. Phase 1 MCPs must have submitted an executed MOU, or proved intent and/or progress made towards an executed MOU, by March 31, 2018. Phase 2 MCPs must submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by September 28, 2018. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS beneficiaries into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization administrative functions from the county CCS program to the MCPs.[8] The transition plan must also include communication with beneficiaries regarding, but not limited to, authorizations, provider network, case management, and ensuring continuity of care and services for beneficiaries in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Inter-County Transfer

County CCS programs use CMSNet to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for COC of already approved service authorization requests, as required by this APL and applicable state and federal laws.

When a CCS-eligible member moves from a WCM county to a non-WCM county, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data

[8] See WIC Section 14094.7(d)(4)(C), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.7.

for members to the county CCS program office. The county CCS program will then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the county CCS program will provide transfer data to the MCP as applicable.

D. Dispute Resolution and Provider Grievances

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[9] The county CCS program shall communicate all resolved disputes in writing to the MCP within a timely manner. Disputes between the MCP and the county CCS program that are unable to be resolved will be referred by either entity to DHCS, via email to CCSWCM@dhcs.ca.gov, for review and final determination.[10]

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[11] A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

A. Risk Level and Needs Assessment Process

The MCP will assess each CCS child's or youth's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include the development of a pediatric risk stratification process (PRSP) and an Individual Care Plan (ICP) for high risk members. All requirements are dependent on the member's risk level that is determined through the PRSP. Furthermore, nothing in this APL shall remove or limit existing survey or assessment requirements that the MCPs are responsible for outside WCM.

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[9] See WIC Section 14093.06(b), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14093.06.
[10] Unresolved disputes must be referred to: CCSWCM@dhcs.ca.gov
[11] See WIC Section 14094.15(d), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.15.

1. **Pediatric Risk Stratification Process**
   MCPs must develop a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the MCP to identify members who have more complex health care needs.

   MCPs are required to complete a risk stratification within 45 days of enrollment for all members including new members, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level by:

   - Review of medical utilization and claims processing data, including data received from the county and DHCS;
   - Utilization of existing member assessment or survey data; and
   - Telephonic or in-person communications, if available at time of PRSP.

   Members that do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
   MCPs must develop a process to assess a member's current health, including the CCS condition, to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS paneled provider; this will be dependent upon the member's designation as high or low risk.

   New Members and Newly CCS-eligible Members Determined High Risk
   Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by the MCP for the purposes of WCM is subject to review and approval by DHCS.

   Risk Assessment
   The risk assessment process must address:

   a) General Health Status and Recent Health Care Utilization. This may include, but is not limited to, caretaker self-report of child's health;

outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time.

b) Health History. This includes both CCS and non-CCS diagnoses and past surgeries.

c) Specialty Provider Referral Needs.

d) Prescription Medication Utilization.

e) Specialized or Customized Durable Medical Equipment (DME) Needs (if applicable).

f) Need for Specialized Therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies (PT/OT /ST), mental or behavioral health services, and educational or developmental services.

g) Limitations of Activities of Daily Living or Daily Functioning (if applicable).

h) Demographics and Social History. This may include, but is not limited to, member demographics, assessment of home and school environments, and cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to assess the need for or impact of future health care services. These may include, but are not limited to, questions related to childhood developmental milestones; pediatric depression, anxiety or attention deficit screening; adolescent substance use; or adolescent sexual behaviors.

Individual Care Plan
MCPs are required to establish an ICP for all members determined high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
- County substance use disorder (SUD) or Drug Medi-Cal services;

[12] See WIC Section 14094.11(b)(4), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

The ICP will be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or their designated caregiver. The ICP should indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP should also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

a) Access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an interdisciplinary team is, and what the community resources are.

b) A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions.

c) Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams.

d) Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess the member's risk level and needs annually at their CCS eligibility redetermination or upon significant change to the member's condition.

[13] See WIC Section 14094.11(c), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

New Members and Newly CCS-eligible Members Determined Low Risk
For new members and newly CCS-eligible members identified as lower risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of their enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination or upon significant change to the member's condition.

WCM Transitioning Members
For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination, or upon significant change to the member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless of the risk level of a member, all communications, whether by phone or mail, must inform the member and/or his or her designated caregiver that the assessment will be provided in a linguistically and culturally appropriate manner and identify the method by which the provider will arrange for an in-person assessment.[14]

MCPs must refer all members, including new members, newly CCS-eligible members and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination
MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs must ensure that information, education and support is continuously provided to the CCS-eligible member and their family to

[14] See APL 99-005, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL1999/MMCDAPL99005.pdf

assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:[15]

- Primary and preventive care services with specialty care services
- Medical therapy units (MTU)
- EPSDT[16]
- Regional center services
- Home and community-based services

1. **High Risk Infant Follow-Up Program**
   High Risk Infant Follow-Up (HRIF) is a program that helps identify infants who might develop CCS-eligible conditions after they are discharged from a Neonatal Intensive Care Unit (NICU). The MCP is responsible for coordinating and authorizing HRIF services for members and ensuring HRIF case management services. MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide COC information to the members.

2. **Age-Out Planning Responsibility**
   MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the members' CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[17]

3. **Pediatric Provider Phase-Out Plan**
   A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the child or youth. The MCPs must provide care coordination to

[15] See WIC Section14094.11(b)(1)-(6), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.11.
[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See APL 18-007, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-007.pdf
[17] See WIC Section 14094.12(j), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.12.

CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

C. Continuity of Care

MCPs must establish and maintain a process to allow for members to receive COC with existing CCS provider(s) for up to 12 months, in accordance with WIC Section 14094.13.[18] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all other applicable APLs regarding COC. The sections below include additional COC requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If the MCP member has an established relationship with a specialized or customized durable medical equipment (DME) provider, MCPs must provide access to that provider for up to 12 months.[19] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service rates, unless the DME provider and the MCP enter into an agreement on an alternative payment methodology that is mutually agreed upon. The MCP may extend the COC period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[20]

Specialized or Customized DME must meet all of the following criteria:

- Is uniquely constructed or substantially modified solely for the use of the member.
- Is made to order or adapted to meet the specific needs of the member.
- Is uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. COC Case Management[21]

MCPs must ensure CCS-eligible members receive expert case management,

[18] See WIC Section 14094.13, which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.13.
[19] See WIC Section 14094.12(f), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.12.&lawCode=WIC
[20] See WIC Section 14094.13(b)(3) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[21] See WIC Section 14094.13(e), (f) and (g), which are available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing the CCS-eligible member, member's family, or designated caregiver to request COC case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with a MCP case manager who has received adequate training on the county CCS Program and who has clinical experience with the CCS population or pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services The MCP must send a follow-up notice 30 days prior to the start of the transition.

3. **Authorized Prescription Drugs**
   CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[22]

4. **Appealing COC Limitations**
   MCPs must provide CCS-eligible members with information regarding the WCM appeal process for COC limitations, in writing, 60 days prior to the end of their authorized COC period. The notice must explain the member's right to petition the MCP for an extension of the COC period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition.[23] The appeals process notice must include the following information:

   - The CCS-eligible member must first appeal a COC decision with the MCP.
   - A CCS-eligible member, member's family or designated caregiver of the CCS-eligible member may appeal the COC limitation to the DHCS director or his or her designee after exhausting the MCP's appeal process.

[22] See WIC Section 14094.13(d)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[23] See WIC Section 14094.13(k), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

- The DHCS director or designee will have five (5) days from the date of appeal to inform the family or caregiver of receipt of the request and must provide a decision on the appeal within 30 calendar days from the date of the request. If the member's health is at risk, the DHCS director or designee will inform the member of the decision within 72 hours.[24]

In addition to the protections set forth above, MCP members also have COC rights under current state law.

D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals and state fair hearing processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal and state fair hearing rights as provided under state and federal law.[25] MCPs must provide timely processes for accepting and acting upon member complaints and grievances. Members appealing a CCS eligibility determination must appeal to the county CCS program.

E. Transportation

MCPs must provide the CCS Maintenance and Transportation (M&T) benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary costs (i.e. parking, tolls, etc.), in addition to transportation expenses, and must comply with all requirements listed in N.L. 03-0810.[26] These services include, but are not limited to, M&T for out of county and out of state services.

MCPs must also comply with all requirements listed in APL 17-010[27] for CCS-eligible members to obtain non-emergency medical transportation (NEMT) and non-medical transportation (NMT) for all other services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.

[24] See APL 17-006, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf
[25] See APL 17-006
[26] See CCS N.L. 03-0810, which is available at: http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl030810.pdf
[27] APL 17-010 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf

F. Out-of-Network Access

MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services.

G. Advisory Committees

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers.[28] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[29] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[30]

III. WCM Payment Structure

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS fee-for-service rates, unless the provider and the MCP enter into

[28] See WIC Section 14094.7(d)(3), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.7.&lawCode=WIC
[29] See WIC Section 14094.17(b)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC
[30] See WIC Section 14094.17(a), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC

an agreement on an alternative payment methodology that is mutually agreed upon.[31]

The payor for NICU services is as follows: an MCP shall pay for NICU services in counties where NICU is carved into the MCP's rate, and DHCS shall pay in counties where NICU is carved out of the MCP's rate.[32]

For WCM counties, all NICU authorizations will be sent to the MCP in which the child is enrolled. The MCP will review authorizations and determine whether or not the services meet CCS NICU requirements. However, claims may be processed and paid by either DHCS or the MCP.

In counties where CCS NICU is carved into the MCP's rate, the MCP will pay all NICU and CCS NICU claims. For counties where CCS is currently carved-out, the MCP will process and pay non-CCS NICU claims, and the State's Fiscal Intermediary will pay CCS NICU claims. Payments made by State's Fiscal Intermediary will be based on the MCP's approval of meeting CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-In Counties: Marin, Merced, Monterey, Napa, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo	MCP	MCP	MCP

[31] See WIC Section 14094.16(b), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.16.
[32] See the Division of Responsibility chart

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-Out: Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Orange, Shasta, Siskiyou, Sonoma, and Trinity	MCP	MCP	DHCS

IV. MCP Responsibilities to DHCS

A. Network Certification

MCPs are required to have an adequate network of providers to serve the CCS-eligible population including physicians, specialists, allied professionals, Special Care Centers, hospitals, home health agencies, and specialized and customizable DME providers. Each network of providers will be reviewed by DHCS and certified annually.

The certification requires the MCP and their delegated entities to submit updated policies and procedures and an updated provider network template to ensure the MCP's network of providers meets network adequacy requirements as described in the Network Certification APL Attachments.[33]

MCPs must demonstrate that the provider network contains an adequate provider overlap with CCS-paneled providers. MCPs must submit provider network documentation to DHCS, as described in APL 18-005. Members cannot be limited to a single delegated entity's provider network. The MCP must ensure members have access to all medically necessary CCS-paneled providers within the MCP's entire provider network. MCPs must submit policies and procedures to DHCS no later than 105 days before the start of the contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional

[33] APL 18-005 and its attachments are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

approval status.[34] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[35] The MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[36]

MCPs are required to verify the credentials of all contracted CCS-paneled providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. The MCP's written policies and procedures must follow the credentialing and recredentialing guidelines of APL 17-019.[37] MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[38]

- Procedures for pre-authorization, concurrent review, and retrospective review.
- A list of services requiring prior authorization and the utilization review criteria.
- Procedures for the utilization review appeals process for providers and members.
- Procedures that specify timeframes for medical authorization.
- Procedures to detect both under- and over-utilization of health care services.

In addition to the UM processes above, MCPs are responsible for conducting NICU acuity assessments and authorizations in all WCM counties.[39]

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[34] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[35] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[36] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf
[37] APL 17-019 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-019.pdf
[38] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[39] See WIC 14094.65, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.65.&lawCode=WIC

D. MCP Reporting Requirements

1. Quality Performance Measures

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a form and manner specified by DHCS.

2. Reporting and Monitoring

DHCS will develop specific monitoring and oversight standards for MCPs. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companions guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required data in a form and manner specified by DHCS and must comply with all contractual requirements.

E. Delegation of Authority

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in APL 17-004.[40] If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[40] APL 17-004 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-004.pdf

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DAVID MAXWELL-JOLLY
Director

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

ARNOLD SCHWARZENEGGER
Governor

Date: August 19, 2010

N.L.: 03-0810
Index: Benefits
(Supercedes N.L.: 01-0104)

To: ALL COUNTY CALIFORNIA CHILDREN'S SERVICES (CCS) ADMINISTRATORS, MEDICAL CONSULTANTS, CHIEF/SUPERVISING THERAPISTS, STATE CHILDREN'S MEDICAL SERVICES (CMS) BRANCH STAFF

Subject: MAINTENANCE AND TRANSPORTATION FOR CCS CLIENTS TO SUPPORT ACCESS TO CCS AUTHORIZED MEDICAL SERVICES

I. PURPOSE

This Numbered Letter (N.L.) on Maintenance and Transportation (M and T) provides:

- County CCS Programs with uniform policies for approving M and T benefits to support access to authorized medical services for CCS clients.
- Procedural guidelines for reimbursement for the costs of M and T benefits through the CCS Administrative Budget.

II. BACKGROUND

A. M and T

1. Section 123840(j) of the Health and Safety Code provides that M and T are a benefit of the CCS Program. M and T for the CCS client and parent(s), or legal guardian(s), may be provided when the authorizing agency, as part of its case management responsibility, determines that the family needs assistance, there are no other available resources, and the assistance is an essential element of the client's diagnostic or treatment plan.

2. In general, it is the responsibility of the client or parent(s)/legal guardian(s) to provide M and T. However, the CCS Program approves M and T services when the costs to the client or family present a barrier to the CCS client's access to CCS authorized care. The intent is to assist the client to get to medical appointments at an outpatient provider or a hospital for admission, testing, or other procedures. This assistance is not intended to sustain a parent or guardian at a hospital for the CCS client's entire stay or to pay for the parent or guardian's frequent trips to visit the child while hospitalized.

B. Reimbursement for M and T Costs

1. The CMS Plan and Fiscal Guidelines Manual for FY 2000-2001, Section 7, Page 7-31, III., C., states that costs incurred for M and T were to be transferred to the CCS Administrative Budget, effective July 1, 2000. County CCS Programs were instructed to add a line item to the CCS Administrative Budget under "Other Expenses" to include the estimated annual cost for reimbursing for M and T expenses. This claiming method provides for Medi-Cal administrative funding to be used for M and T reimbursement for CCS/Medi-Cal clients.

2. Non-emergency medical transportation is not covered in the M and T Administrative Budget line item. Non-emergency medical transportation is a service that requires prior authorization by the CCS Program based on medical necessity.

   a. Non-emergency medical transportation is defined as transport in an ambulance or medical transport van when the client's medical condition(s) does not allow the client to travel by bus, passenger car, taxicab, or other form of public or private conveyance.

   b. Funding for medically necessary non-emergency medical transportation is a direct treatment service cost.

   c. Non-emergency medical transportation must be authorized to an enrolled Medi-Cal medical transportation provider.

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III. DEFINITIONS - M and T services are defined as follows:

- Transportation cost(s): The cost(s) for the use of a private vehicle or public conveyance to provide the client access to authorized CCS medical services.

- Maintenance cost(s): The cost(s) for lodging (such as a motel room, etc.) and food for the client, parent(s), or legal guardian(s) when needed to enable the client to access CCS authorized medical services.

IV. POLICY

A. M and T Authorization Requirements

M and T for the CCS client and parent(s)/legal guardian(s) may be approved to provide the client with access to CCS authorized medically necessary services when:

1. The client has met one of the following:

   a. Has an authorization for diagnostic or treatment services and a signed CCS application;

   b. The client is a full scope, no share of cost Medi-Cal beneficiary;

   c. The client is a Healthy Families (HF) Program subscriber; or

   d. The client has been determined to be CCS-eligible, and

2. The CCS Program has determined that no other available resources exist to assist the client/parent(s)/legal guardian(s) to access the medically necessary authorized service. This should include:

   a. The determination that the client and/or parent(s)/legal guardian(s) have no means of reaching the authorized facility or provider without outside help; and

   b. The determination that alternative resources for M and T services in the community are not available.

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B. The CCS Program may authorize the most appropriate, medically necessary, and cost effective mode of transportation to access the CCS authorized medical services. If the client and/or parent(s)/legal guardian(s) chooses to go to a facility/provider that is not the closest CCS approved facility/paneled provider, the transportation costs beyond those to reach the closest provider capable of delivering the level/type of service required by the client's CCS-eligible condition are the responsibility of the client and/or parent(s)/legal guardian(s).

C. A client/family should not be reimbursed for meals or lodging if the client/family could make the trip in one day if they had traveled to the nearest appropriate provider for services.

D. Maintenance may be authorized when:

1. The client is obtaining authorized outpatient services and the distance from the client's home is such that it precludes the family from making the trip in one day; or

2. The parent(s)/legal guardian(s) are staying with and supporting a hospitalized client and the distance precludes the family from making the trip in one day; and

3. Alternative resources have been explored and are unavailable; and

4. The client and/or parent(s)/legal guardian(s) have no means of providing for their maintenance without assistance from the CCS Program.

E. Transportation to a Medical Therapy Unit (MTU)

Transportation to a MTU for physical or occupational therapy or to attend a Medical Therapy Conference may be approved if a transportation need has been identified jointly by the family and the MTU treating therapist as necessary for the client's access to therapy services and when:

1. Criteria in IV., A. 1 and 2 above have been met; and

2. Transportation is not included in a child's Individualized Education Plan (IEP). Note: County CCS Programs should ensure that, when possible, transportation is included in the client's IEP.

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F. M and T for Out-of-State Services

M and T may be a benefit for CCS authorized medical care provided outside California. Consultation must be sought from the State Regional Office consultant staff before out-of-state services or M and T are authorized.

G. Denial of M and T Requests

When a county CCS Program receives a clearly stated written request from the medical provider/client/parent/legal guardian, or verbal request from the client/parent/legal guardian, for M and T services and the request is denied or modified, the county shall issue a Notice of Action to inform the CCS client/parent/legal guardian of the decision.

V. POLICY IMPLEMENTATION

A. County CCS Program Procedures

1. County CCS Programs shall develop written procedures to review, approve, and pay for M and T services to assure that CCS clients can access medically necessary services. The *CCS Maintenance and Transportation Assistance Worksheet* (enclosed) can be utilized to document the request, alternative resources explored, qualifying criteria for M and T services, and the decision of the county program.

2. The following standards/parameters for authorization of the costs of M and T services have been established for accessing both in-patient and out-patient services.

   a. To access in-patient services

      - Maintenance

        i. For intensive care settings when the parent/legal guardian is not permitted to stay at the client's bedside, county CCS Programs may initially authorize up to seven days lodging and meals per hospitalization for one or two parent(s)/legal guardian(s). The need for additional days of lodging nights and meals should be evaluated based on the client's circumstances.

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ii. For non-intensive care settings when parent(s)/legal guardian(s) are able to stay at the client's bedside, the county CCS Program may authorize one day of lodging for one or two parent(s)/legal guardian(s) after every six nights of client hospitalization.

iii. The total maximum M and T authorization when the CCS client is in an intensive or non-intensive care setting shall be 15 days of lodging and associated meals for each 30 days of client hospitalization, beginning with the day of the client's admission. Each new client hospitalization shall begin a new 30-day M and T benefit period.

- Transportation

  i. Two round trips per client hospitalization can be authorized for stays of less than seven days duration.

  ii. One round-trip for every seven days of client hospitalization can be authorized in addition to the initial two trips, if the hospitalization lasts longer than seven days.

- Post-hospitalization

  i. If the client's discharge plan documents the need for daily medical visits for treatment of the CCS-eligible condition, and the distance precludes making the trip to the hospital in one day, lodging and meals may be authorized for the client and parent or guardian.

b. To access out-patient services

- Maintenance

  i. If the family's trip to the outpatient provider can be completed in one day (round trip travel and appointment time included) there should not be reimbursement for meals or lodging.

  ii. If the total time for the trip will exceed one day, lodging and meals for one or two parent(s)/legal guardian(s) and the CCS client may be authorized.

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- Transportation

  i. If the distance to the provider is such that the trip may be made in one day, then the family may be assisted with transportation if lack of transportation is a barrier to the family's compliance with the treatment plan.

  ii. Prior approval is required for each trip. Approvals may be given as a block for multiple trips when it is known a client must make a specified number of visits to the provider for treatment, such as radiation therapy, chemotherapy, etc.

  iii. County CCS Programs may develop procedures to determine when and upon what basis advance payment will be made to a CCS client/family for the reimbursement of authorized M and T services.

  iv. County CCS Programs shall develop procedures to inform clients or parent(s)/legal guardian(s):

    a. How to submit requests for reimbursement;

    b. How to submit required receipts and/or other documentation for expenses incurred as M and T (gasoline, hotel/motel, meals, parking, tolls, etc.); and

    c. That failure to comply with these requirements could preclude future authorization of M and T services for the client/family.

B. County CCS Program Review and Approval of M and T Services

1. Requests for authorization of M and T services shall be reviewed by county CCS Program Administrators or designees to determine that:

   a. Medically necessary services linked to the request for M and T services have been authorized by the CCS Program; and

   b. The client is eligible for M and T services based on the criteria outlined in IV.A, above.

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2. CCS Medical Consultants or their designees should review the M and T services requested in relationship to the authorized CCS treatment services and provide recommendations to the Administrator on the number of trips needed by the client or the anticipated length of stay if services require inpatient care.

VI. REIMBURSEMENT

A. Private Car Mileage Reimbursement will be at the Internal Revenue Service (IRS) standard mileage rate for medical transportation ($0.165 per mile as of 01/01/2010). The rate paid will be the rate in effect on the date the travel occurred, not the rate in effect at the time the claim is submitted for payment.

B. Lodging Costs for Client/Parent(s)/Legal Guardian(s)

Reimbursement shall be based on the usual or actual costs of one room up to the maximum amount per night based on the State of California employee lodging (Note: Reimbursement for the cost of lodging provided by facilities sponsored by charitable organizations should not be greater than the customary charges to families). If circumstances exist that require approval of lodging reimbursement at higher levels, these circumstances should be documented.

C. Meals

Reimbursement for meals should be at actual costs per person up to $15 per day. Hospital meal voucher(s) will be credited as part of the $15 per day meal assistance. Reimbursement will be based on actual costs supported by receipts for meals. Hospital meal vouchers provided to the clients or parent(s)/legal guardian(s) will be paid based upon the invoice submitted by the hospital.

D. Other Necessary Expenses

Reimbursement may be made for other necessary expenses (e.g., parking, tolls) based on actual costs supported by receipts.

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VII. RECORD KEEPING

A. Log of Authorized M and T Services

1. County CCS Programs should develop and maintain a log of authorizations of M and T services.

2. The log should contain, at a minimum, the following:

   a. Start and end dates of authorization of maintenance and/or transportation services;

   b. Name of the CCS-eligible child;

   c. CCS record number;

   d. Type and number of authorized services;

   e. Identification of the funding category of client (CCS, Medi-Cal, or HF); and

   f. Name of individual approved to submit claims for reimbursement of authorized M and T.

B. Reimbursement Record

County CCS Programs should keep records on reimbursements for M and T. These records should be linked to the M and T services log.

VIII. CLAIMING M AND T SERVICES COST AS A COUNTY CCS PROGRAM ADMINISTRATIVE EXPENDITURE

State share financial reimbursement for expenditures by county CCS Programs for M and T services shall be claimed on the quarterly CCS Administrative Invoice form. Instructions for invoicing M and T expenditures for CCS clients or parent(s)/legal guardian(s) are found in the CMS Plan and Fiscal Guideline Manual, Section 9.

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If you have any questions, please contact your Regional Office Administrative Consultant.

Original signed by Louis R. Rico

Louis R. Rico, Chief
Systems of Care Division

Enclosure

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CCS Maintenance and Transportation Assistance Worksheet

CCS Dx: _____

M&T requested by: _____ Client ___ Parent/guardian ___

CCS Provider: _____ Location: _____ Date(s)_____

Language spoken: _____ Will interpreter accompany family? ___ yes ___ no

Authorized person(s) for M&T (including interpreter if necessary):

_____

_____

The following assistance has been requested for authorized person(s)

- ☐ Lodging: Site: _____ Dates: _____ Actual costs: _____
- ☐ Meals: Dates: _____ Actual costs: _____
- ☐ Transportation: Bus ___ Train ___ Private car ___ Taxi ___ Other (specify) _____

  Private car departure point (e.g. home address): _____

  Total car mileage: _____ Other transportation costs: _____

Review alternative sources of services with client and/or responsible adult:

___ Friends, family, faith institution, neighbors ___ Amer Cancer Soc ___ Easter Seals ___ Regional Center

___ Hemophilia Society ___ Ronald McDonald House, etc. ___ Managed care plan ___ Picnic cooler

___ Alternative appointment schedules to minimize need for M&T ___ Parent in-room option

Other organizations (specify) _____

Comments: _____

Client/adult initial if present; CCS staff initial per phone interview with (name): _____

The client/responsible adult:

_____ States that there are no other resources available to obtain the needed services.

_____ Has been informed of need to submit receipts and appropriately use funds in order to obtain CCS services.

_____ Has been informed that misuse of funds or failure to follow above requirements may result in denial of future requests.

_____ Has been informed that the County of _____ is not responsible for any incidents/injury that occur in conjunction with the authorized appointment or associated travel.

_____ Has submitted proof of current auto insurance, vehicle registration, and driver's license for vehicle driven and driver if gas vouchers, parking fees or toll fees have been requested. (optional --per county policy)

Client: _____ **CCS #:** _____ **M-C** ___ **CCS** ___ **HFP** ___

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CCS Use Only

1. ☐ Request is for service authorized by CCS Program.
2. ☐ Request is not for Non-Emergency Medical Transportation.
3. ☐ CCS client with a signed Program Service Agreement or
   ☐ CCS client with full-scope Medi-Cal, no share of cost or
   ☐ CCS client is member of Healthy Families Program
4. ☐ Alternative community resources are not available (see above) and
   ☐ Client or parents/legal guardian have no means of reaching authorized service on their own and
   ☐ Authorized care is to the closest medical facility capable of providing the appropriate medical service.

Comments: _____

_____

___ **Request approved by:** _____ Date: _____

Service(s) authorized: Vendor/individual: _____

Amount(s): _____

Date(s): _____

Service(s) authorized: Vendor/individual: _____

Amount(s): _____

Date(s): _____

Service(s) authorized: Vendor/individual: _____

Amount(s): _____

Date(s): _____

___ **Request denied--reason:** _____

___ **NOA sent--date:** _____

- ☐ Recorded on M&T Tracking Log
- ☐ Recorded on M&T Client Log
- ☐ M&T authorization generated and sent

Client: _____ **CCS #:** _____ **M-C** ___ **CCS** ___ **HFP** ___

M&T Asst. Wksheet 6-03

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Policy #:	GG.1547
Title:	**Maintenance and Transportation**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/19
Last Review Date:	N/A
Last Revised Date:	N/A

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I. PURPOSE

This policy defines the criteria and process for administration of the Maintenance and Transportation benefit for CalOptima Members eligible with the California Children's Services (CCS) Program.

II. POLICY

A. CalOptima is responsible for authorizing and reimbursing Maintenance and Transportation for CCS-eligible Members enrolled in CalOptima Direct and the Health Networks. The Health Networks shall be responsible for identifying CCS-eligible Members that may be eligible for the Maintenance and Transportation benefit and forward the necessary information to CalOptima to determine benefit eligibility.

B. CalOptima shall provide Maintenance and Transportation benefits to CalOptima CCS-eligible Members or such Member's family seeking transportation to a Covered Service related to their CCS-Eligible Condition when the cost of Maintenance and Transportation presents a barrier to accessing authorized diagnostic or treatment services.

C. CalOptima may authorize Maintenance and Transportation when CalOptima determines:

1. No other available resources exist to assist the CCS-eligible Member/parent(s)/legal guardian(s) to access authorized Medically Necessary medical services related to the Member's CCS-Eligible Condition, including:

    a. The Member, parent(s)/legal guardian(s) have no means of reaching the approved provider/facility without outside help; and

    b. Alternative resources for these services are not available in the community

D. A Health Network shall coordinate with the CalOptima Case Management Department to ensure timely and appropriate delivery of Maintenance and Transportation services in accordance with Section III.B. of this Policy.

E. Transportation

1. CalOptima will arrange the most appropriate and cost-effective mode of transportation to access authorized medical services. If the CCS-eligible Member and/or parent(s)/legal

guardian(s) choose to go to a provider/facility that is not the closest CCS approved facility/paneled provider, transportation costs beyond those to reach the closest provider capable of delivering the level/type of services required are the responsibility of the Member and/or parent(s)/legal guardian(s).

F. Non-Emergency Medical Transportation (NEMT) is not covered under the Maintenance and Transportation benefit. NEMT is provided in accordance with CalOptima Policy GG.1505: Transportation: Emergency, Non-emergency and Non-medical.

G. CalOptima may approve Transportation to a Medical Therapy Unit (MTU) for physical or occupational therapy, or to attend a Medical Therapy Conference if a transportation need has been identified jointly by the family and the MTU treating therapist as necessary for the CCS-eligible Member's access to these services in accordance with the provisions of this Policy and when transportation is not included in the Member's Individualized Education Plan (IEP).

H. Maintenance and Transportation may be a benefit for authorized medical care provided outside the state of California for a CCS-eligible condition in accordance with the provisions of this Policy.

I. A Member, family or legal guardian may appeal a denial for Maintenance and Transportation assistance in accordance with CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services.

III. PROCEDURE

A. A Health Network shall identify a CCS-eligible Member who may be eligible for the Maintenance and Transportation benefit through communication with the Member, family or legal guardian and confirmation of an approved treatment request meeting the criteria in this Policy.

B. The Health Network shall forward the following information to CalOptima via fax or other secure method:

1. Completed WCM Maintenance and Transportation Assistance Worksheet;

2. Approval notification for the Medically Necessary diagnostic and/or treatment services for the CCS-Eligible Condition for which Maintenance and Transportation is requested; and

3. Name and contact number for Health Network case manager.

4. The CalOptima case management transportation coordinator shall review the Maintenance and Transportation request and documentation submitted.

    a. If the request meets the requirements for Maintenance and Transportation assistance, as outlined in this Policy, CalOptima shall send notification of approval to the WCM Member/family or legal guardian and the Member's Health Network.

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i. CalOptima shall coordinate with CalOptima's transportation vendor Special Arrangements Liaison to ensure approved Maintenance and Transportation arrangements are made, either prospectively or for reimbursement of allowable expenses incurred by the CCS-eligible Member, family or legal guardian.

ii. CalOptima shall be responsible to pay approved Maintenance and Transportation costs to the contracted vendor.

b. If the request does not meet the requirements for Maintenance and Transportation assistance as outlined in this Policy, CalOptima shall issue a Notice of Action (NOA)/Notice of Adverse Benefit Determination (NABD) to the CCS-eligible Member, family or legal guardian and provide a copy of the notice to the Health Network.

i. The Health Network case manager shall work with the WCM Member, family or legal guardian to provide alternative resources.

C. CalOptima shall identify CCS-eligible Members assigned to CalOptima Direct who may be eligible for the Maintenance and Transportation benefit through communication with the CCS-eligible Member, family or legal guardian and approval for treatment request meeting the criteria in this Policy.

1. The assigned CalOptima case manager shall complete the WCM Maintenance and Transportation Assistance Worksheet, attach the document in the medical management system and send a request for action in the medical management system to the CalOptima case management transportation coordinator.

2. The CalOptima case management transportation coordinator shall review the Maintenance and Transportation request and documentation submitted.

a. If the request meets the requirements for Maintenance and Transportation assistance as outlined in this Policy, notification of approval will be sent to the Member/family or legal guardian and a request for action will be sent to the assigned Case Manager.

i. CalOptima shall coordinate with CalOptima's transportation vendor Special Arrangements Liaison to ensure approved Maintenance and Transportation arrangements are made, either prospectively or for reimbursement of allowable expenses incurred by the CCS-eligible Member, family or legal guardian.

b. If the request does not meet the requirements for Maintenance and Transportation assistance as outlined in this Policy, CalOptima shall issue a NOA/NABD to the Member, family or legal guardian.

i. The assigned case manager shall work with the WCM Member, family or legal guardian to provide alternative resources.

D. CalOptima may authorize Maintenance when:

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1. The CCS-eligible Member is obtaining authorized outpatient services and the distance from the CCS-eligible Member's home to the facility/provider authorized for outpatient services is such that the trip cannot be made in one (1) calendar day; or

2. If the parent(s)/legal guardian(s) are staying with and supporting a hospitalized CCS-eligible Member and the distance from the Member's home to the facility is such that the trip cannot be made in one (1) calendar day; and

3. Alternative resources have been explored and are unavailable; and

4. The CCS-eligible Member and/or parent(s)/legal guardian(s) have no means of providing for their Maintenance without the assistance from CalOptima.

5. CalOptima shall not reimburse a family for meals and lodging if the family could make the trip in one (1) calendar day if they had traveled to the nearest appropriate provider for services.

E. Access to Inpatient Services

1. Maintenance

a. For intensive care settings, when the parent/legal guardian is not permitted to stay at the CCS-eligible Member's bedside, CalOptima may initially authorize up to seven (7) calendar days of lodging and meals per hospitalization for one (1) or two (2) parent(s)/legal guardian(s). CalOptima will evaluate the need for additional lodging and meals based on the Member's circumstances.

b. For non-intensive care settings when parent(s)/legal guardian(s) are able to stay at the CCS-eligible Member's bedside, CalOptima may authorize one (1) calendar day of lodging for one (1) or two (2) parent(s)/legal guardian(s) after every six (6) nights of Member hospitalization.

c. CalOptima may authorize the total maximum Maintenance and Transportation authorization when a CCS-eligible Member is in intensive or non-intensive care setting shall be fifteen (15) calendar days of lodging and associated meals for each thirty (30) calendar days of Member hospitalization, beginning with the day of the Member's admission. Each new Member hospitalization shall be a new thirty (30) calendar day Maintenance and Transportation benefit period.

2. Transportation

a. Two (2) round trips per CCS-eligible Member's hospitalization for stays of less than seven (7) calendar days duration.

b. One (1) round trip for every seven (7) calendar days of a CCS-eligible Member's hospitalization in addition to the initial two (2) trips, if the hospitalization lasts longer than seven (7) calendar days.

3. Post-hospitalization

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a. CalOptima may authorize lodging and meals for a Member and the Member's parent or guardian if the Member's discharge plan documents the need for daily medical visits for treatment of the CCS-Eligible Condition, and the distance precludes making the trip to the hospital in one (1) calendar day.

F. Access to Outpatient Services

1. Maintenance

a. If a family's trip to the outpatient provider can be completed in one (1) calendar day (round trip travel and appointment time included), there should not be reimbursement for meals or lodging.

b. If the total time for the trip will exceed one (1) calendar day, lodging and meals for one (1) or two (2) parents/legal guardian(s) and the CCS-eligible Member may be authorized.

2. Transportation

a. If the distance to the provider is such that the trip may be made in one (1) calendar day, then the family may be assisted with Transportation if lack of transportation is a barrier to the family's compliance with the treatment plan.

b. CalOptima may provide approval for a block of multiple trips when it is known that a CCS-eligible Member must make a specified number of visits to the provider for treatment, such as radiation therapy, chemotherapy, etc.

G. Reimbursement

1. Private Car Mileage: Reimbursement will be at the Internal Revenue Service (IRS) standard mileage rate for medical transportation. The rate paid will be the rate in effect on the date the travel occurred, not the rate in effect at the time the claim is submitted for payment.

2. Lodging costs for Member/parent(s)/ legal guardian(s): Reimbursement shall be based on the usual or actual costs of one (1) room up to the maximum amount per night based on the State of California employee lodging. Reimbursement for the cost of lodging provided by facilities sponsored by charitable organizations should not be greater than the customary charges to families.

3. Meals: Reimbursement shall be at actual costs per person, up to $15/day. Hospital meal voucher(s) will be credited as part of the $15/day meal assistance. Reimbursement will be based on actual costs supported by receipts for meals. Hospital meal vouchers provided to the Member/parent(s)/legal guardian(s) will be paid based upon the invoice submitted by the hospital.

4. Other necessary expenses: Reimbursement may be made for other necessary expenses, including, but not limited to, parking and tolls based upon actual costs supported by receipts.

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5. CalOptima shall inform CCS-eligible Members or parent(s)/legal guardian(s), in writing, of the following, upon approval of the Maintenance and Transportation request:

    a. How to submit requests for reimbursement;

    b. How to submit required receipts and/or other documentation for expenses incurred as Maintenance and Transportation (gasoline, hotel/motel, meals, parking, tolls, etc.); and

    c. That failure to comply with these requirements could preclude future authorization of Maintenance and Transportation services for the Member/family

D. CalOptima shall maintain a record of authorizations for Maintenance and Transportation services, which includes:

1. Start and end dates of authorization for Maintenance and/or Transportation services;

2. Member name;

3. Member Client Index Number (CIN);

4. CCS number;

5. Type and number of authorized services; and

6. Vendor contact information.

IV. ATTACHMENTS

A. WCM Maintenance and Transportation Assistance Worksheet

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Department of Health Care Services (DHCS) All Plan Letter 18-011: California Children's Services Whole Child Model Program
C. CCS Numbered Letter 03-0810: Maintenance and Transportation for CCS Clients to Support Access to CCS Authorized Medical Services
D. CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency & Non-Medical
E. CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services
F. California Health and Safety Code, §123840(j)
G. U.S. Code Title 26, Subtitle A, Chapter 1, Subchapter B, Part VII, §213

VI. REGULATORY AGENCY APPROVALS

A. 10/29/18: Department of Health Care Services

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

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VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2019	GG.1547	Maintenance and Transportation	Medi-Cal

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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: Enrollment in/Eligibility with CalOptima Direct.
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services-Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
Individualized Education Plan (IEP)	A written document for an individual with exceptional needs that is developed, reviewed, and revised in a meeting in accordance with Sections 300.320 to 300.328, inclusive, of Title 34 of the Code of Federal Regulations and California Education Code, Title 2, Division 4, Part 30. It also means "individualized family service plan" as described in Section 1436 of Title 20 of the United States Code if the individualized education program pertains to an individual with exceptional needs younger than three (3) years of age.
Health Network	A Physician Hospital Consortium (PHC), physician medical 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
Maintenance	The cost(s) for lodging (such as motel room, etc.) and food for the Member, parent(s), or legal guardian(s) when needed to enable the Member to access authorized services for a CCS-Eligible Condition.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	A 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.
Non-Emergency Medical Transportation	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
Transportation	For purposes of this Policy, the cost(s) for the use of a private vehicle or public conveyance to provide the Member access to authorized services.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Authorizing a Contract for Pre-Payment of Services Provided to CalOptima Medi-Cal Members at the Be Well OC Wellness Hub Using Intergovernmental Transfer (IGT) 5 Funds in an Amount Not to Exceed $11.4 Million

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action

Authorize the CEO, with the assistance of Legal Counsel, to execute a contract with the County of Orange Health Care Agency, including indemnification, defense and hold harmless provisions by the County of Orange, in an amount not to exceed $11.4 million in IGT 5 funds, in exchange for the County of Orange securing Sobering Station and Peer Support services provided to CalOptima Medi-Cal members at the Be Well OC Wellness Hub (Hub) for the greater of five years, or until the funding amount is exhausted, to commence once the Hub is operational.

Background

IGTs are transfers of public funds between governmental entities that meet state and federal requirements and approved by the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS). CalOptima utilizes IGT funds towards health care services and administrative purposes that improve quality, access and efficiency in the Medi-Cal program for the benefit of CalOptima Medi-Cal members.

In December 2016, the CalOptima Board of Directors (Board) authorized an allocation of IGT 5 funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA were used to identify potential areas of interest for IGT funded initiatives. The areas of interest included community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health.

During the December 6, 2018 CalOptima Board meeting, up to $11.4 million was approved from IGT 5 as prepayment toward enhanced services to be provided to CalOptima Medi-Cal members at the Hub to commence once the Hub is operational and continuing for the greater of five (5) years or until the funding amount is exhausted. The Hub, which is currently in development, will provide enhanced services for CalOptima's Medi-Cal members by integrating and co-locating CalOptima and County of Orange mental health and substance abuse services.

The County is expected to establish referral and intake processes, leveraging existing county processes to ensure that the conditions of those individuals who complete the intake process are appropriate for the Hub services. As appropriate, CalOptima staff, health networks and providers would refer members following these processes. Sobering station center services could be referred directly through ambulances and law enforcement.

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In accordance with CalOptima Board's December 2018 action, prepayment for enhanced services for CalOptima Medi-Cal members is contingent upon:

- Receipt of written attestation that Mind OC has obtained the balance of funds required to complete construction of the first Wellness Hub, and that CalOptima's prepayment for services funding will be up to $11.4 million or one-third of the costs of development of the Wellness Hub, whichever is less.
- The parties' agreement for specific services, oversight and CalOptima Medi-Cal member access to the agreed upon services as part of a contract between CalOptima and the County of Orange (and Mind OC, if appropriate).
- Contract approval and execution prior to disbursement of funds.

Discussion

The Hub is being developed in partnership with the County of Orange and numerous local entities, hospital systems, non-profit organizations, faith-based organizations, and other community stakeholders, now formally known as Be Well OC. In addition, a non-profit entity, Mind OC has been established to develop financial resources to support construction of the Hub. Services provided to CalOptima Medi-Cal members at the Hub will be coordinated through the County of Orange. In order to provide the up to $11.4 million prepayment for Hub services, CalOptima staff plans to execute a contract with the County of Orange that will identify the enhanced services to be provided to CalOptima Medi-Cal members (i.e., other than Medi-Cal covered services for which providers can separately bill, and also other than services that the County is separately obligated to provide). The contract will include indemnification, defense and hold harmless provisions to provide that the IGT 5 funds are to be returned to CalOptima if the Hub project does not go forward, does not ultimately deliver enhanced services that benefit CalOptima Medi-Cal members, or the use of the funds for the Hub is challenged and/or recovered by any regulatory agency.

Initially, the intent is for the Hub to provide peer support and sobering station services to CalOptima Medi-Cal Members at no additional cost to those members for the greater of five (5) years or until the funding amount is exhausted. CalOptima staff will return to the Board with further recommendations if additional services are to be added to the contract at a later time. The contract will include prepayment and reconciliation provisions to ensure an accurate accounting of contracted services provided to CalOptima Medi-Cal members. CalOptima staff has worked with the County of Orange to develop appropriate and reasonable pricing for peer support and sobering station services. The following table provides a description of peer support and sobering station services:

Category	County of Orange Provided Wellness Hub Services under this Contract
Peer support services	• Link members to needed behavioral health services • Help members develop capacity and access to resources • Educate members about their mental health condition(s) • Provide informal counseling, support and follow up
Sobering station services	• Community facility, an alternative to jailing and prosecuting intoxicated individuals.

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	• CalOptima Medi-Cal members can sober up, be assessed regarding their mental health status, and get referred to treatment services as needed.
	• The Sobering station benefits members by providing the resources they need to address health problems. It also benefits the general public by freeing up law enforcement and emergency medical staff and resources so they can provide for the health and safety of the community.
	• Goals:
	  ○ Provide public inebriates with treatment rather than incarceration and prosecution.
	  ○ Eliminate unnecessary paramedic trips and time at hospital emergency departments.
	  ○ Improve public safety by freeing up law enforcement resources.
	  ○ Free up beds in emergency departments of local hospitals.
	  ○ Improve member outcomes, including mortality rates, by offering immediate treatment as well as linkages to treatment services for long-term recovery.
	  ○ Coordinate assistance for recurrent clients of County resources.

Fiscal Impact
The recommended action to approve a contract of up to $11.4 million from existing IGT 5 funding to the Orange County Health Care Agency in exchange for the above-referenced enhanced services for CalOptima Medi-Cal members has no fiscal impact on the CalOptima Operating Budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of its vision of working Better. Together, CalOptima, as the community health plan for Orange County, is committed to working with community stakeholders to address the unique health care needs of Medi-Cal members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Board Action dated December 6, 2018, Consider Authorizing a Contract for Be Well Wellness Hub Services Provided to CalOptima Medi-Cal Members using Inter Governmental Transfer (IGT) 5 Funds

/s/ Michael Schrader — *4/24/2019*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing a Contract for Be Well Wellness Hub Services Provided to CalOptima Medi-Cal Members using Inter Governmental Transfer (IGT) 5 Funds

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400
Cheryl Meronk, Director, Strategic Development (714) 246-8400

Recommended Action

1. Approve allocation of up to $11.4 million for Be Well Wellness Hub services to CalOptima Medi-Cal members from Board-approved Intergovernmental Transfer (IGT) 5 Adult and Children Mental Health priority area;
2. Authorize the CEO, with the assistance of Legal Counsel, to enter into a contract with the County of Orange Health Care Agency, or a three-way agreement with the Orange County Health Care Agency and Mind OC, including indemnification, defense and hold harmless provisions by the County of Orange and also by Mind OC (if three-way agreement), in an amount not to exceed $11.4 million, in exchange for at least five years of enhanced services provided to CalOptima Medi-Cal members at the Be Well Wellness Hub to commence once the Hub is operational.

Background

IGTs must meet state and federal requirements and must be approved by the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS).
Funding agreements provide that provider recipients will use their share of IGT-funded capitation rate increases for the provision of health care services to CalOptima Medi-Cal members. Similarly, where CalOptima retains portions of IGT-funded capitation increases, such funds are designated for health care services and administrative purposes that improve quality, access and efficiency in the Medi-Cal program for the benefit of CalOptima Medi-Cal members.

In December 2016, the CalOptima Board of Directors authorized an allocation of IGT 5 funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to award approximate $14.4 million in remaining IGT 5 funds. The funding categories included in DHCS-approved IGT 5 included:

- Community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health; and
- Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver Initiatives. This would be one-time funding allocation for planning and to implement pilot programs as required.

At the February 2018 Board of Directors meeting, staff presented the Executive Summary of the MHNA as well as categories of needs in the community identified by the MHNA. The Board-approved categories included:

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- Adult Mental Health
- Older Adult Mental Health
- Children's Mental Health
- Nutrition Education and Physical Activity
- Children's Dental Services
- Medi-Cal Benefits Education and Outreach
- Primary Care Access and Social Determinants of Health
- Adult Dental Services

Discussion

Be Well OC Regional Wellness Hub

The County of Orange and numerous other local public agencies, hospital systems, non-profit organizations, faith-based organizations and other community stakeholders have been meeting to discuss the mental health care system in Orange County. This group of stakeholders, known as the Orange County Coalition for Behavioral Health (the Coalition), now formally known as Be Well OC, came together to promote, facilitate and support existing mental health services and identify gaps in care that exist across the County. In addition, the Coalition formed a non-profit entity, Mind OC, to develop financial resources to support the goal of creating a high-quality behavioral health system of care.

While CalOptima Medi-Cal members are each assigned a primary care provider and a health network that are responsible for meeting member health care needs, results from the MHNA suggest that as many as 40% of CalOptima members may not know who to call or where to go for mental health services. In addition, Orange County hospital data indicates that more than 50% of Emergency Department (ED) visits for mental health and substance use disorder (SUD) issues involve Medi-Cal members[1]. The costs for these ED visits fall on CalOptima and its delegated health networks. The ED environment is often counter-indicated for the treatment of mental health and SUD. In certain situations, the ED may exacerbate the condition, potentially leading to longer stays and increasing the likelihood of an inpatient admission to a hospital-based psychiatric facility.

The Regional Wellness Hub (Hub), which is currently in its initial stages of development, will provide enhanced services for CalOptima's Medi-Cal members by integrating and co-locating CalOptima and County of Orange mental health and substance abuse services, and community-based social support services in a central, easily accessible location that improves access, addresses whole-person care, improves outcomes, and reduce recidivism. The goal is to redirect a meaningful percentage of mental health patients from the ED to the more appropriate care setting of a Regional Wellness Hub. Staff's understanding is that the County of Orange acquired 265 Anita Street in March of 2018 for the amount of $7.8 million and Be Well OC has provided additional financial resources to develop project plans and cost estimations.

Based on these factors, the CalOptima Board of Directors IGT 5 Ad Hoc Committee comprised of Supervisor Do and Director DiLuigi, recommends that CalOptima commit up to $11.4 million for the Be

[1] 2016 Office of Statewide Health Planning and Development (OSHPD)

Well OC Regional Wellness Hub, to be drawn from IGT 5 funds, consistent with DHCS-approved uses, to address the behavioral health needs of CalOptima members that are not carved out of CalOptima's State Contract.

Advance Funding Requirements

Operational details and services to be offered at the Hub have been developed including the go-live date, specific scope of mental health and other services; some other key considerations still need to be finalized. In addition, the volume of CalOptima members who will use the Hub is uncertain at this time and it is unknown how long it will take for services to meet the advance funding amount. As proposed, funds are being provided prior to commencement of services at the Hub, such that the County of Orange and Mind OC may end up using these funds for facility development, construction and/or other start-up costs, subject to the obligation to provide CalOptima Medi-Cal members services once the Hub is up and running. Given the uncertainty of these factors and CalOptima's advance funding, CalOptima will include indemnification, defense and hold harmless provisions to provide that the IGT 5 funds are returned if the Regional Wellness Hub project does not go forward, does not ultimately deliver mental health services that benefit CalOptima Medi-Cal members, or the use of the funds for the Hub by the County of Orange or Mind OC is challenged and/or recovered by any regulatory agency.

The up to $11.4 million advance funding for services to CalOptima Medi-Cal beneficiaries will be based on the following requirements:

- Services prepayment funding is contingent upon receiving written attestation that Mind OC has obtained the balance of funds required to complete construction of the first Wellness Hub, and that CalOptima's prepayment for services funding will be up to $11.4 million or one-third of the costs of development of the Wellness Hub, whichever is less;
- Commencement of development of the Wellness Hub by July 2020 and provision of agreed upon services to CalOptima Medi-Cal members no later than July 2021 based on Be Well's proposed construction schedule plus over an additional year for any potential delay;
- The Wellness Hub is to provide mental health and other related services to CalOptima Medi-Cal members at no additional cost to the members for the greater of five years or until the funding amount is exhausted (services provided to CalOptima Medi-Cal to be valued at the Medi-Cal Fee-for-Service equivalent cost for such services or other comparable agreed upon methodology). Service areas may include the following:
    - Triage
    - Psychiatric intake and referral
    - Substance use disorder intake and referral
    - Residential treatment services
    - An integrated support center providing community and faith-based services
- Services provided to CalOptima members (and charged to the CalOptima funding amount pursuant to this proposed arrangement) do not include mental health services (e.g., Specialty Mental Health Services) that are carved out of CalOptima's State Contract and are the financial responsibility of the County of Orange Health Care Agency (OCHCA) or Social Services Agency;
- The Wellness Hub must accept all CalOptima Medi-Cal members whose condition is appropriate for the facility; and

- The parties will agree upon specific services as part of a contract (between CalOptima, County of Orange, and Mind OC, as appropriate), ensuring OCHCA will oversee all Wellness Hub operations and services, and ensure CalOptima Medi-Cal members access to the agreed upon services. The contract must be approved by the CalOptima Board prior to funds being disbursed.

The Orange County Board of Supervisors and Be Well OC will finalize operational and program plans in early 2019. The CalOptima Board of Directors will be provided with an update at that time.

Fiscal Impact

The recommended action to approve a contract of up to $11.4 million from IGT 5 to the Orange County Health Care Agency, or the Orange County Health Care Agency and Mind OC in exchange for mental health services for CalOptima Medi-Cal members has no fiscal impact on CalOptima's operations 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 CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work 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.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Be Well OC Regional Wellness Hub
2. Be Well Orange County 265 Anita St. Proposal

/s/ Michael Schrader — *11/28/2018*
Authorized Signature — **Date**

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Be Well OC Regional Wellness Hub

Board of Directors Meeting
December 6, 2018

Cheryl Meronk
Director, Strategic Development

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Mental Health in Orange County

- CalOptima's Member Health Needs Assessment highlighted Mental Health as a priority need in the community
  - Providers identified mental/behavioral health as one of the most important health problems facing Medi-Cal beneficiaries
  - Lack of knowledge and fear of stigma are key barriers to receiving mental health services
    - Approximately 1 in 4 CalOptima members who needed mental health services did not see a mental health specialist
      - Members did not know who to call or how to ask for help
      - Members did not feel comfortable talking about personal problems

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Be Well OC Regional Wellness Hub

- CalOptima is participating in Be Well OC, a collaborative initiative to make improvements to the mental health system of care in Orange County
- Be Well initiative includes creation of Regional Wellness Hubs
- Services available at the Wellness Hubs are expected to include (but may not be limited to):
  - Variety of mental health services
  - Substance Use Disorder treatment programs
  - Integrated support services linking community and social services
- Services available to any OC resident
  - Access based on clinical need

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Wellness Hub Services May Include:

- Triage
- Psychiatric intake and referral
- Substance use disorder intake and referral
- Residential treatment services
- Integrated support services center
  - Mobile crisis response team
  - Transportation
  - Social and community-based services
  - Faith-based organizations
  - Education, employment and legal services

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Be Well OC Regional Wellness Hub

- Benefits for CalOptima members
  - Centralized and accessible services
  - Whole person approach to address needs and coordination of care
  - Co-location of community-based social support services
  - Improved health outcomes and reduction in recidivism

- Estimates are that more than 50% of local Emergency Department visits for mental health and substance use disorder issues are CalOptima members

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Anita St. Wellness Hub

- OCHCA 2016 Strategic Financial Plan includes a priority to develop an integrated behavioral health services campus
  - 44,600-square-foot building purchased at 265 Anita St. in Orange
- Planning for the facility evolved in parallel with Be Well OC Blueprint
  - 60,000-square-foot new construction planned in partnership with Be Well
- Initial project cost estimate: $34.2 million

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Wellness Hub Funding Deliverables

- Up to $11.4 million funding contract for services to CalOptima members conditioned on the following:
  - Funding contingent upon receiving written attestation that Mind OC has obtained the balance of funds required to complete development of the first Wellness Hub
  - Construction of Wellness Hub to start no later than July 2020
  - Grand opening of Wellness Hub with full range of agreed upon services available to CalOptima members no later than July 2021
  - Wellness Hub must include agreed upon services at no cost to CalOptima or the member
  - Wellness Hub must accept all CalOptima members for first five years of operation until the funding amount is exhausted
    - Services provided to CalOptima Medi-Cal members to be valued at the Medi-Cal Fee-for-Service equivalent cost for such services or other comparable agreed-upon methodology
  - MindOC to enter into a three-way contract with OCHCA and CalOptima

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Recommended Actions

- Approve allocation of up to $11.4 million for Be Well Wellness Hub services to CalOptima Medi-Cal members from Board-approved IGT 5 Adult and Children Mental Health priority area;
- Authorize a contract with County and Mind OC (including indemnity provisions) in an amount not to exceed $11.4 million, in exchange for at least five years of enhanced services for CalOptima Medi-Cal members at the Be Well Wellness Hub.

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Be Well

ORANGE COUNTY

265 ANITA ST. PROPOSAL

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Vision: Be Well Orange County will lead the nation in optimal mental health[1] and wellness for all residents.

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[1]In the following document, the terms mental health and wellness encompass substance dependence and abuse.

A community in action.

Families across Orange County are suffering in the face of increasing mental health and substance use disorders. For many families, these challenges have become devastating catastrophes. If you are a resident of the Orange County community today, you undoubtedly have your own story – direct or indirect – to underscore this unfortunate reality.

265 Anita in the city of Orange is the first manifestation of Systems Change in Orange County. It is the place where we begin to build a new reality for this community, where together in public-private partnership we boldly impact individual, systemic and societal conditions so that all residents can Be Well.

265 Anita is a best-in-class regional treatment and wellness hub. It is a symbol of the strength and possibilities created when public and private partners strive together.

Orange County needs and deserves more than a new services building. **Let's build a beacon.**

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Executive Summary

Background

265 Anita St.

The Orange County HCA 2016 Strategic Financial Plan identified as a priority the creation of a campus-like setting for co-location of behavioral health services. In order to meet this need, HCA worked in collaboration with Orange County CEO/ Real Estate to purchase 265 Anita St. in the city of Orange. The 2.1 acre property hosts a 44,556 sq. ft. freestanding, two-story, stucco and glass office building with a landscaped, open-air atrium.

The HCA program planning process for the Anita St. building evolved in parallel with the public-private co-creation of the Be Well OC Blueprint (described in further detail in this section). Within that context, an opportunity emerged for a public-private partnership, between HCA and Mind OC (a not-for-profit organization described in further detail in this section), to design and develop a 60,000 sq. ft. building de novo, for the purpose of providing mental health and substance use disorder (SUD) services for all residents of Orange County regardless of payer.

Proposed here is the recommended plan to leverage public-private collaboration and actualize the full potential of 265 Anita St. as the county's first Be Well OC Regional Mental Health and Wellness Hub.

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Opportunity

In Process

As the first Regional Wellness Hub, 265 Anita will be a trusted beacon for the Orange County community. To optimize this opportunity, HCA can leverage Mind OC's private sector expertise in real estate development and healthcare facility design to benefit from past learning and efficiencies in planning, project management and construction. Three primary advantages to this approach include:

- speed to market
- cost
- quality

With HCA's approval and collaboration, an exploration of this approach is underway. The contents of this proposal are the result of that work to date. The following pages include a target population assessment, program and services descriptions, design and construction options, financing recommendations, and additional operational considerations. Notably, the 265 Anita clinical program proposed here is comprised of multiple services identified to meet specific community needs as reflected in both county and hospital data. The clinical program and operational facility design have been co-created by the clinical leaders of the HCA and Mind OC.

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Executive Summary

Context

Be Well OC Blueprint

Co-created by a variety of public and private stakeholders across the county, a branded Be Well OC Blueprint clearly articulates the steps needed to actualize the Be Well OC vision. Success starts with acceptance that the mental health sector alone cannot solve this pervasive healthcare challenge. Neither can the public or private sectors sufficiently address the complexities alone. Be Well OC brings together a robust, community-based, cross-sector strategy – public, private, academic, faith and others – to positively impact those challenges that diminish mental health and well-being.

Be Well OC harnesses a best practice model known as Collective Impact, with a clearly defined leadership structure, to advance: education and prevention of mental illness, reduction of stigma, promotion of mental health, early identification of problems, and comprehensive, coordinated treatment. Be Well OC will establish a community-wide, coordinated ecosystem of optimal mental health support and services.

Mind OC

Mind OC is a community-owned, not-for-profit, 501(c)3 created to support the advancement of Be Well OC and the Orange County mental health and wellness ecosystem. The Mind OC governance board is comprised of a cross-sector, multidisciplinary team of Orange County leaders. The team sets goals, develops strategy and deploys plans through focused work streams and specialized project workgroups, managing the cross-functional alignment of these efforts. Accountabilities include oversight and management of work streams and projects, ensuring adequate information, resources and support are provided, and serving as liaison to key stakeholders. Mind OC has three primary areas of focus:

1. Mental health and wellness infrastructure development

2. Value optimization and transparency in mental health and SUD services

3. Be Well OC sustainability and public/private partnerships

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Regional Hubs

As a foundational component of the Blueprint, and essential to effective services coordination, three regional anchoring Wellness Hubs are required to support the Be Well mental health system of care. The Wellness Hubs will include a variety of mental health and SUD treatment programs and are uniquely available to all residents of Orange County, regardless of payer. Access is based on clinical need.

The Wellness Hubs will be intentionally located and designed in synergistic compliment with the Homeless System of Care, and the goals of each respective Service Planning Area (SPA). It is critical to note the three Wellness Hubs are not designed exclusively to serve the OC homeless population. Hubs will have sufficient service and staffing capacity to address a range of mental health and wellness levels of risk and complexity. Each Hub will also integrate support services providing necessary linkage with myriad complimentary community and social services.

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Community Need

OC Emergency Department Volume, 2016 OSHPD

DIAGNOSES	Total OC Market	5 Mile Radius of 265 Anita	% of Total
Alcohol-related disorders	10,645	2,773	26.1%
Substance-related disorders	6,388	1,984	31.1%
Mood disorders	5,695	1,890	33.2%
Suicide and intentional self-inflicted injury	4,498	1,306	29.0%
Schizophrenia and other psychotic disorders	4,067	1,477	36.3%
Delirium dementia and amnestic and other cognitive disorders	960	285	29.7%
Miscellaneous mental health disorders	888	322	36.3%
Attention-deficit conduct and disruptive behavior disorders	484	174	35 9%
Screening and history of mental health and substance abuse codes	252	66	26.4%
Personality disorders	105	41	39.0%
Totals:	**34,024**	**10,336**	**30.4%**

Payer Mix	5 Mile Radius Payer Mix %	Total OC Market	5 Mile Radius of 265 Anita
Medi-Cal	52.9%	15,441	5,463
Commericial	23.0%	10,772	2,379
Self Pay	11.4%	3,823	1,176
Medicare	11.3%	3,464	1,172
Other	1.4%	525	147
Totals:	**100.0%**	**34,024**	**10,336**

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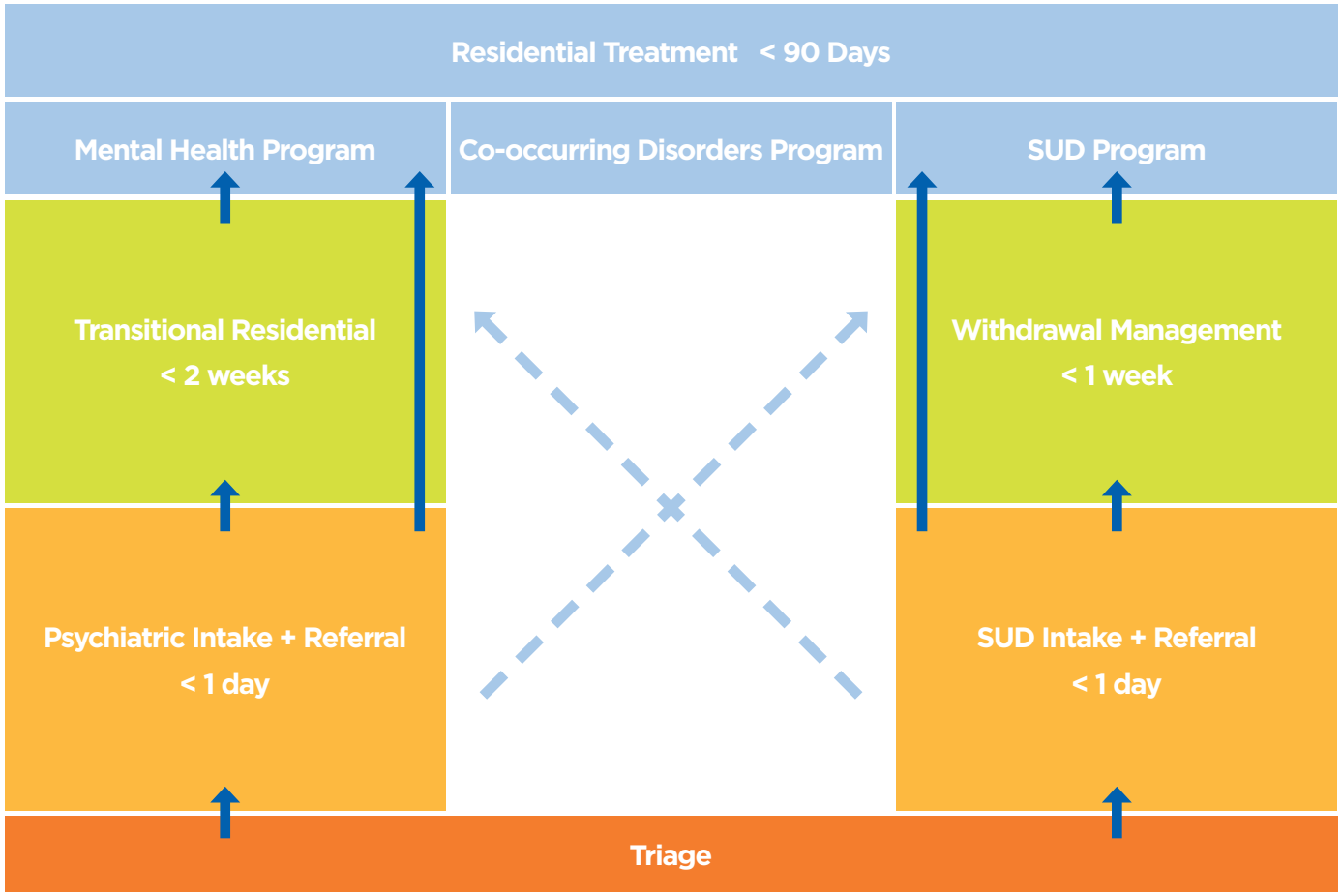
Proposed Program

The sum is greater than the parts. Integration of mental health and substance abuse services in a central, easily accessible location improves access. Coordination in care and operational synergy among services improves experience for patients and providers. Co-locating community-based social support services honors whole-person needs and a whole-systems approach, improves outcomes and reduces recidivism.



Integrated Support Services:

- Mobile Crisis Response Teams
- Transportation
- Social Services Support
- Community Based Organizations
- Faith Based Organizations
- Supportive Employment
- Supportive Education
- Legal Aid Services

*See Appendix for Program Access Projections and Discharge Planning.

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Proposed Services

There are seven different service elements that make-up the program at this first Be Well Regional Hub. OCHCA will hold the contracts with the various organizations providing the clinical services. The contracted providers will be required to contract with commercial health plans to ensure access to all members of the community regardless of the payer. Revenue from commercial health plans to the service provider will be applied to the cost reimbursement funds they are paid, lowering HCA's cost burden.

Program	Description	Length of Stay
Triage	**Target population:** Adults and adolescents are separated in this receiving area for walk-in/drop-offs to the campus. Screening is completed to determine clinical fit for the onsite programs. If onsite services are not appropriate for the need, a referral and transportation are provided.	**N/A**
Psychiatric Intake + Referral	**Target population:** Walk-in/drop off services for adults and adolescents with acute behavioral health challenges, who are at risk of hospitalization and present on a voluntary or involuntary basis. Services include: basic medical and medication services, psychiatric and psychosocial evaluation, crisis intervention, therapeutic support, education, and linkage to the clinically indicated level of continuing care.	**< 1 day**
Substance Use Disorder (SUD) Intake/Referral	**Target Population:** Walk-in/drop-off services for adults under the influence of drugs and alcohol. Services include: voluntary screening, assessment, physical safety and monitoring, and linkage to the clinically indicated level of continuing care.	**< 1 day**
Withdrawal Management	**Target Population:** Individuals who can safely withdrawal from alcohol and/or other drugs in a safe and supportive community/residential environment. Services include: counseling, withdrawal monitoring and support.	**< 1 week**
Transitional Residential	**Target Population:** Adults in psychiatric decline requiring longer term stabilization to ensure safe transition. Services include: on-going assessment, psychiatric medication management, individual and group intervention, substance abuse education and treatment, and family and significant-other involvement.	**< 2 weeks**
Residential Treatment	**Target Population:** Persons living with Serious Mental Illness and co-occurring SUD. Specialized residential treatment services include: assessment, individual and group counseling, monitoring psychiatric medications, substance abuse education and treatment, and family and significant-other involvement.	**< 90 days**
Integrated Support Center	Through the expansion of the existing footprint of the building, additional services have been identified that function synergistically in support of the above programs. These include: • Mobile Crisis Response Team • Transportation • Social Services • Community Based Organizations • Faith Based Organizations • Supportive Employment • Supportive Education • Legal Aid Services	**N/A**

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Financing Model

Syndicated Prorata Share

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Approval of Modifications to CalOptima's Policy and Procedure Related to CalOptima's Whole-Child Model Program

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to modify existing Policy and Procedure in connection with Whole-Child Model program as follows:

A. GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs [Medi-Cal, OneCare, OneCare Connect].

Background and Discussion

The California Children's Services (CCS) is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children under age 21 who meet eligibility criteria based on financial and medical conditions. Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal Managed Care Plan (MCP) contracts for County Organized Health Systems (COHS) on a phased-in basis.

On November 9, 2018, DHCS delayed the implementation of Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS determined that more time is needed to ensure effective preparation and a robust number of CCS-paneled providers. Additionally, on December 23, 2018, DHCS released All Plan Letter (APL) 18-023 California Children's Services Whole-Child Model, which superseded the APL originally published on June 28, 2018, and included clarifying language and new guidance regarding Neonatal Intensive Care Unit (NICU), High Risk Infant Follow-up (HRIF) program, pediatric palliative care, and continuity of care appeals.

Below is additional information regarding the modified policy which includes revisions related to WCM as well as clarification related to existing operations:

A. GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs outlines the criteria and process for coverage of durable medical equipment (DME) for a member, excluding wheelchair rental, purchase, and repairs. CalOptima revised this policy pursuant to the CalOptima review process to ensure alignment with current operations to include continuity of care with a specialized or customized DME provider for up to 12 months in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services. This policy is in alignment with the California Children's Services Whole Child Model program requirements.

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Additional policies are expected to be submitted for Board approval at a later time.

Fiscal Impact
Management will include all projected revenues and expenses associated with the WCM program in the Fiscal Year 2019-20 Operating Budget. Therefore, the fiscal impact of the recommended action to modify CalOptima Policy GG.1502 is a budgeted item and is not expected to have an additional fiscal impact in the current year.

Rationale for Recommendation
To ensure CalOptima meets all requirements of the Whole-Child Model program, approval of the requested action is recommended.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs [Medi-Cal, OneCare, OneCare Connect]
2. GG.1325: Continuity of Care for Members Transitioning into CalOptima Service [Medi-Cal]
3. DHCS All Plan Letter 18-023 California Children's Services Whole-Child Model Program

/s/ Michael Schrader — *4/24/2019*
Authorized Signature — **Date**

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Policy #:	GG.1502
Title:	**Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2000
~~Last Review Date:~~	~~08/01/17~~
~~Last~~ Revised Date:	05/02/2019~~08/01/17~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the criteria and process for coverage of **Durable Medical Equipment (DME)** for a **Member**, excluding wheelchair rental, purchase, and repairs.

II. POLICY

A. CalOptima or a **Health Network** shall provide **DME** for a **Member** when **Medically Necessary**.

B. CalOptima or a **Health Network** shall define **Medically Necessary** as reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, **DME** prescribed for a **Member** may be a **Covered Service** when it is **Medically Necessary** to:

1. Preserve bodily functions essential to **Activities of Daily Living (ADL)** or to prevent significant physical disability; or

2. Improve the medical status or functional ability of a **Member** through the stabilization of the **Member's** condition or the prevention of additional deterioration of the **Member's** medical status, or functional ability.

C. The following items are not **Covered Services**:

1. Modification of automobiles or other highway motor vehicles, with the exception of **Automobile Orthopedic Positioning Devices (AOPDs)**, in accordance with CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices;

2. Alterations or improvements to real property, except when authorized for home dialysis services;

3. Books or other items of a primarily educational nature;

4. Air conditioners, air filters or heaters;

5. Food blenders;

6. Reading lamps or other lighting devices;

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7. Bicycles, tricycles, or exercise equipment, except as otherwise permitted in this Ppolicy;

8. Television sets;

9. Orthopedic mattresses, recliners, rockers, seat lift chairs (for Medi-Cal only), or other furniture items;

10. Waterbeds;

11. Household items;

12. Items required solely for, educational, or vocational needs; and

13. Other items not generally used primarily for health care and which are regularly and primarily used by an individual who does not have a specific medical need for such item.

D. CalOptima or a **Health Network** shall not grant an authorization for **DME**, if a household or furniture item will adequately serve the **Member's** medical needs.

E. CalOptima or a **Health Network** shall limit authorization for **DME** to the lowest cost item that meets a **Member's** medical needs.

F. If a **Member** has a speech, language or hearing disorder, CalOptima, or a **Health Network**, shall authorize an Augmentation and Alternative Communication Device (AAC) for the **Member** when the following conditions are met:

1. A licensed speech and language pathologist conducts an assessment of the **Member's** medical need for AAC.

2. A physical or occupational therapist conducts an assessment of the **Member's** medical need for AAC if the **Member** has physical limitations which may impact his or her ability to use the AAC.

G. CalOptima or a **Health Network** will provide **Continuity of Care** with a **Specialized or Customized Durable Medical Equipment (DME)** provider for up to twelve (12) months, in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services.

~~G.~~H. CalOptima or a **Health Network** may authorize the following **DME** for a **Member** who is an inpatient in a **Skilled Nursing Facility (SNF)** or **Intermediate Care Facility (ICF)**:

1. Equipment that is necessary for the continuous care and unusual medical needs of the **Member**. A **Member** may be considered to have unusual medical needs if a disease or medical condition is exacerbated by physical characteristics such as height, weight, and build. Physical characteristics, as such, shall not constitute an unusual medical condition.

2. Canes, crutches, wheelchair cushions, and walkers that are custom made or modified to meet the unusual medical needs of the **Member** and the need is expected to be permanent.

3. Suction and position pressure apparatuses that a **Member** will continuously use or must be immediately available to the **Member** for one (1) month or more.

~~H.~~I. CalOptima or a **Health Network** shall authorize **DME** for a **Member**, in accordance with the following provisions:

1. A **Practitioner** shall obtain prior authorization for the following:

   a. Purchase of **DME** when the ~~cumulative~~total cost of items purchased within a **DME** category group exceeds five hundred dollars ($500) within one (1) calendar month;

   b. Repair or maintenance of **DME** when the ~~cumulative~~total cost of the repair and maintenance of items within a **DME** category group exceeds five hundred dollars ($500) within one (1) calendar month. The cost of repairs shall not exceed the replacement value of the item being repaired;

   c. Rental of **DME** when the ~~cumulative~~total cost of renting items within a **DME** category group exceeds five hundred dollars ($500) within a fifteen (15) month period. This includes any daily amount that an individual item, or combination of a similar group of items, exceeds the five hundred dollar ($500) threshold. The fifteen (15) month period begins on the date the first item is rented;

   ~~d. Provision of oxygen when more than the equivalent of two (2) H tanks are provided during one (1) calendar month; and~~

   d. Rental or purchase of an oxygen delivery system;

   e. Purchase, rental, repair, or maintenance of any unlisted devices or equipment, regardless of the dollar amount for any individual item or the ~~cumulative~~total cost.

2. CalOptima or a **Health Network** may audit **DME** authorization requests for appropriateness and accuracy, as necessary.

~~I.~~J. A **Member** is responsible for the appropriate use and care of **DME** purchased for the **Member's** benefit.

~~J.~~K. A **DME** provider shall ensure that the **DME** provided to a **Member** is appropriate for the **Member's** medical needs. A **DME** provider shall, at no cost to CalOptima, or a **Health Network**, adjust, modify, or replace the **DME**, as necessary, when the **DME** provided does not:

1. Meet the **Member's** medical needs and the **Member's** medical condition has not changed since the date the **DME** was originally provided; or

2. Meet the **Member's** functional needs when in actual use.

K. CalOptima or a **Health Network** shall consider **DME** to be purchased when previously paid rental charges equal the maximum allowable purchase price of the rented **DME**. CalOptima, or the **Health Network**, shall provide no further reimbursement to the **DME** provider for the use of such **DME**, unless payment is for the subsequent repair and maintenance of the **DME**, as authorized by CalOptima, or the **Health Network**.

L. Effective no sooner than July 1, 2019, CalOptima or a **Health Network** shall be responsible for authorization and claims processing for the rental, purchase and repair of **Specialized or Customized DME** for Whole Child Model (WCM) **Members** whose custom **DME** is **Medically Necessary** to treat or ameliorate the effects of their **California Children's Services (CCS)-eligible Condition**. **Specialized or Customized DME** may include, but is not limited, to devices to assist

in standing, ambulating, or positioning parts of the body to improve or maintain function, or to prevent the development of conditions that may result from inadequate support or positioning of the individual's anatomy.

M. With respect to the WCM program, CalOptima and the **Health Networks** shall ensure compliance with all current and applicable:

1. State and federal laws and regulations, as well as contractual requirements;

2. California Department of Health Care Services (DHCS) guidance, including All Plan Letter 18-023: California Children's Services Whole Child Model;

3. CCS programs guidelines, including CCS program regulations, regulations related to WCM program. CCS Numbered Letters, and CCS program information notices, in developing criteria for use by their respective chief medical officer or the equivalent and any other care management staff.

a. When applicable CCS clinical guidelines to not exist, CalOptima and the **Health Networks** shall use evidence-based guidelines or treatment protocols that are medically appropriate given the **Member's CCS-eligible condition**.

b. Any CCS Numbered Letters that fall within the Index Category of Authorizations/Benefits, as identified by DHCS, are applicable to CalOptima and the **Health Networks**. For these applicable CCS Numbered Letters, including those referenced in Section V. of this Policy, CalOptima and the **Health Network** shall assume the role of the county or state CCS program as described in the CCS Numbered Letters.

III. PROCEDURE

A. A **Practitioner** shall identify a **Member** who has a **Medical Necessity** for **DME** and issue a written prescription to the **Member** for the purchase, rental, repair, or maintenance of the **DME**. Such prescription shall include:

1. Full name, address, telephone number, and signature of the prescribing **PCP**, or **Provider**;

2. Date of prescription;

3. Specific item(s) prescribed;

4. Estimated length of time the **DME** is determined to be **Medically Necessary**; and

5. **Member's** medical condition or diagnosis necessitating the **DME**, including:

a. **Member's** medical status and functional limitation(s); and

b. Description of how the requested **DME** is expected to improve the medical status or functional ability of the **Member**, stabilize the **Member's** medical condition, or prevent additional deterioration of the **Member's** medical status or functional ability.

B. A **Practitioner** shall obtain authorization to provide **DME** to a **Member** by submitting a request form with a copy of the signed and dated prescription to the CalOptima Utilization Management (UM) Department, or a **Health Network**.

1. For a **CalOptima Direct** or **CalOptima Community Network (CCN) Member**, the **Practitioner** shall submit a CalOptima Authorization Request Form (ARF), in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

2. For a **Health Network Member**, the **Practitioner** shall follow the **Health Network's** authorization procedures.

3. A **Practitioner** shall include the following information, at a minimum, in the authorization request for **DME** submitted to CalOptima, or a **Health Network**:

    a. Date of request;

    b. **Member's** name, appropriate health care identification, or, and address;

    c. Medical justification for the requested **DME**;

    d. Description of the **DME**, including:

        i. Manufacturer name, model type or serial number, and purchase price;

        ii. Product description;

        iii. Monthly rental charge, if applicable, and whether it may be applied toward the purchase of the **DME**;

        iv. Billing and procedure codes; and

        v. Estimated length of need, whether rental or purchase is requested, and associated charges.

    e. **DME Provider's** name, address, telephone number, contact name and telephone number, and National Provider Identification (NPI) number; and

    f. Copy of prescription containing the information required as set forth in Section III.A. of this Policy.

4. For unlisted **DME** requests, a **Provider** shall provide the documentation as set forth in Section III.B.3. of this Policy and copies of catalog pages and medical justification to substantiate the reason(s) a listed item is insufficient to meet the **Member's** medical needs.

C. CalOptima or a **Health Network** shall review the authorization request submitted by a **Member's Provider**. If the authorization request is incomplete, CalOptima, or a **Health Network**, shall require the **PCP**, or **Provider**, to provide additional information.

D. A **Member** may appeal a CalOptima or **Health Network** decision to a requested service in accordance with CalOptima Policies GG.1510: Appeal Process for Decisions Regarding Care and Services, MA.9003: Standard Service Appeal, and CMC.9003: Standard Appeal.

E. Medical Therapy Program - California Children's Services (CCS)/Whole Child Model Program (WCM) **Members**:

1. Effective no sooner than July 1, 2019, for Members eligible with the CCS Program who participate in the Orange County CCS Medical Therapy Program (MTP), the MTP shall submit all requests for **Specialized or Customized DME** and **Specialized or Customized DME** repairs with a total cost of over five hundred dollars ($500) to CalOptima. The request will include:

    a. Completed Custom DME Authorization Referral Form;

    b. Signed prescription/provider order for the requested **Specialized or Customized DME**;

        i. The provider order must be prescribed by a CCS-paneled physician who is approved to treat the child's **CCS eligible medical condition**, and who has examined the child within six (6) months.

        ii. If the recommending or prescribing physician is not a CCS-paneled physician approved to treat the child's **CCS eligible medical condition**, the request shall be reviewed by the CCS-approved paneled physician for concurrence prior to submission for authorization; and

    c. Vendor specifications that have been reviewed/confirmed by Medical Therapy Unit (MTU) therapist/supervisor.

2. CalOptima will review and triage these requests to CalOptima Utilization Management/Prior Authorization Department or the **Health Network** staff via secure communication for review and processing.

3. If a referral for **Specialized or Customized DME** or **Specialized or Customized DME** repair for a CCS-eligible Member is received by CalOptima or a **Health Network** directly from a vendor and not from the MTU, the request will be denied, and the **Member** referred to the MTU for evaluation.

4. If the **Member** requests **Specialized or Customized DME** or **Specialized or Customized DME** repair that the MTU does not recommend, the MTU will notify CalOptima who will issue or instruct the **Health Network** to issue the appropriate Notice of Action letter.

5. For **Specialized or Customized DME** or **Specialized or Customized DME** repairs that are covered and recommended by the MTU and are in accordance with the current and applicable CCS numbered letter, CalOptima or a **Health Network** will approve the request in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and CalOptima Policy GG.1508: Authorization and Processing of Referrals.

6. Following approval, CalOptima or a Health Network will notify the requesting provider, the Member's MTP and Specialized or Customized DME Provider within standard prior authorization turn around-time requirements for Specialized or Customized DME requests.

F. Effective July 1, 2019, for CCS-eligible Members who are not eligible with Orange County CCS MTP, **Specialized or Customized DME**-related requests will be processed by the **Member's Health Network** consistent with evidence-based medical necessity guidelines and current, applicable CCS numbered letters that define **medical necessity** criteria, except with regard to **Continuity of Care** as described in Section III.F. of this Policy

G. CalOptima or a **Health Network** shall provide **Continuity of Care** for a **Member** eligible with the CCS Program and transitioned into the WCM program with a **Specialized or Customized DME** provider for up to twelve (12) months, in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services. For **Specialized or Customized DME** under warranty, the **Continuity of Care** period may be extended to the duration of the warranty when deemed **Medically Necessary** by the treating provider.

IV. ATTACHMENT(S)

A. CalOptima Authorization Request Form (ARF)
B. ~~Medicare Physician Certification~~Certificate of Medical Necessity for All Durable Medical Equipment, Except Wheelchairs and Scooters

V. REFERENCES

A. CalOptima Contract for DME Services
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract for Health Care Services
E. CalOptima Health Network Service Agreement
F. CalOptima Policy CMC.9003: Standard Appeal
~~F.~~G. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~G.~~H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
I. CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services
J. CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices
~~H.~~K. CalOptima Policy GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair
L. CalOptima Policy MA.9003: Standard Appeal
M. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
N. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
~~I.~~O. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
P. CCS Numbered Letter 01-0111: Authorization of Insulin Infusion Pumps
Q. CCS Numbered Letter 02-0102: Pulse Oximeters
R. CCS Numbered Letter 02-0107: Authorization of Rental of Portable Home Ventilators Purpose
S. CCS Numbered Letter 02-0197: Authorization of Flutter Valves and ThAIRapy Vests
T. CCS Numbered Letter 09-0514: Powered Mobility Devices
U. CCS Numbered Letter 09-0703: Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R)
V. CCS Numbered Letter 10-0707: Revised Guidelines for Authorization of Oxygen, Oxygen Delivery Equipment, and Related Supplies
W. CCS Numbered Letter 14-0801: Synthesized Speech Augmentative Communication (SSAC) Devices (Formerly Known as Augmentative/Alternative Communication (AAC) Devices
X. CCS Numbered Letter 18-0605: Nationwide Recall of Vail Enclosed Bed Systems
Y. Department of Health Care Services All Plan Letter 18-023: California Children's Services Whole Child Model Program
~~J.~~Z. Department of Health Care Services Medi-Cal Allied Health Provider Manual Durable Medical Equipment (DME): An Overview
~~K.~~AA. Title 22, California Code of Regulations (C.C.R), §§51303, 51104, 51160, and 51321

~~L.~~BB. Title 42, Code of Federal Regulations (C.F.R), §414.202

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	01/01/2000	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal
Revised	03/01/2012	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal
Revised	11/01/2015	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	05/02/2019	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Activities of Daily Living (ADL)	Personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing.
Augmentation and Alternative Communication Device (AAC)	A set of tools and strategies that a Member uses to solve everyday communicative challenges, including but not limited to, speech, a shared glance, text, gestures, facial expressions, touch, sign language, symbols, pictures and speech-generating devices.
Automobile Orthopedic Positioning Device (AOPD)	A non-standard positioning device (car seat and/or harness/vest) for use in a motor vehicle. An AOPD is designed to hold a larger child (over 40 pounds or over 40 inches in length) who requires positioning options such as pads that assist in head and trunk positioning while being transported in a motor vehicle.
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9
California Children's Services Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima	For purposes of this policy, CalOptima means CalOptima Direct and CalOptima Community Network (CCN).
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: Enrollment in/Eligibility with CalOptima Direct.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.

Term	Definition
Covered Services	Medi-Cal: 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. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way agreement with the Department of Health Care Services and Centers for Medicare & Medicaid Services (CMS).
Disability	A physical or mental condition that limits a person's movements, senses, or activities.
Durable Medical Equipment	Any equipment that is prescribed by a licensed practitioner to meet the medical equipment needs of the patient that: (a) can withstand repeated use; (b) is used to serve a medical purpose; (c) is not useful to a Member in the absence of an illness, injury functional impairment, or congenital anomaly; and (d) is appropriate for use in or out of the Member's home.
Health Network	For purposes of this policy, a Health Network is a Physician Medical Group (PMG), 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.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	An enrollee/beneficiary of a CalOptima program.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.

Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182(b)(11).
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.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

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Policy #:	GG.1502
Title:	**Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2000
Revised Date:	05/02/2019
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the criteria and process for coverage of **Durable Medical Equipment (DME)** for a **Member**, excluding wheelchair rental, purchase, and repairs.

II. POLICY

A. CalOptima or a **Health Network** shall provide **DME** for a **Member** when **Medically Necessary**.

B. CalOptima or a **Health Network** shall define **Medically Necessary** as reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, **DME** prescribed for a **Member** may be a **Covered Service** when it is **Medically Necessary** to:

1. Preserve bodily functions essential to **Activities of Daily Living (ADL)** or to prevent significant physical disability; or

2. Improve the medical status or functional ability of a **Member** through the stabilization of the **Member's** condition or the prevention of additional deterioration of the **Member's** medical status, or functional ability.

C. The following items are not **Covered Services**:

1. Modification of automobiles or other highway motor vehicles, with the exception of **Automobile Orthopedic Positioning Devices (AOPDs)**, in accordance with CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices;

2. Alterations or improvements to real property, except when authorized for home dialysis services;

3. Books or other items of a primarily educational nature;

4. Air conditioners, air filters or heaters;

5. Food blenders;

6. Reading lamps or other lighting devices;

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7. Bicycles, tricycles, or exercise equipment, except as otherwise permitted in this Policy;

8. Television sets;

9. Orthopedic mattresses, recliners, rockers, seat lift chairs (for Medi-Cal only), or other furniture items;

10. Waterbeds;

11. Household items;

12. Items required solely for, educational, or vocational needs; and

13. Other items not generally used primarily for health care and which are regularly and primarily used by an individual who does not have a specific medical need for such item.

D. CalOptima or a **Health Network** shall not grant an authorization for **DME**, if a household or furniture item will adequately serve the **Member's** medical needs.

E. CalOptima or a **Health Network** shall limit authorization for **DME** to the lowest cost item that meets a **Member's** medical needs.

F. If a **Member** has a speech, language or hearing disorder, CalOptima, or a **Health Network**, shall authorize an Augmentation and Alternative Communication Device (AAC) for the **Member** when the following conditions are met:

1. A licensed speech and language pathologist conducts an assessment of the **Member's** medical need for AAC.

2. A physical or occupational therapist conducts an assessment of the **Member's** medical need for AAC if the **Member** has physical limitations which may impact his or her ability to use the AAC.

G. CalOptima or a **Health Network** will provide **Continuity of Care** with a **Specialized or Customized Durable Medical Equipment (DME)** provider for up to twelve (12) months, in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services.

H. CalOptima or a **Health Network** may authorize the following **DME** for a **Member** who is an inpatient in a **Skilled Nursing Facility (SNF)** or **Intermediate Care Facility (ICF)**:

1. Equipment that is necessary for the continuous care and unusual medical needs of the **Member**. A **Member** may be considered to have unusual medical needs if a disease or medical condition is exacerbated by physical characteristics such as height, weight, and build. Physical characteristics, as such, shall not constitute an unusual medical condition.

2. Canes, crutches, wheelchair cushions, and walkers that are custom made or modified to meet the unusual medical needs of the **Member** and the need is expected to be permanent.

3. Suction and position pressure apparatuses that a **Member** will continuously use or must be immediately available to the **Member** for one (1) month or more.

I. CalOptima or a **Health Network** shall authorize **DME** for a **Member**, in accordance with the following provisions:

1. A **Practitioner** shall obtain prior authorization for the following:

   a. Purchase of **DME** when the total cost of items purchased within a **DME** category group exceeds five hundred dollars ($500) within one (1) calendar month;

   b. Repair or maintenance of **DME** when the total cost of the repair and maintenance of items within a **DME** category group exceeds five hundred dollars ($500) within one (1) calendar month. The cost of repairs shall not exceed the replacement value of the item being repaired;

   c. Rental of **DME** when the total cost of renting items within a **DME** category group exceeds five hundred dollars ($500) within a fifteen (15) month period. This includes any daily amount that an individual item, or combination of a similar group of items, exceeds the five hundred dollar ($500) threshold. The fifteen (15) month period begins on the date the first item is rented;

   d. Rental or purchase of an oxygen delivery system;

   e. Purchase, rental, repair, or maintenance of any unlisted devices or equipment, regardless of the dollar amount for any individual item or the total cost.

2. CalOptima or a **Health Network** may audit **DME** authorization requests for appropriateness and accuracy, as necessary.

J. A **Member** is responsible for the appropriate use and care of **DME** purchased for the **Member's** benefit.

K. A **DME** provider shall ensure that the **DME** provided to a **Member** is appropriate for the **Member's** medical needs. A **DME** provider shall, at no cost to CalOptima, or a **Health Network**, adjust, modify, or replace the **DME**, as necessary, when the **DME** provided does not:

1. Meet the **Member's** medical needs and the **Member's** medical condition has not changed since the date the **DME** was originally provided; or

2. Meet the **Member's** functional needs when in actual use.

K. CalOptima or a **Health Network** shall consider **DME** to be purchased when previously paid rental charges equal the maximum allowable purchase price of the rented **DME**. CalOptima, or the **Health Network**, shall provide no further reimbursement to the **DME** provider for the use of such **DME**, unless payment is for the subsequent repair and maintenance of the **DME**, as authorized by CalOptima, or the **Health Network**.

L. Effective no sooner than July 1, 2019, CalOptima or a **Health Network** shall be responsible for authorization and claims processing for the rental, purchase and repair of **Specialized or Customized DME** for Whole Child Model (WCM) **Members** whose custom **DME** is **Medically Necessary** to treat or ameliorate the effects of their **California Children's Services (CCS)-eligible Condition**. **Specialized or Customized DME** may include, but is not limited, to devices to assist in standing, ambulating, or positioning parts of the body to improve or maintain function, or to prevent the development of conditions that may result from inadequate support or positioning of the individual's anatomy.

M. With respect to the WCM program, CalOptima and the **Health Networks** shall ensure compliance with all current and applicable:

1. State and federal laws and regulations, as well as contractual requirements;

2. California Department of Health Care Services (DHCS) guidance, including All Plan Letter 18-023: California Children's Services Whole Child Model;

3. CCS programs guidelines, including CCS program regulations, regulations related to WCM program. CCS Numbered Letters, and CCS program information notices, in developing criteria for use by their respective chief medical officer or the equivalent and any other care management staff.

   a. When applicable CCS clinical guidelines to not exist, CalOptima and the **Health Networks** shall use evidence-based guidelines or treatment protocols that are medically appropriate given the **Member's CCS-eligible condition**.

   b. Any CCS Numbered Letters that fall within the Index Category of Authorizations/Benefits, as identified by DHCS, are applicable to CalOptima and the **Health Networks**. For these applicable CCS Numbered Letters, including those referenced in Section V. of this Policy, CalOptima and the **Health Network** shall assume the role of the county or state CCS program as described in the CCS Numbered Letters.

III. PROCEDURE

A. A **Practitioner** shall identify a **Member** who has a **Medical Necessity** for **DME** and issue a written prescription to the **Member** for the purchase, rental, repair, or maintenance of the **DME**. Such prescription shall include:

1. Full name, address, telephone number, and signature of the prescribing **PCP**, or **Provider**;

2. Date of prescription;

3. Specific item(s) prescribed;

4. Estimated length of time the **DME** is determined to be **Medically Necessary**; and

5. **Member's** medical condition or diagnosis necessitating the **DME**, including:

   a. **Member's** medical status and functional limitation(s); and

   b. Description of how the requested **DME** is expected to improve the medical status or functional ability of the **Member**, stabilize the **Member's** medical condition, or prevent additional deterioration of the **Member's** medical status or functional ability.

B. A **Practitioner** shall obtain authorization to provide **DME** to a **Member** by submitting a request form with a copy of the signed and dated prescription to the CalOptima Utilization Management (UM) Department, or a **Health Network**.

1. For a **CalOptima Direct** or **CalOptima Community Network (CCN) Member**, the **Practitioner** shall submit a CalOptima Authorization Request Form (ARF), in accordance with

CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

2. For a **Health Network Member**, the **Practitioner** shall follow the **Health Network's** authorization procedures.

3. A **Practitioner** shall include the following information, at a minimum, in the authorization request for **DME** submitted to CalOptima, or a **Health Network**:

   a. Date of request;

   b. **Member's** name, appropriate health care identification, or, and address;

   c. Medical justification for the requested **DME**;

   d. Description of the **DME**, including:

      i. Manufacturer name, model type or serial number, and purchase price;

      ii. Product description;

      iii. Monthly rental charge, if applicable, and whether it may be applied toward the purchase of the **DME**;

      iv. Billing and procedure codes; and

      v. Estimated length of need, whether rental or purchase is requested, and associated charges.

   e. **DME Provider's** name, address, telephone number, contact name and telephone number, and National Provider Identification (NPI) number; and

   f. Copy of prescription containing the information required as set forth in Section III.A. of this Policy.

4. For unlisted **DME** requests, a **Provider** shall provide the documentation as set forth in Section III.B.3. of this Policy and copies of catalog pages and medical justification to substantiate the reason(s) a listed item is insufficient to meet the **Member's** medical needs.

C. CalOptima or a **Health Network** shall review the authorization request submitted by a **Member's Provider**. If the authorization request is incomplete, CalOptima, or a **Health Network**, shall require the **PCP**, or **Provider**, to provide additional information.

D. A **Member** may appeal a CalOptima or **Health Network** decision to a requested service in accordance with CalOptima Policies GG.1510: Appeal Process for Decisions Regarding Care and Services, MA.9003: Standard Service Appeal, and CMC.9003: Standard Appeal.

E. Medical Therapy Program - California Children's Services (CCS)/Whole Child Model Program (WCM) **Members**:

1. Effective no sooner than July 1, 2019, for Members eligible with the CCS Program who participate in the Orange County CCS Medical Therapy Program (MTP), the MTP shall submit all requests for **Specialized or Customized DME** and **Specialized or Customized DME**

repairs with a total cost of over five hundred dollars ($500) to CalOptima. The request will include:

a. Completed Custom DME Authorization Referral Form;

b. Signed prescription/provider order for the requested **Specialized or Customized DME**;

i. The provider order must be prescribed by a CCS-paneled physician who is approved to treat the child's **CCS eligible medical condition**, and who has examined the child within six (6) months.

ii. If the recommending or prescribing physician is not a CCS-paneled physician approved to treat the child's **CCS eligible medical condition**, the request shall be reviewed by the CCS-approved paneled physician for concurrence prior to submission for authorization; and

c. Vendor specifications that have been reviewed/confirmed by Medical Therapy Unit (MTU) therapist/supervisor.

2. CalOptima will review and triage these requests to CalOptima Utilization Management/Prior Authorization Department or the **Health Network** staff via secure communication for review and processing.

3. If a referral for **Specialized or Customized DME** or **Specialized or Customized DME** repair for a CCS-eligible Member is received by CalOptima or a **Health Network** directly from a vendor and not from the MTU, the request will be denied, and the **Member** referred to the MTU for evaluation.

4. If the **Member** requests **Specialized or Customized DME** or **Specialized or Customized DME** repair that the MTU does not recommend, the MTU will notify CalOptima who will issue or instruct the **Health Network** to issue the appropriate Notice of Action letter.

5. For **Specialized or Customized DME** or **Specialized or Customized DME** repairs that are covered and recommended by the MTU and are in accordance with the current and applicable CCS numbered letter, CalOptima or a **Health Network** will approve the request in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and CalOptima Policy GG.1508: Authorization and Processing of Referrals.

6. Following approval, CalOptima or a Health Network will notify the requesting provider, the Member's MTP and Specialized or Customized DME Provider within standard prior authorization turn around-time requirements for Specialized or Customized DME requests.

F. Effective July 1, 2019, for CCS-eligible Members who are not eligible with Orange County CCS MTP, **Specialized or Customized DME**-related requests will be processed by the **Member's Health Network** consistent with evidence-based medical necessity guidelines and current, applicable CCS numbered letters that define **medical necessity** criteria, except with regard to **Continuity of Care** as described in Section III.F. of this Policy

G. CalOptima or a **Health Network** shall provide **Continuity of Care** for a **Member** eligible with the CCS Program and transitioned into the WCM program with a **Specialized or Customized DME** provider for up to twelve (12) months, in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services. For **Specialized or Customized DME**

under warranty, the **Continuity of Care** period may be extended to the duration of the warranty when deemed **Medically Necessary** by the treating provider.

IV. ATTACHMENT(S)

A. CalOptima Authorization Request Form (ARF)
B. Certificate of Medical Necessity for All Durable Medical Equipment, Except Wheelchairs and Scooters

V. REFERENCES

A. CalOptima Contract for DME Services
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract for Health Care Services
E. CalOptima Health Network Service Agreement
F. CalOptima Policy CMC.9003: Standard Appeal
G. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
I. CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services
J. CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices
K. CalOptima Policy GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair
L. CalOptima Policy MA.9003: Standard Appeal
M. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
N. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
O. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
P. CCS Numbered Letter 01-0111: Authorization of Insulin Infusion Pumps
Q. CCS Numbered Letter 02-0102: Pulse Oximeters
R. CCS Numbered Letter 02-0107: Authorization of Rental of Portable Home Ventilators Purpose
S. CCS Numbered Letter 02-0197: Authorization of Flutter Valves and ThAIRapy Vests
T. CCS Numbered Letter 09-0514: Powered Mobility Devices
U. CCS Numbered Letter 09-0703: Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R)
V. CCS Numbered Letter 10-0707: Revised Guidelines for Authorization of Oxygen, Oxygen Delivery Equipment, and Related Supplies
W. CCS Numbered Letter 14-0801: Synthesized Speech Augmentative Communication (SSAC) Devices (Formerly Known as Augmentative/Alternative Communication (AAC) Devices
X. CCS Numbered Letter 18-0605: Nationwide Recall of Vail Enclosed Bed Systems
Y. Department of Health Care Services All Plan Letter 18-023: California Children's Services Whole Child Model Program
Z. Department of Health Care Services Medi-Cal Allied Health Provider Manual Durable Medical Equipment (DME): An Overview
AA. Title 22, California Code of Regulations (C.C.R), §§51303, 51104, 51160, and 51321
BB. Title 42, Code of Federal Regulations (C.F.R), §414.202

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2000	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal
Revised	03/01/2012	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal
Revised	11/01/2015	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	05/02/2019	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Activities of Daily Living (ADL)	Personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing.
Augmentation and Alternative Communication Device (AAC)	A set of tools and strategies that a Member uses to solve everyday communicative challenges, including but not limited to, speech, a shared glance, text, gestures, facial expressions, touch, sign language, symbols, pictures and speech-generating devices.
Automobile Orthopedic Positioning Device (AOPD)	A non-standard positioning device (car seat and/or harness/vest) for use in a motor vehicle. An AOPD is designed to hold a larger child (over 40 pounds or over 40 inches in length) who requires positioning options such as pads that assist in head and trunk positioning while being transported in a motor vehicle.
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9
California Children's Services Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima	For purposes of this policy, CalOptima means CalOptima Direct and CalOptima Community Network (CCN).
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: Enrollment in/Eligibility with CalOptima Direct.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.

Term	Definition
Covered Services	Medi-Cal: 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. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way agreement with the Department of Health Care Services and Centers for Medicare & Medicaid Services (CMS).
Disability	A physical or mental condition that limits a person's movements, senses, or activities.
Durable Medical Equipment	Any equipment that is prescribed by a licensed practitioner to meet the medical equipment needs of the patient that: (a) can withstand repeated use; (b) is used to serve a medical purpose; (c) is not useful to a Member in the absence of an illness, injury functional impairment, or congenital anomaly; and (d) is appropriate for use in or out of the Member's home.
Health Network	For purposes of this policy, a Health Network is a Physician Medical Group (PMG), 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.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	An enrollee/beneficiary of a CalOptima program.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.

Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182(b)(11).
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.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

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CalOptima
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P.O. BOX 11033 ORANGE, CA 92856 Phone: (714) 246-8686

AUTHORIZATION REQUEST FORM (ARF)

☐ ROUTINE Fax to (714) 246-8579 ☐ RETRO Fax to (714) 246-8579

*** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE ***

PROVIDER: Authorization does not guarantee payment, ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ (Last) _____ (First) ☐ M ☐ F D.O.B. _____ Age: _____

Mailing Address: _____ City: _____ ZIP: _____ Phone: _____

Client Index # (CIN): _____ Name of ICF/SNF (if applicable): _____

Referring Provider:	Provider Rendering Service (Physician, Facility, Vendor):
Provider NPI#: _____ TIN#: _____ Medi-Cal ID#: _____	Provider NPI#: _____ TIN#: _____ Medi-Cal ID#: _____
Address: Phone: _____ Fax: _____	Address: Phone: _____ Fax: _____
Office Contact: _____ Physician's Signature: _____	Office Contact: _____
Diagnosis: _____	ICD-10: _____

AUTHORIZATION REQUEST

☐ URGENT REQUEST Fax to (714) 338-3137. ***Definition: "Urgent" is ONLY when normal time frame for authorization will be detrimental to patient's life or health, jeopardize patient's ability to regain maximum function, or result in loss of life, limb or other major bodily function. Urgent requests are addressed within 72 hours.***

☐ Inpatient Facility ☐ Outpatient Facility ☐ SNF Estimated Length of Stay: _____

Date(s) of Services: _____ Retro Date(s) of Service: _____

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

DO NOT WRITE BELOW THIS LINE FOR CalOptima USE ONLY

STATUS		Authorization Number #:
☐ Approved	☐ Alternative Treatment	Signature: Date:
☐ Not a Covered Benefit	☐ Modified	Comments:
☐ Not Medically Indicated	Affiliated Health Plan:	Phone:

Revised 6/12/14

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CERTIFICATE OF MEDICAL NECESSITY
FOR ALL DURABLE MEDICAL EQUIPMENT (DME)
(EXCEPT WHEELCHAIRS AND SCOOTERS)

The provider must complete all applicable areas not completed by the clinician or therapist.

Dear Clinician/DME Provider: Cooperation in completing this form will ensure that the beneficiary receives full Medi-Cal consideration regarding the request for Durable Medical Equipment. Medi-Cal reimbursement is based on the least expensive medically appropriate equipment that meets the patient's medical need.

Incomplete information will result in a deferral, denial or delay in payment of the claim.

REQUIRES THE ATTENDING CLINICIAN TO COMPLETE AND SIGN

SECTION 1—Clinician's Information:

Clinician Name *(Print)* Last	First	Phone Number ( )	License Number

Address Street	City	State	ZIP

Clinician's description of the patient's current functional status and need for the requested equipment: _____

SECTION 2—Patient's Information: New Rx ***(For Rx Renewal, please also complete 2A below)***

Patient Name *(Print)* Last	First	Phone Number ( )	Date of Birth mm / dd / yy	Medi-Cal Number

Address Street	City	State	ZIP

Date of last face-to-face visit with the beneficiary: _____

Is this beneficiary expected to be institutionalized within the next 10 months? Yes ❒ ❒No Explain ''Yes'' answer: _____

Equipment required for:

❒ Less than 10 months *(code the TAR for a rental)*

❒ More than 10 months *(code the TAR for a purchase)*

SECTION 2A—For Renewal:

Verification of continued medical necessity and continued usage by the beneficiary must be done at each TAR renewal.

SECTION 3—Equipment Requested:

a) _____

b) STANDARD: _____ BARIATRIC: _____

c) Replacing existing equiment? Yes ❒ ❒No If yes, explain why: _____

d) Attach repair estimate if replacement with similar equipment is requested.

e) Other DME the beneficiary has: _____

f) How many hours per day of usage? _____

g) Accessories requested and why:

_____

h) Custom features requested and why: _____

i) Other equipment currently in the home: Cane ❒ Walker ❒ Crutches ❒ Prosthesis ❒ Manual Wheelchair ❒

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Patient currently using the following equipment: _____

k) When/How often: _____

State specific reason for accessories requested: _____

_____

Power Wheelchair ❒ Hospital Bed ❒ Oxygen ❒ POV (scooter) ❒ Other: j)

l)

DHCS 6181 (08/09)

SECTION 4—Diagnosis Information

Diagnoses: Date of onset:

Prognosis: _____ _____

_____

SECTION 5—Pertinent History:

_____

_____

SECTION 6—Functional Status:

Beneficiary's height: _____ Beneficiary's weight: _____

a) Ambulation: Independent ❒ Walker/Cane ❒ Assisted ❒ Unassisted❒ Unable ❒ Bed confined ❒

Recent fall(s) ❒ Dizziness/Vertigo ❒ Incoordination❒ Ataxia ❒ Severe shortness of breath ❒

b) Transfer: Self ❒ Self, but with great dificulty ❒ Self with a transfer device ❒

Stand by assistant ❒ With assistance ❒ Mechanical or person lift ❒

c) Pertinent physical findings: Edema (location):

Pressure sore(s), state and location: Amputee ❒ Cast ❒ Ataxia ❒

Paralysis/weakness (location): _____ Sitting Posture/Deformity: _____

Cognitive status: _____ Vision: Impaired ❒ Normal ❒

Contractures:

SECTION 7—Living Environment:

House/condominium ❒ Apartment ❒ Stairs ❒ Elevator ❒ Ramp ❒ Hills ❒ SNF ❒ ICF/DD ❒ B&C ❒

Other:

_____

Living Assistance: Lives alone ❒ With other person(s) ❒ Alone most of the day ❒ Alone at night ❒ Attendant care:

Live in attendant ❒ or _____ Hours/day Homemaker ❒ Hours _____

Transportation:

SECTION 8—Hospital Bed:

Document that this beneficiary requires positioning not feasible in an ordinary bed:

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Is frequent repositioning required throughout the night? Yes ❒ ❒No
Can the beneficiary or caretaker use a ‘‘manual’’ bed? Yes ❒ ❒No
If no, explain why:

Is frequent repositioning required throughout the day? Yes ❒ ❒No
Explain:

For any anti-decubitus bed, please attach to the TAR, photos and explanation of previous therapies attempted, the nutritional status, and the latest hemoglobin and hematocrit of the beneficiary.

SECTION 9—DME provider/Therapist attestation and signature/date:

By my signature below, I certify to the best of my knowledge that the information contained in this Certificate of Medical Necessity is true, accurate and complete and I understand that any falsification, omission or concealment may subject me to criminal liability under the laws of the State of California.

Name of therapist answering these sections, if other than prescribing clinician or DME provider (please print):

Name: _____ Title: _____ DME Provider Name: _____
(Please print) *(OT, PT, RESNA, etc.)*

Date: *(Please print)*

(Use Ink - A signature stamp is not acceptable) *(Use Ink - A signature stamp is not acceptable)*

SECTION 10—Clinician attestation and signature/date:

I certify that I am the clinician identified in this document. I have reviewed this Certificate of Medical Necessity and I certify to the best of my knowledge that the medical information is true, accurate, current and complete, and I understand that any falsification, omission, or concealment may subject me to criminal liability under the laws of the State of California.

Clinician’s Signature:

_____ Date: _____
(Use Ink - A signature stamp is not acceptable)

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Policy #:	GG.1325
Title:	**Continuity of Care for Members Transitioning into CalOptima Services**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader
Effective Date:	01/01/15
Review Date:	10/04/18
Revised Date:	10/04/18

I. PURPOSE

This policy establishes the Continuity of Care guidelines and the process to identify Members who have expedited care needs for newly enrolled Medi-Cal Members who transition into CalOptima or existing Members whose Covered Services are transitioned from Medi-Cal Fee-for-Service (FFS) to CalOptima.

II. POLICY

A. Effective July 1, 2017, CalOptima shall screen all new Members for the need for expedited services upon their enrollment into CalOptima as described in Section III.B. of this Policy.

B. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with this Policy, CalOptima or a Health Network shall ensure Continuity of Care for a Medi-Cal beneficiary transitioning from Medi-Cal FFS, another Medi-Cal Managed Care Plan, or existing Members whose Covered Services are transitioned from Medi-Cal FFS to CalOptima, with his or her Existing Out-of-Network Provider for a period of no more than twelve (12) months, unless otherwise provided in Section III.C. of this Policy, if the following criteria are met:

1. A Member has an existing relationship with one (1) of the following. There is an existing relationship with:

   a. An out-of-network Primary Care Practitioner (PCP) or Specialty Care Provider if the Member has seen the out-of-network PCP, or Specialty Care Provider for a non-emergency visit at least once during the twelve (12) months prior to the date of enrollment in CalOptima;

   b. An out-of-network Behavioral Health Treatment (BHT) Service Provider if the Member has seen the out-of-network BHT Service Provider for a non-emergency visit at least once during the six (6) months prior to either the transition of services from the Regional Center of Orange County (RCOC) to CalOptima or the date of the Member's initial enrollment in CalOptima if the enrollment occurred on or after July 1, 2018;

   b. An out-of-network nursing facility if the Member has resided in the out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima; and

   c. A County Mental Health Plan Provider for non-specialty mental health services in instances where a Member's mental health condition has stabilized such that the Member no longer

qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima.

2. The Existing Out-of-Network Provider will accept CalOptima, or Medi-Cal FFS rates, whichever is higher;

3. The Existing Out-of-Network Provider meets applicable professional standards and has no disqualifying quality of care issues;

4. The Existing Out-of-Network Provider has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS;

5. The Existing Out-of-Network Provider is a California State Plan-approved provider;

6. The Existing Out-of-Network Provider supplies CalOptima with all relevant assessment, diagnosis, and treatment information, for the purposes of determining Medical Necessity, as well as a current treatment plan as allowed under federal and state privacy laws and regulations; and

7. The Member, Authorized Representative of the Member, or the Existing Out-of-Network Provider requests Continuity of Care. For a Member residing in an out-of-network nursing facility prior to enrollment in CalOptima or receiving BHT services at RCOC, Continuity of Care is guaranteed and need not be requested.

D. CalOptima or a Health Network shall provide Continuity of Care for a Member as described in this Policy, except for the following types of providers:

1. Durable Medical Equipment (DME), excluding Specialized or Customized DME for Members eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program as described in Section III.O.8.b.i. of this Policy;

2. Transportation; and

3. Other ancillary services.

E. CalOptima and Health Networks are also required to comply with existing state law Continuity of Care obligations which may allow a Medi-Cal beneficiary a longer period of treatment by an out-of-network provider than would be required under DHCS All Plan Letter 18-008 (Revised).: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.

F. CalOptima or a Health Network shall not provide Continuity of Care for:

1. Services not covered by Medi-Cal; and

2. Services carved-out of CalOptima's contract with the Department of Health Care Services (DHCS).

G. If a Member changes Medi-Cal Managed Care Plans (MCP), the twelve (12) month Continuity of Care period may start over one (1) time. If a Member changes MCPs a second time (or more), the

Continuity of Care period does not start over, meaning that the Member does not have the right to a new twelve (12) months of Continuity of Care. If a beneficiary changes MCPs, this Continuity of Care Policy does not extend to providers that the beneficiary accessed through their previous MCP. If the Member returns to Medi-Cal FFS and later reenrolls in CalOptima, the Continuity of Care period does not start over, but may be completed only if the Member:

1. Returned to FFS for less than the twelve (12) month Continuity of Care period; and

2. Was eligible for and elected to receive Continuity of Care during the previous CalOptima enrollment period.

H. An approved Existing Out-of-Network Provider must work with CalOptima and its contracted network and cannot refer the Member to another out-of-network provider without prior authorization from CalOptima or a Health Network.

I. CalOptima shall inform Members of the Continuity of Care protections and how to initiate a Continuity of Care request in written Member materials, including but not limited to, the Member Handbook, available by request and on the CalOptima website at www.caloptima.org, and Member newsletter.

J. CalOptima or a Health Network shall provide training to call center staff who come into regular contact with Members about the Continuity of Care protections.

III. PROCEDURE

A. CalOptima shall include a health information form in each New Member Welcome Packet mailing with a postage paid envelope.

1. If the Member does not respond to the mailed health information form, CalOptima shall make two (2) call attempts within ninety (90) calendar days to remind the Member to complete the form.

B. CalOptima shall conduct an initial screening of all responses received within ninety (90) calendar days of the Members' effective date(s) of enrollment.

1. Additional outreach and care coordination activities may occur in accordance with CalOptima Policies GG.1301: Comprehensive Case Management Process and GG.1209: Population –Based Care: Disease Management.

2. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with the requirements of this Policy, CalOptima or a Health Network shall provide the completion of Covered Services by an out-of-network nursing facility, PCP, or Specialty Care Provider when the Member presents with any of the following:

1. An Acute Condition: For the duration of treatment of the acute condition;

2. A serious Chronic Health Condition: Up to twelve (12) months;

3. Pregnancy: For the duration of the pregnancy;

4. Terminal Illness: For the duration of the terminal illness, which may exceed twelve (12) months;

5. Care of a newborn child between birth and thirty-six (36) months: Up to twelve (12) months;

6. Surgery that is part of a documented course of treatment and has been recommended and documented by the out-of-network PCP, or Specialty Care Provider, to occur within one hundred-eighty (180) calendar days of the effective date of coverage for a new Member; or

7. Residing in an out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima: Up to twelve (12) months.

D. CalOptima or a Health Network shall accept requests for Continuity of Care over the telephone, by facsimile, or by mail, according to the requestor's preference, from the following sources:

1. Member;

2. Authorized Representative of the Member; or

3. Provider.

E. Upon receiving a request for Continuity of Care, CalOptima's Customer Service Department shall initiate the following actions, as appropriate:

1. Assist the Member with requests to change the Member's Health Network and PCP, if the Member is requesting a PCP outside of his or her current Health Network and the PCP is contracted with another Health Network.

2. Establish the existence of an ongoing relationship with the requested provider.

a. CalOptima shall utilize FFS data provided by DHCS, or utilization data from another Medi-Cal program administrator such as another Medi-Cal Managed Care Plan, if available.

b. If CalOptima does not receive FFS data from DHCS, or if the data does not support a pre-existing relationship, and the Member has seen a provider in accordance with the criteria included in Section II.C.1. of this Policy, a provider shall submit a signed attestation to CalOptima that confirms the provider saw the Member for a medical visit within the qualifying period stated in Section II.C.1., and include the last date upon which services were provided .

i. A self-attestation from a Member is insufficient to provide proof of a relationship with a provider.

c. The Continuity of Care process shall begin when CalOptima or the Health Network begin the process to determine if the Member has a pre-existing relationship with the provider.

d. If DHCS has notified CalOptima of a Provider suspension, termination, or decertification, CalOptima, or a Health Network, shall not approve the Continuity of Care request.

3. Refer the Member to his or her Health Network for a request to change the Member's PCP within the Member's Health Network. The Health Network shall process this request pursuant to this Policy.

4. Refer the Member to the CalOptima Behavioral Health Line for Behavioral Health Treatment (BHT) and outpatient mental health services.

5. Refer the case to CalOptima's Case Management Department for access to care issues.

F. For access to care issues, CalOptima's Case Management and Customer Service Departments shall work with one another and the Member's Health Network to outreach and connect the Member with his or her requested PCP, Specialty Care Provider, or other healthcare provider, in accordance with this Policy.

G. If the PCP, Specialty Care Provider or other provider specified in this Policy is an out-of-network provider, CalOptima or the Health Network shall make a good faith effort to enter into a contract, letter of agreement (LOA), or single-case agreement, to establish a Continuity of Care relationship for the Member. Upon the execution of a Continuity of Care agreement, CalOptima or a Health Network shall establish a Member care plan with the Existing Out-of-Network Provider.

H. CalOptima or a Health Network shall accommodate all requests they receive directly from Members who wish to be reassigned Existing Out-of-Network Provider in accordance with this Policy.

I. CalOptima or a Health Network shall initiate the review process within five (5) working days after receiving the Continuity of Care request.

J. CalOptima or a Health Network shall complete the Continuity of Care request review process within the following timelines:

1. Thirty (30) calendar days from the date of request;

2. Fifteen (15) calendar days if the Member's medical condition requires more immediate attention, such as there are upcoming appointments, or other pressing care needs; or

3. Three (3) calendar days if there is risk of harm to the Member. For purposes of this policy, risk of harm means an imminent and serious threat to the health of the Member.

K. CalOptima or a Health Network shall notify the Member of the following, in writing, and within seven (7) calendar days of the completion of a Continuity of Care request:

1. The outcome of the request (approval or denial) sent to the Member by U.S. Mail;

2. The duration of the Continuity of Care arrangement, if approved;

a. For any Continuity of Care response for which a provider is only willing to continue providing services for less than twelve (12) months, CalOptima or a Health Network shall allow the Member to have access to that provider for the shorter period of time.

3. The process that will occur to transition the Member at the end of the Continuity of Care period, if approved; and

4. The Member's right to choose a different provider from CalOptima's provider network.

5. If CalOptima and the Existing Out-of-Network Provider are unable to reach an agreement on the rate, or CalOptima has documented quality of care issues with the provider, CalOptima will offer the Member an in-network alternative. If the Member does not make a choice, the Member will be assigned to an in-network provider.

6. If the Member does not agree with the result of the Continuity of Care process, he or she retains the right to pursue a grievance, in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint.

L. Thirty (30) calendar days prior to the end of the Continuity of Care period, CalOptima or a Health Network shall notify, in writing via U.S. Mail, the Member and the Existing Out-of-Network Provider of the transition of the Member's care to an in-network provider to ensure continuity of services through the transition to a new provider, except as provided in Section III.O.8.b.iv. for Members in the WCM program.

M. CalOptima or a Health Network shall accept and approve retroactive requests for Continuity of Care, subject to the provisions of this Policy and that:

1. Occurred after the Member's enrollment into CalOptima;

2. Have dates of service(s) that occur after December 29, 2014;

3. Have dates of service(s) within thirty (30) calendar days of the first date of service for which the Existing Out-of-Network Provider requested Continuity of Care retroactive reimbursement; and

4. Are submitted within thirty (30) calendar days of the first service for which retroactive Continuity of Care is requested.

N. The Continuity of Care request shall be considered complete when:

1. The Member is informed of the outcome of the request;

2. CalOptima or a Health Network and the provider are unable to agree to a rate;

3. CalOptima or a Health Network has documented quality of care issues with the provider; or

4. CalOptima or a Health Network has made a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days.

O. Other Continuity of Care Requirements

1. Former Covered California Enrollees

a. CalOptima shall outreach to all former Covered California enrollees within fifteen (15) calendar days of their enrollment into CalOptima to inquire if the Member has upcoming

appointments, or scheduled treatments. CalOptima shall assist the Member in making a Continuity of Care request at that time, as appropriate.

b. CalOptima or a Health Network shall honor any active prior treatment authorizations for a former Covered California Member for up to sixty (60) calendar days, or until a new assessment is completed by a CalOptima contracted provider or a Health Network.

c. CalOptima or a Health Network shall offer up to twelve (12) months of Continuity of Care with out-of-network PCP, or Specialty Care Providers, in accordance with Section II.C. of this Policy.

d. CalOptima or a Health Network shall provide Continuity of Care for pregnant and post-partum Members and newborn children who transition from Covered CA with terminated or out-of-network providers in accordance with Health & Safety Code Section 1373.96 and Section III.C. of this Policy.

2. Seniors and Persons with Disabilities

a. CalOptima or a Health Network shall honor, without request by the Member or the Member's out-of-network PCP or Specialty Care Providers, any active FFS Treatment Authorization Request (TAR) for a newly enrolled Seniors and Persons with Disabilities (SPDs) Member for sixty (60) calendar days from enrollment, or until a new assessment is completed by a CalOptima contracted provider to the extent FFS TAR data is available from DHCS.

i. CalOptima or a Health Network shall provide continued access for newly enrolled SPD Members for up to twelve (12) months in accordance with the Policy.

b. CalOptima shall further identify an SPD Member's health care needs by conducting a Health Risk Assessment in accordance with CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment.

3. Members Under Twenty-One Years of Age Receiving BHT Services

a. CalOptima shall provide continued access to an out-of-network BHT Service Provider in accordance with Section II.C. of this Policy for up to twelve (12) months beginning on the date of the Member's enrollment in CalOptima, provided the Member has an existing relationship with the provider as defined in this Policy.

b. Retroactive requests for BHT service continuity of care reimbursement are limited to services provided after a Member's transition date into CalOptima, or the date of the Member's enrollment into CalOptima, if enrollment date occurred after the transition.

4. Children Receiving BHT Services at the RCOC

a. For a Member receiving BHT services at RCOC Continuity of Care need not be requested and shall be automatic.

b. CalOptima shall provide continued access to BHT services for a Member who transitions from RCOC to CalOptima for BHT services.

c. If a Member is receiving BHT services from a non-contracted BHT Service Provider, CalOptima shall utilize diagnosis, utilization information, and assessment data provided by RCOC, or DHCS, to proactively identify the current BHT Service Provider(s). If the data indicates that the Member has multiple BHT Service Providers, CalOptima shall contact the Member's parent(s) or guardian be telephone, letter, or other resource and make a good faith effort to obtain information that will assist in offering Continuity of Care. Once a preferred current provider has been identified, CalOptima shall proactively contact such BHT Service Provider(s) to begin the Continuity of Care process.

d. CalOptima shall make a good faith effort to enter into a Continuity of Care agreement with a Member's existing BHT Service Provider prior to the transition of the Member. CalOptima shall ensure Continuity of Care for a period of no more than twelve (12) months from the date of the Member's transition, if the criteria as described in Section II.C. of the Policy are met.

e. If CalOptima and the Member's existing BHT Service Provider(s) are unable to reach a Continuity of Care agreement, CalOptima shall contact the Member's parent(s), or guardian, to transition to an in-network BHT Provider through a warm hand off transfer to ensure there are no gaps in access to services. CalOptima shall ensure BHT services continue at the same level until a comprehensive diagnostic evaluation (CDE) and assessment, as appropriate, is conducted and a treatment plan established.

5. Pregnant and Post-Partum Members

a. CalOptima or a Health Network shall provide continued access to out-of-network providers in accordance with Section II.C. of this Policy for up to twelve (12) months.

6. Nursing Facility Services

a. CalOptima or a Health Network shall offer a Member residing in an out-of-network skilled nursing facility (SNF) when the Member transitioned into CalOptima the opportunity to return to the out-of-network SNF after a Medically Necessary absence, such as a hospital admission, for the duration of the Coordinated Care Initiative (CCI). CalOptima, or a Health Network, is not required to honor a request to return to an out-of-network SNF if the Member is discharged from the SNF into the community, or a lower level of care.

b. CalOptima or a Health Network shall maintain Continuity of Care by recognizing any TARs made by DHCS for Nursing Facility (NF) services that were in effect when a Member enrolled into CalOptima to the extent DHCS provides FFS TAR data to CalOptima. CalOptima or a Health Network shall honor such TARs for twelve (12) months, or for the duration of the treatment authorization if the remaining authorized duration is less than twelve (12) months, following the enrollment of the Member into CalOptima.

c. CalOptima or a Health Network shall not require a Member who is a resident of an NF prior to enrollment in CalOptima to change NFs during the duration of the CCI if the facility is licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and CalOptima agree to Medi-Cal rates.

7. Non-Specialty Mental Health Services

a. CalOptima shall provide continuity of care with an out-of-network Specialty Mental Health provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima. In this situation, the Continuity of Care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services, referred to in the State Plan as "Psychology."

b. CalOptima shall allow, at the request of the Member, the Member's Specialty Mental Health provider, or the Member's Authorized Representative, up to twelve (12) months Continuity of Care with the out-of-network County Mental Health Plan provider in accordance with the requirements of this Policy.

c. After the Continuity of Care period ends, the Member must choose a mental health provider in CalOptima's network for non-specialty mental health services. If the Member later requires additional SMHS from the County Mental Health Plan to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to CalOptima for non-specialty mental health services, the twelve (12)-month Continuity of Care period may start over one (1) time. If the Member requires SMHS from the County Mental Health Plan subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the Member returns to CalOptima or changes MCPs (i.e., the Member does not have the right to a new twelve (12) months of Continuity of Care).

8. Whole Child Model (WCM) Program

a. Effective January 1, 2019, CalOptima or a Health Network shall provide Continuity of Care for a Member eligible with the California Children's Services (CCS) Program and transitioned into the WCM program with the eligible Member's existing CCS provider for up to twelve (12) months in accordance with Section II.C.1. of this Policy.

b. For Members eligible with the CCS Program and transitioned into the WCM program, CalOptima or a Health Network shall also provide Continuity of Care for the following:

i. Specialized or Customized DME

a) If an eligible Member has an established relationship with a Specialized or Customized DME provider, CalOptima or a Health Network must provide access to that Specialized or Customized DME provider for up to twelve (12) months.

b) CalOptima or a Health Network shall pay the Specialized or Customized DME provider at rates that are at least equal to the applicable CCS FFS rates, unless the Specialized or Customized DME provider and CalOptima or Health Network enter into an agreement on an alternative payment methodology that is mutually agreed upon.

c) CalOptima or a Health Network may extend the Continuity of Care period beyond twelve (12) months for Specialized or Customized DME still under warranty and deemed Medically Necessary by the treating provider.

ii. Case Management

a) An eligible Member shall have the opportunity to request, within the first ninety (90) calendar days of the transition, to continue to receive case management from their existing CCS Public Health Nurse in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program.

iii. Authorized Prescription Drugs

a) An eligible Member shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy for the Member's CCS-Eligible Condition or conditions immediately prior to the date of transition of responsibility for the Member's CCS services to CalOptima in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process.

iv. Appealing Continuity of Care Limitations

a) CalOptima or a Health Network must provide an eligible Member with information regarding the WCM appeal process for Continuity of Care limitations, in writing, sixty (60) calendar days prior to the end of their authorized Continuity of Care period. The notice must explain the Member's right to petition CalOptima or a Health Network for an extension of the Continuity of Care period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition. The appeals process notice must include the following information:

1) The eligible Member must first appeal a Continuity of Care decision with CalOptima in accordance with CalOptima Policy GG.1510: Appeals Process Regarding Care and Services; and

2) A eligible Member, the Member's family or designated caregiver of the eligible Member may appeal the Continuity of Care limitation to the Department of Health Care Services (DHCS) director or his or her designee after exhausting CalOptima's appeal process.

P. Health Networks shall report all requests and outcomes from former Medi-Cal FFS and former Covered California enrollees asking to remain with their PCPs, or Specialty Care Providers, to CalOptima's Health Network Relations Department in a format and at a frequency prescribed by CalOptima.

Q. CalOptima's Customer Service and Case Management Departments shall compile and maintain a log of Continuity of Care requests and outcomes made directly to CalOptima.

R. CalOptima's Customer Service, Health Network Relations, and Case Management Departments shall submit their Continuity of Care reports to CalOptima's Regulatory Affairs & Compliance Department. The Regulatory Affairs & Compliance Department shall submit the data to DHCS, in a manner and with a frequency prescribed by DHCS.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1401: Pharmacy Authorization Process
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy HH.1102: CalOptima Member Complaint
E. CalOptima Policy GG.1301: Comprehensive Case Management
F. CalOptima Policy GG.1209: Population- Based Care: Disease Management
G. CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment
H. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
I. CalOptima Policy GG.1401: Pharmacy Authorization Process
J. CalOptima Policy GG.1510: Appeals Process Regarding Care and Services
K. California Health and Safety Code, §1374.73
L. California Health and Safety Code, §1373.96
M. California Welfare and Institutions Code §§ 14094.13(a)-(d), 14094.13(d)
N. Department of Health Care Services, All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
O. Department of Health Care Services, All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care (Revised)
P. Department of Health Care Services, All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

A. 10/18/18: Department of Health Care Services
B. 09/20/18: Department of Health Care Services
C. 06/26/18: Department of Health Care Services
D. 01/31/18: Department of Health Care Services
E. 07/11/17: Department of Health Care Services
F. 08/23/16: Department of Health Care Services
G. 05/15/15: Department of Health Care Services

VII. BOARD ACTION

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	07/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	09/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	04/01/2016	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	07/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	11/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	10/04/2018	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Acute Condition	A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Behavioral Health Treatment (BHT)	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and 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.
Behavioral Health Treatment (BHT) Service Provider	There are three (3) classifications: 1. Qualified Autism Services (QAS) Provider – A licensed practitioner or Board Certified Behavior Analyst (BCBA) 2. QAS Professional – A Behavior Management Consultant (BMC), BCBA, Behavior Management Assistant (BMA), or Behavior Analyst Associate (Board Certified Assistant Behavior Analyst) 3. QAS Paraprofessional – Minimum high school level with 40 hours of BHT training who is employed and supervised by a QAS provider.
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations Sections 41515.2 through 41518.9.
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Existing Out-of-Network Provider	For purposes of this Policy, an out-of-network nursing facility, Primary Care Practitioner (PCP), Specialty Care Provider, Behavioral Health Treatment (BHT) Service Provider, Specialized or Customized Durable Medical Equipment (DME), or Specialty Mental Health provider.
Health Risk Assessment	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.[1]

Term	Definition
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.
Medi-Cal Managed Care Plan	A health plan contracted with the Department of Health Care Services (DHCS) that provides Covered Services to Medi-Cal beneficiaries.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	A 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.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182(b)(11).
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Specialty Mental Health Services	Specialty Mental Health Services, which are the responsibility of the County Mental Health Plan, include the following: 1. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services. 2. Psychiatric inpatient hospital services. 3. Targeted Case Management. 4. Psychiatrist services. 5. Psychologist services. 6. EPSDT supplemental Specialty Mental Health Services.

Term	Definition
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one year or less.
Treatment Authorization Request (TAR)	The form a provider uses to request authorization from Medi-Cal Fee-for-Service. Authorization is granted by a designated Medi-Cal consultant obtained through submission and approval of a TAR.

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 23, 2018

ALL PLAN LETTER 18-023
SUPERSEDES ALL PLAN LETTER 18-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,[1] which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program. This APL supersedes APL 18-011.

BACKGROUND:
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[2] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[3, 4]

[1] CCS N.L.s can be found at: https://www.dhcs.ca.gov/services/ccs/pages/ccsnl.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[3] See Health and Safety Code (HSC) Section 123850(b)(1). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=HSC&tocTitle=+Health+and+Safety+Code+-+HSC
[4] See Welfare and Institutions Code (WIC) Section 14094.11. WIC is searchable at: https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC&tocTitle=+Welfare+and+Institutions+Code+-+WIC

MCPs will authorize care that is consistent with CCS program standards and provided by CCS-paneled providers, approved Special Care Centers (SCCs), and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as continuity of care (C.O.C.), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

MCP	COHS Counties
Phase 1 – Implemented July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – No sooner than January 1, 2019	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – No sooner than July 1, 2019	
CalOptima	Orange

POLICY:
Starting July 1, 2018, as designated above, MCPs assumed full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.[5] Independent CCS counties will maintain responsibility for CCS program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility

[5] A link to the Division of Responsibility chart can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage, with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP). WCM counties participating with the MTP will continue to receive a separate allocation for this program and are responsible for care coordination of MTP services.

MCPs are required to use all current and applicable CCS program guidelines in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. CCS program guidelines include CCS program regulations, additional forthcoming regulations related to the WCM program, CCS N.L.s, and county CCS program information notices. Any N.L.s. that fall within the following Index Categories, as identified by DHCS, are applicable to WCM MCPs:[6]

Index Category
Authorizations/Benefits
Case Management
Pharmaceutical
Standards, Hospital/Pediatric Intensive Care Unit/Neonatal Intensive Care Unit (NICU)

For these applicable N.L.s, the WCM MCP must assume the role of the county or state CCS program as described in the N.L. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations, as well as all contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures,

[6] See the WCM CCS N.L. Category List. is available at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-Index-Category-List-June2018.xls

and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP serves as the primary vehicle for ensuring collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP. The MOU must include, at a minimum, all of the provisions specified in the MOU template and must be consistent with the requirements of SB 586. MCPs are required to submit an executed MOU to DHCS 105 days prior to implementation. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS members into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization, including administrative functions, from the county CCS program to the MCPs.[8] The transition plan must also include communication with members regarding, but not limited to, authorizations, provider network, case management, and ensuring C.O.C. and services for members who are in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Inter-County Transfer

County CCS programs use the Children's Medical Services Net (CMS Net) system to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for C.O.C. of already approved service authorization requests, as required by this APL and applicable state and federal laws.

[7] See footnote 5. The MOU template can be found on the CCS WCM website.
[8] See footnote 4. WIC Section 14094.7(d)(4)(C).

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When a CCS-eligible member moves from one county to another, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data for members to the county CCS program office. The county CCS program will then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the county CCS program will provide transfer data to the MCP, as applicable.

D. Dispute Resolution and Provider Grievances

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[9] The county CCS program must communicate all resolved disputes in writing to the MCP. Disputes between the MCP and the county CCS program that are unable to be resolved will be referred by either entity to DHCS, via email to CCSRedesign@dhcs.ca.gov, for review and final determination.[10]

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[11] A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

A. Risk Level and Needs Assessment Process

The MCP must assess each CCS member's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include the development of a pediatric risk stratification process (PRSP) and an Individual Care Plan (ICP) for high risk members. All requirements are dependent on the member's risk level that is determined through the PRSP. Furthermore, nothing in this APL removes or limits existing survey or assessment requirements that the MCPs are responsible for outside of the WCM.

[9] See footnote 4. WIC Section 14093.06(b).
[10] Unresolved disputes must be referred to: CCSRedesign@dhcs.ca.gov
[11] See footnote 4. WIC Section 14094.15(d).

1. **Pediatric Risk Stratification Process**
   MCPs must develop a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the MCP to identify members who have more complex health care needs.

   MCPs are required to complete a risk stratification within 45 days of enrollment for all members including new CCS members enrolling in the MCP, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level through:

   - Review of medical utilization and claims processing data, including data received from the county and DHCS;
   - Utilization of existing member assessment or survey data; and
   - Telephonic or in-person communications, if available at time of PRSP.

   Members who do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
   MCPs must develop a process to assess a member's current health, including the CCS condition, to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS-paneled provider, as described below:

   <u>New Members and Newly CCS-Eligible Members Determined High Risk</u>
   Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by the MCP for the purposes of WCM is subject to review and approval by DHCS.

   <u>Risk Assessment</u>
   The risk assessment process must address:

   - General health status and recent health care utilization. This may include, but is not limited to, caretaker self-report of child's health; outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time;

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- Health history. This includes both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to identify the need for, or impact of, future health care services. These may include, but are not limited to, questions related to childhood developmental milestones, pediatric depression, anxiety or attention deficit screening, adolescent substance use, or adolescent sexual behaviors.

Individual Care Plan

MCPs are required to establish an ICP for all members determined to be high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment, by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

[12] See footnote 4. WIC Section 14094.11(b)(4).

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The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver. The ICP must indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may understand the goals, treatment plan, and course of care the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;
- Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams; and
- Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess members' risk levels and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

<u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination or upon a significant change to a member's condition.

[13] See footnote 4. WIC Section 14094.11(c).

WCM Transitioning Members

For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members, and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination, or upon a significant change to a member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless a member's risk level, all communications, whether by phone or mail, must inform the members and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and identify the method by which the providers will arrange for in-person assessments.[14]

MCPs must refer all members, including new members, newly CCS-eligible members, and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and must not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination[15]

MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs that delegate the provision of CCS services to subcontractors must ensure that all subcontractors provide case management and care coordination for members and allow members to access CCS-paneled providers within all of the MCP's subcontracted provider networks for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:

- Primary and preventive care services with specialty care services;
- Medical therapy units;

[14] See Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population APL 99-005. APLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[15] See footnote 4. WIC Section 14094.11(b)(1)-(6).

- EPSDT services, including palliative care;[16]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-Up Program**
   The High Risk Infant Follow-Up (HRIF) program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[17] MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide C.O.C. information to the members.

2. **Age-Out Planning Responsibility**
   MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the member's CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[18]

3. **Pediatric Provider Phase-Out Plan**
   A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the member. The MCPs must provide care coordination to CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

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[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 APL 18-007, or any superseding APL.
[17] HRIF Eligibility Criteria is available at:
https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[18] See footnote 4. WIC Section 14094.12(j).

C. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive C.O.C. with existing CCS provider(s) for up to 12 months.[19] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding C.O.C.[20] The C.O.C. requirements extend to MCP's subcontractors. The sections below include additional C.O.C. requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If the MCP member has an established relationship with a specialized or customized DME provider, MCPs must provide access to that provider for up to 12 months.[21] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the C.O.C. period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[22]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- Uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. Continuity of Care Case Management[23]

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing CCS-eligible members, their families, or designated caregivers, to request C.O.C. case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with an MCP case manager who has received adequate training on the county CCS

[19] See footnote 4. WIC Section 14094.13.
[20] See footnote 3. HSC Section 1373.96.
[21] See footnote 4. WIC Section 14094.12(f).
[22] See footnote 4. WIC Section 14094.13(b)(3).
[23] See footnote 4. WIC Section 14094.13(e), (f) and (g).

program and who has clinical experience with the CCS population or with pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services. The MCP must send a follow-up notice 30 days prior to the start of the transition. These notices must be submitted to DHCS for approval.

3. Authorized Prescription Drugs

CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed drug that is part of their therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[24]

4. Extension of Continuity of Care Period[25]

MCPs, at their discretion, may extend the C.O.C. period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the C.O.C. period informing members of their right to request a C.O.C. extension and the WCM appeal process for C.O.C. limitations.

The notification must be submitted to DHCS for approval and must include:

- The member's right to request that the MCP extend of the C.O.C. period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section D below).

Including the WCM C.O.C. protections set forth above, MCP members also have C.O.C. rights under current state law as required in the Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care APL 18-008, including any superseding APL.[26]

[24] See footnote 4. WIC Section 14094.13(d)(2).
[25] See footnote 3. HSC Section 1373.96.
[26] See footnote 14. APL 18-008.

D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal, and SFH rights as other MCP members. This will not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a C.O.C. period.[27] MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to Section 1557 of the Affordable Care Act.[28]

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended C.O.C. with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments APL 17-006, including any superseding APL.

If MCPs deny requests for extended C.O.C., they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, including any superseding APL, when denying extended C.O.C. requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

E. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[29]

MCPs must provide and authorize the CCS M&T benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary

[27] See footnote 4. WIC Section 14094.13(j).
[28] See footnote 14. For Section 1557 requirements, see Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act APL 17-011, including any superseding APL.
[29] See Non-Emergency Medical and Non-Medical Transportation Services APL 17-010, including any superseding APL.

costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810.[30] These services include, but are not limited to, M&T for out-of-county and out-of-state services.

MCPs must also comply with all requirements listed in the Non-Emergency Medical and Non-Medical Transportation Services APL 17-010 for CCS-eligible members to obtain NEMT and NMT for services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.[31]

F. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network, or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services. These out-of-network access requirements also apply to the MCP's subcontractor's provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition. If CCS-eligible members require services or treatments for a CCS condition that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

G. Advisory Committees

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information

[30] See footnote 1. CCS N.L. 03-0810.
[31] See footnote 14. APL 17-010.

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centers.[32] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[33] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[34]

III. WCM Payment Structure

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[35] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

The MCP will review authorizations and determine whether or not services meet CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-In Counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo	MCP	MCP	MCP

[32] See footnote 4. WIC Section 14094.7(d)(3).
[33] See footnote 4. WIC Section 14094.17(b)(2).
[34] See footnote 4. WIC Section 14094.17(a).
[35] See footnote 4. WIC Section 14094.16(b).

IV. MCP Responsibilities to DHCS

A. Network Certification[36]

MCPs and their subcontractors are required to meet specific network certification requirements in order to participate in WCM, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals, SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[37]

Subcontracted provider networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all subcontractors' provider networks to ensure network certification requirements for WCM are met.

In accordance with Network Certification Requirements APL 18-005, or any other superseding APL, WCM MCPs may request to add a subcontractor to their WCM network 105 days prior to the start of each contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[38] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[39] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[40]

MCPs are required to verify the credentials of all contracted CCS-paneled

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[36] See footnote 14. These requirements are further outlined in the Network Certification Requirements APL.
[37] See footnote 14. The WCM Provider Network Reporting Template is an attachment of APL 18-005.
[38] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[39] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[40] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and recredentialing guidelines contained in the Provider Credentialing/Recredentialing and Screening Enrollment APL 17-019, or any superseding APL. MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[41]

- Procedures for pre-authorization, concurrent review, and retrospective review;
- A list of services requiring prior authorization and the utilization review criteria;
- Procedures for the utilization review appeals process for providers and members;
- Procedures that specify timeframes for medical authorization; and
- Procedures to detect both under- and over-utilization of health care services.

MCP Reporting Requirements

1. Quality Performance Measures

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a format and manner specified by DHCS.

2. Reporting and Monitoring

DHCS has developed specific monitoring and oversight standards for MCPs participating in the WCM. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required

[41] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

data in a form and manner specified by DHCS and must comply with all contractual requirements.

D. Delegation of Authority

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in the Subcontractual Relationships and Delegation APL 17-004, or any superseding APL. If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to Agreement 16-93274 with the California Department of Health Care Services in Order to Continue Operation of the OneCare and OneCare Connect Programs

Contact

Silver Ho, Executive Director of Compliance, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment to Agreement 16-93274 between CalOptima and the California Department of Health Care Services (DHCS), in order to continue operation of the OneCare and OneCare Connect programs.

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 new five-year Primary and Secondary Agreements with DHCS that have been subsequently extended and amended. Amendments to these agreements are summarized in the attached appendix. Until 2016, the Primary Agreement included language that incorporated provisions related to Medicare Improvements for Patients and Providers Act (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs).

In 2016, DHCS extracted the MIPPA-compliant language from the Primary agreement and placed it in a standalone agreement, Agreement 16-93274. The Chairman of CalOptima's Board of Directors executed that agreement, an action that was ratified during the August 2016 meeting of the Board.

Subsequently, the Chairman of CalOptima's Board of Directors has executed two amendments to the agreement pursuant to Board authority. Agreement 16-93274 is set to terminate on December 31, 2019. The agreement contains no rates of payment.

Discussion

Amendment to Agreement 16-93274

On March 20, 2019, DHCS notified CalOptima of its intention to provide CalOptima with a forthcoming amendment to extend Agreement 16-93274 for an additional year, through December 31, 2020. CalOptima has requested that DHCS send the amendment to CalOptima as soon as possible, in order to allow for immediate signature by CalOptima and prompt return to DHCS for countersignature.

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The Centers for Medicare & Medicaid Services (CMS) requires that plans renewing their D-SNP programs must submit evidence of a MIPPA-compliant Medicaid contract for the 2020 contract year no later than July 1, 2019. Executing Amendment 03 (A-03) to Agreement 16-93274 is required in order for CalOptima to meet CMS's filing requirements, and to continue to operate CalOptima's D-SNP "OneCare" and its Cal MediConnect program "OneCare Connect" in contract year 2020.

The amendment is expected to contain no language changes other than the extension of the expiration date. If the amendment contains unexpected language changes, staff will return to the CalOptima Board of Directors to request a revised and updated authority as a matter of ratification. The amendment contains no rates of payment.

Fiscal Impact
The recommended action to ratify Amendment ~~02~~ 03 to Agreement 16-93274 between CalOptima and DHCS is projected to be budget neutral to CalOptima.

Rationale for Recommendation
CalOptima's execution of Amendment 03 (A-03) to the Agreement 16-93274 with the DHCS is necessary to ensure that CalOptima meets CMS requirements in order for CalOptima to operate the OneCare and OneCare Connect programs during 2020.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Appendix summary of amendments to Agreements with DHCS

/s/ Michael Schrader — *4/24/2019*
Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 6

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

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

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

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)

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A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018

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

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken May 2, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
7. Consider Appointment to the CalOptima Board of Directors' Provider Advisory Committee

Contact
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Action
The Provider Advisory Committee (PAC) recommends the appointment of Harold Patton, MSN, RN, to fulfill the remainder of the Hospital Representative term ending June 30, 2020.

Background
The CalOptima Board of Directors established the PAC by resolution on February 14, 1995 to provide input to the Board. The PAC is comprised of fifteen voting members. Pursuant to Resolution No. 15-0806-03, PAC members serve three-year terms with the exception of the one standing seat, which is the representative from the Health Care Agency. The CalOptima Board is responsible for the appointment of all PAC members. In December 2018, PAC incurred a vacancy for the Hospital Representative due to the resignation of Member Suzanne Richards.

Discussion
CalOptima conducted a special recruitment to ensure that there would be a diverse applicant pool from which to choose a hospital representative. The special recruitment included notification methods, such as: sending numerous outreach flyers to Orange County hospitals and the Hospital Association of Southern California's Orange County office notifying them of the opening. At the conclusion of the recruitment period, CalOptima staff received one single applicant and submitted this applicant to the Nominations Ad Hoc Subcommittee for review. There were no other candidates who applied for this seat.

Prior to the Nominations Ad Hoc Subcommittee meeting on March 6, 2019, subcommittee members individually evaluated and scored the applicant. The subcommittee, consisting of Vice Chair Miranti, Members Myers and Dr. Sweidan, selected the candidate and forwarded the proposed candidate to the full PAC for consideration.

At the March 14, 2019 meeting, the PAC considered and approved the recommended candidate, Harold Patton, MSN, RN, as proposed by the Nominations Ad Hoc.

Candidate for the open position is as follows:

Hospital Representative
Harold Patton, MSN, RN

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Mr. Patton has been the Chief Nursing Officer for the University of California Irvine Medical Center since 2016. He is responsible for oversight of all nursing operations including acute care, inpatient and outpatient as well as ambulatory services. He is an active and valued participant on a variety of hospital committee. Mr. Patton is a member of UCI Health's Medi-Cal Strategies Committee, which is aimed at advancing population health management for UCI's Medi-Cal patients, the majority of which are CalOptima members. Mr. Patton holds a Master of Science in Nursing (MSN) specializing in nursing administration. He also holds memberships in the American Organization of Nurse Executives (AONE), American Nurses Association (ANA), Association of California Nurse Leaders.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policy, the PAC established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the Committee. The PAC met to discuss the recommended candidate and concurred with the Subcommittee's recommendations. The PAC forwards the recommended candidate to the Board of Directors for consideration.

Concurrence
Provider Advisory Committee Nominations Ad Hoc Subcommittee
Provider Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *4/24/2019*
Authorized Signature — **Date**

*Indicates PAC recommendation

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
8. Consider Authorizing Further Action Related to the Regulatory Requirement for Medi-Cal Provider Enrollment by the California Department of Health Care Services

Contact
Michelle Laughlin, Executive Director Network Operations, (714) 246-8400

Recommended Actions
Authorize the following action related to the requirement that all contracted providers be enrolled in the Medi-Cal program through the Department of Health Care Services (DHCS) by January 1, 2019:

1. Authorize CalOptima to continue contracts with the non-Medi-Cal enrolled contracted providers through December 31, 2019, whose application to the State to become enrolled in the Medi-Cal program remains pending and were submitted to the DHCS prior to January 1, 2019.

Background
In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The revised regulation included requirements that providers in Managed Care Plans (MCPs) including CalOptima be subject to the same provider enrollment and screening requirements as providers who participate in Medicaid State fee-for-service programs. Provider enrollment and screening is in addition to credentialing requirements and is meant to reduce the incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

On November 14, 2017, DHCS issued All Plan Letter (APL) 17-019, which specified MCP's responsibilities related to the screening and enrollment of all Medi-Cal network providers.

Due to the backlog of provider enrollment applications, the State's Medi-Cal enrollment process is taking longer than the six-month period previously authorized by the Board to complete. It is unlikely that all of the approximately 548 CalOptima providers not currently enrolled will complete this process by June 30, 2019. Staff has gathered information on non-enrolled providers currently serving CalOptima Medi-Cal beneficiaries, identifying the number, specialty and potential member impact of terminating provider contracts. In the event that the existing contracts of the remaining 528 currently non-enrolled CalOptima Medi-Cal providers were terminated, the results would affect over 20,939 Members' PCP assignments and more than 7,922 Members who access specialty care. To mitigate this potential disruption to the provider network and assure member's continued access to care, Staff is requesting Board approval of the recommended actions.

Discussion
During the November 8, 2018 CalOptima Board meeting, the Board approved that providers who are not currently enrolled with Medi-Cal but have provided proof to CalOptima that their Medi-Cal provider

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enrollment application and all required information was submitted to the State prior to January 1, 2019, continue as contracted CalOptima participating providers until June 30, 2019. Due to the Board approval to extend these participating providers, 309 providers are now Medi-Cal enrolled.

The prior request indicated that staff will consider returning to the Board with further recommendations in the event that there were further delays in the state's enrollment process. Staff is returning to provide an update on the progress and further recommends that the remaining 548 providers who are not currently enrolled with Medi-Cal but have provided proof that their Medi-Cal provider enrollment application and all required information was submitted to the State prior to January 1, 2019, continue as contracted CalOptima participating providers until such a time as DHCS renders a decision on that provider's Medi-Cal enrollment application, not to extend past December 31, 2019. As noted above, the Medi-Cal enrollment process with the state is taking many months to complete. This is a concern shared by many health plans state wide, with many opting for a similar approach of attempting to minimize member care disruption while the state works through the backlog of provider Medi-Cal enrollment applications, while also working to comply with the prescribed timelines.

While the proposed approach of allowing additional time for the Medi-Cal enrollment process to be completed without reassigning Members from Providers with pending applications to those who have completed the DHCS Medi-Cal provider enrollment process potentially places CalOptima at risk for payment and for DHCS audit findings of CalOptima's non-compliance with the terms of the DHCS-CalOptima contract, as indicated, our understanding is that this is an approach being followed by numerous other plans to allow time for DHCS to work through the backlog of Medi-Cal provider enrollment applications.

Under the proposed approach to continue the contracts with the providers who remain pending in the DHCS Medi-Cal enrollment process, if any such provider is still not Medi-Cal enrolled by December 31, 2019, their contract with CalOptima will be terminated effective January 1, 2020. In addition, all non-enrolled PCPs will continue to have their panels closed to new members until their Medi-Cal enrollment is complete.

As indicated, implementation of these actions without DHCS approval could potentially place CalOptima and other plans throughout the state at risk for any payments made to such non-Medi-Cal enrolled providers and may also result in audit findings from the State, the consequences of which may be corrective action plan(s) and/or sanctions. However, with a focus on ensuring member access to crucial healthcare services, staff recommends proceeding with the proposed approach.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget, approved by the Board on June 7, 2018, includes forecasted professional medical expenses. The recommended action to continue contracts with certain non-Medi-Cal enrolled providers through December 31, 2019, is not projected to result in a material change to the budgeted medical expenses. Therefore, it is a budgeted item with no additional fiscal impact assuming the State takes no actions related to payments made to non-enrolled providers and does not find CalOptima to be non-compliant, issue sanctions or take other related action(s).

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Management will include revenue and expenses for the period of July 1, 2019, through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

Continued access to providers in the process of being enrolled in Medi-Cal and services identified as crucial to avoid barriers in access to care will allow members to receive uninterrupted care notwithstanding the DHCS requirements that all providers enroll in the Medi-Cal program effective January 1, 2019.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS issued All Plan Letter (APL) 17-019
2. Board Action dated November 1, 2018, Consider Authorizing Actions Related to the Regulatory Requirement for Medi-Cal Provider Enrollment by the California Department of Health Care Services

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

4/24/2019 — **Date**

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: November 14, 2017

ALL PLAN LETTER 17-019
SUPERSEDES ALL PLAN LETTER 16-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROVIDER CREDENTIALING / RECREDENTIALING AND SCREENING / ENROLLMENT

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their responsibilities related to the screening and enrollment of all network providers pursuant to the Centers for Medicare and Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule), CMS-2390-F,[1] dated May 6, 2016. Additionally, this APL clarifies MCPs' contractual obligations related to credentialing and recredentialing as required in Title 42 Code of Federal Regulations (CFR), Section 438.214.[2] This APL supersedes APL 16-012.[3] The screening and enrollment responsibilities are located in Part: 1 and the credentialing and recredentialing responsibilities are located in Part: 2 of this APL.

All MCP network providers must enroll in the Medi-Cal Program. MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through the Department of Health Care Services (DHCS). MCPs electing to establish their own enrollment process are expected to have their infrastructure in place by January 1, 2018.

BACKGROUND:
On February 2, 2011, CMS issued rulemaking CMS-6028-FC[4] to enhance fee-for-service (FFS) provider enrollment screening requirements pursuant to the Affordable Care Act. The intent of Title 42 CFR, Part 455, Subparts B and E[5] was to reduce the

[1] CMS-2390-F is available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[2] Title 42 CFR Section 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=755076fcbadfbe6a02197ec96e0f7e16&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_1214
[3] APL 16-012 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-012.pdf
[4] CMS-6028-FC is available at: https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf
[5] Title 42 CFR, Part 455, Subparts B and E are available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=3471319414e845a757a46ec42cde2b72&mc=true&node=pt42.4.455&rgn=div5

incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

In May 2016, CMS issued rulemaking CMS-2390-F, which extended the provider screening and enrollment requirements of 42 CFR, Part 455, Subparts B and E to MCP contracted providers (Title 42 CFR, Section 438.602(b)). These requirements are designed to reduce the number of providers who do not meet CMS provider enrollment requirements from participating in the MCPs' provider networks.

MCPs are required to maintain contracts with their network providers (Plan-Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. However, prior to the Final Rule, the MCPs' network providers were not required to enroll in the Medi-Cal Program. Title 42 CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, in accordance with the requirements of Title 42 CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting network providers[6] as well as prospective network providers.

The Medi-Cal FFS delivery system currently enforces a statewide set of enrollment standards that the Medi-Cal managed care program and MCPs must now implement.[7] Although the implementation date for Title 42 CFR Section 438.602(b) is not scheduled until July 1, 2018, Section 5005(b)(2) of the 21st Century Cures Act (Cures Act),[8] requires managed care network provider enrollment to be implemented by January 1, 2018.

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes. The credentialing and recredentialing process is one component of the comprehensive quality improvement system required in all MCP contracts.[9] Credentialing is defined as the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, and/or professional association membership. The credentialing process ensures that providers are properly licensed and certified as required by state and federal law.

[6] Exhibit E, Attachment 1 Definitions. The MCP Boilerplate contracts can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[7] State-specific Medi-Cal FFS provider enrollment requirements are contained in Title 22, CCR, Section 51000 through 51051, and Welfare & Institutions Code, Division 9, Part 3, Chapter 7 (commencing with Section 14043).
[8] 42 USC § 1396u-2 (d)(6)(A)
[9] Exhibit A, Attachment 4, Credentialing and Recredentialing.

POLICY:

Part 1: Medi-Cal Managed Care Screening and Enrollment Requirements

Available Enrollment Options

MCPs may screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, MCPs may also rely on the enrollment and screening results conducted by DHCS or other MCPs. MCPs can access the California Health and Human Services' (CHHS) Open Data Portal[10] to obtain a list of currently enrolled Medi-Cal FFS providers. MCPs are required to issue network providers a "verification of enrollment" that MCPs can rely on to prevent enrollment duplication. MCPs may collaborate with each other to share provider screening and enrollment results.

Providers who enroll through the DHCS enrollment process may participate in both the Medi-Cal FFS program as well as contract with an MCP (provided the MCP chooses to contract with the provider). However, providers who only enroll through an MCP may not also participate in the Medi-Cal FFS program. Although DHCS does not require that managed care providers enroll as FFS providers, if a provider wishes to participate in, or receive reimbursement from, the Medi-Cal FFS program, the provider must enroll as a Medi-Cal FFS provider through DHCS.

MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis.

MCP Enrollment Processes

If the MCP elects to enroll a provider, the MCP must comply with the following processes:

General Requirements:

A. MCP Provider Application and Application Fee

MCPs are not required to use DHCS' provider enrollment forms. However, MCPs must ensure that they collect all the appropriate information, data elements, and supporting documentation required for each provider type.[11] In addition, MCPs must ensure that every network provider application they process is reviewed for both accuracy and

[10] The CHHS Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017

[11] Applications packages by provider type can be found at the following: http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx. For associated definitions and provider types see Title 22 CCR 51000 – 51000.26 and 51051.

completeness. MCPs must ensure that all information specified in Title 22, California Code of Regulations (CCR), including but not limited to, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60, including all required submittals and attachments to the application package have been received. The MCP must obtain the provider's consent in order for DHCS and the MCP to share information relating to the provider's application and eligibility, including but not limited to issues related to program integrity.

MCPs may collect an application fee, established by CMS from unenrolled prospective network providers, to cover the administrative costs of processing a provider's screening and enrollment application. The MCP's application fee policy must be comparable to, and must not exceed, the state's application fee.[12] The application fee for calendar year 2017 is $560. Before collecting this fee, the MCP should be certain that the network provider is not already enrolled.

B. DHCS Provider Enrollment Agreement and Plan Provider Agreement

All Medi-Cal providers are required to enter into a provider enrollment agreement with the state (DHCS Provider Enrollment Agreement) as a condition of participating in the Medi-Cal Program pursuant to Section 1902(a)(27) of the Social Security Act and Section 14043.1 of the Welfare & Institutions Code. As part of the enrollment process, MCPs are responsible for ensuring that all successfully enrolled providers execute and sign the DHCS Provider Enrollment Agreement. This provider agreement is separate and distinct from the Plan Provider Agreement (see below). MCPs must maintain the original signed DHCS Provider Enrollment Agreement for each provider and must submit a copy to DHCS, CMS, and other appropriate agencies upon request. MCPs are responsible for maintaining all provider enrollment documentation in a secure manner and place that ensures the confidentiality of each provider's personal information. These enrollment records must be made available upon request to DHCS, CMS, or other authorized governmental agencies.

The agreement between the MCP and a provider (Plan Provider Agreement) is separate and distinct from the DHCS Provider Enrollment Agreement. Both the DHCS Provider Enrollment Agreement and the Plan Provider Agreement are required for MCP network providers. The DHCS Provider Enrollment Agreement does not expand or alter the MCP's existing rights or obligations relating to its Plan Provider Agreement.

C. Review of Ownership and Control Disclosure Information

As a requirement of enrollment, providers must disclose the information required by Title 42, CFR, Sections 455.104, 455.105, and 455.106, and Title 22, CCR, Section 51000.35. Providers who are unincorporated sole-proprietors are not required to

[12] Application Fee information is available at: http://www.dhcs.ca.gov/provgovpart/Pages/AppFeeChange2017.aspx

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disclose the ownership or control information described in Title 42, CFR, Section 455.104. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by Title 42, CFR, Section 455.104.

Full disclosure throughout the enrollment process is required for participation in the Medi-Cal Program. These disclosures must be provided when:

- A prospective provider submits the provider enrollment application.
- A provider executes the DHCS Provider Enrollment Agreement.
- A provider responds to an MCP's request during the enrollment re-validation process.
- Within 35 days of any change in ownership of the network provider.

Upon MCP request, a network provider must submit within 35 days:

- Full and complete information about the ownership of any subcontractor with whom the network provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and,
- Any significant business transactions between the network provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.[13]

Additionally, MCPs must comply with the requirements contained in Title 22, CCR, Section 51000.35, Disclosure Requirements. MCPs are not required to utilize the DHCS disclosure forms (DHCS 6207 and 6216[14]); however, MCPs must collect all information and documentation required by Title 22, CCR, Section 51000.35.

D. "Limited," "Moderate," "High" Risk Assignment

MCPs must screen initial provider applications, including applications for a new practice location, and any applications received in response to a network provider's reenrollment or revalidation request to determine the provider's categorical risk level as "limited," "moderate," or "high." If a provider fits within more than one risk level, the MCP must screen the provider at the highest risk level.

The federal requirements for screening requirements and for MCPs to stratify their network providers by risk level are set forth in Attachment 1 to this APL. These federal requirements list provider types considered as limited risk, moderate risk, and high risk, and define the screening requirements for each level of risk. A provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated provider lists, and criminal background checks. MCPs are

[13] 42 CFR 455.105(b)
[14] DHCS Forms 6207 and 6216 are available at: http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

not able to enroll a provider who fails to comply with the screening criteria for that provider's assigned level of risk.

Providers are subject to screening based on verification of the following requirements:

Limited-Risk Providers:

- Meet state and federal requirements.
- Hold a license certified for practice in the state and has no limitations from other states.
- Have no suspensions or terminations on state and federal databases.

Medium-Risk Providers:

- Screening requirements of limited-risk providers.
- Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to the MCP and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

High-Risk Providers:

- Screening requirements of medium-risk providers.
- Criminal background checks based in part on a set of fingerprints.

The MCP and DHCS will adjust the categorical risk level when any of the following circumstances occur:

- The state imposes a payment suspension on a provider based on a credible allegation(s) of fraud, waste, or abuse.
- The provider has an existing Medicaid overpayment based on fraud, waste, or abuse.
- The provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten years, or when a state or federal moratorium on a provider type has been lifted.

DHCS will provide the information necessary to determine provider risk level to MCPs on a regular basis. MCPs may also obtain this information upon request from their DHCS Managed Care Operations Division (MCOD) contract manager.

E. Additional Criteria for High Risk Providers - Fingerprinting and Criminal Background Check

High-risk providers are subject to criminal background checks, including fingerprinting and the screening requirements for medium-risk providers. Regardless of whether a high-risk provider has undergone fingerprinting in the past, the requirement to submit to a criminal background check and fingerprinting remains the same. Any person with a

5% or more direct or indirect ownership in a high-risk applicant must submit to a criminal background check.[15] In addition, information discovered in the process of onsite reviews or data analysis may lead to a request for fingerprinting and criminal background checks for applicants.

DHCS will coordinate all criminal background checks. DHCS will make a pre-filled Live Scan form available to all MCPs to distribute to providers. When fingerprinting is required, MCPs must furnish the provider with the Live Scan form and instructions on where to deliver the completed form. It is critical that MCPs distribute the designated Live Scan form as this ensures the criminal history check results are forwarded directly to DHCS. The provider is responsible for paying for any Live Scan processing fees. MCPs must notify DHCS upon initiation of each criminal background check for a provider that has been designated as high risk. DHCS will provide notification of the Live Scan results directly to the MCP. The MCP must maintain the security and confidentiality of all of the information it receives from DHCS relating to the provider's high-risk designation and the results of criminal background checks.

F. Site Visits

MCPs must conduct pre- and post-enrollment site visits of medium-risk and high-risk providers to verify that the information submitted to the MCP and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements, including but not limited to, Title 22, CCR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60. In addition, all providers enrolled in the Medi-Cal Program, including providers enrolled through MCPs,[16] are subject to unannounced onsite inspections at all provider locations.

Onsite visits may be conducted for many reasons including, but not limited to, the following:

- The provider was temporarily suspended from the Medi-Cal Program.
- The provider's license was previously suspended.
- There is conflicting information in the provider's enrollment application.
- There is conflicting information in the provider's supporting enrollment documentation.
- As part of the provider enrollment process, the MCP receives information that raises a suspicion of fraud.

[15] Welfare and Institutions Code 14043.38(c)(2)
[16] 42 CFR 455.432

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G. Federal and State Database Checks

During the provider enrollment process, MCPs are required to check the following databases to verify the identity and determine the exclusion status of all providers:

- Social Security Administration's Death Master File.[17]
- National Plan and Provider Enumeration System (NPPES).[18]
- List of Excluded Individuals/Entities (LEIE).[19]
- System for Award Management (SAM).[20]
- CMS' Medicare Exclusion Database (MED).[21]
- DHCS' Suspended and Ineligible Provider List.[22]

H. Denial or Termination of Enrollment/Appeal Process

MCPs may enroll providers to participate in the Medi-Cal Managed Care Program. However, if the MCP declines to enroll a provider, it must refer the provider to DHCS for further enrollment options. If the MCP acquires information, either before or after enrollment, that may impact the provider's eligibility to participate in the Medi-Cal Program, or a provider refuses to submit to the required screening activities,[23] the MCP may decline to accept that provider's application. However, only DHCS can deny or terminate a provider's enrollment in the Medi-Cal Program.

If at any time the MCP determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, the MCP must immediately suspend the enrollment process. The MCP must inform the prospective provider that he/she may seek enrollment through DHCS.[24]

MCPs are not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.[25]

I. Provider Enrollment Disclosure

At the time of application, MCPs must inform their network providers, as well as any providers seeking to enroll with an MCP, of the differences between the MCP's and

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[17] Social Security Administration's Death Master File is available at: https://www.ssdmf.com/
[18] NPPES is available at: https://nppes.cms.hhs.gov
[19] LEIE is available at: https://oig hhs.gov/exclusions/exclusions_list.asp
[20] SAM is available at: https://www.sam.gov
[21] MED is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html
[22] Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
[23] 42 CFR 455.416
[24] Provider Enrollment information can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx.
[25] 42 CFR 455.422

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DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

DHCS has provided a disclosure statement (Attachment 2), which MCPs may use to advise providers. MCPs are not required to use this exact form, but any disclosure used must contain, at a minimum, the same information contained in Attachment 2. DHCS may periodically require MCPs to provide additional disclosures to providers relating to differences in the enrollment processes.

The provider enrollment disclosure must include, but is not limited to, the following elements:

- A statement that certain enrollment functions will not be performed by the MCP, but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.
- Notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a provider chooses to enroll through an MCP, including provisional provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal an MCP's decision to suspend the enrollment process.
- A provision informing the provider that if the MCP receives any information that impacts the provider's eligibility for enrollment, the MCP will suspend processing of the provider's enrollment application and make the provider aware of the option to apply through the DHCS' Medi-Cal FFS provider enrollment process.
- A statement clarifying that in order for the provider to participate in the Medi-Cal FFS Program, the provider must enroll through DHCS, and that enrolling through DHCS will also make the provider eligible to contract with the MCP.

J. Post Enrollment Activities

Revalidation of Enrollment

To ensure that all enrollment information is accurate and up-to-date, all providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process. MCPs may align revalidation efforts with their recredentialing efforts to reduce duplication of activities. MCPs must revalidate the enrollment of each of their limited-risk and medium-risk network providers at least every five years,[26] and their high-risk network providers every three years. MCPs are not required to revalidate providers that were enrolled through DHCS or revalidated by another MCP.

[26] 42 CFR 455.414

Data Base Checks
MCPs must review the SAM and LEIE databases on a monthly basis. All other databases must be reviewed upon a provider's reenrollment to ensure that the provider continues to meet enrollment criteria. Each MCP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal Programs; any provider terminated from the Medicare or Medicaid/Medi-Cal Program may not participate in the MCP's provider network.

Retention of Documents
MCPs are required to retain all provider screening and enrollment materials and documents for ten years.[27] Additionally, MCPs must make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

K. Miscellaneous Requirements

Timeframes
Within 120 days of receipt of a provider application, the MCP must complete the enrollment process and provide the applicant with a written determination. MCPs may allow providers to participate in their network for up to 120 days, pending the outcome of the screening process, in accordance with Title 42, CFR, Section 438.602(b)(2).

Delegation of Screening and Enrollment
MCPs may delegate their authority to perform screening and enrollment activities to a subcontractor. When doing so, the MCP remains contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor's ability to perform these activities, including an initial review to ensure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the delegated functions.

Part 2: Medi-Cal Managed Care Credentialing and Recredentialing Requirements

MCPs must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, certified, or registered. MCPs must implement the provider credentialing and recredentialing policy described below by developing and maintaining written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of their network providers. Each MCP must ensure that its governing

[27] 42 CFR 438.3(u)

body, or the designee of its governing body, reviews and approves these policies and procedures, and must ensure that the responsibility for recommendations regarding credentialing decisions rest with a credentialing committee or other peer-review body.

Some screening and enrollment requirements overlap with credentialing and recredentialing requirements. Any such overlap does not require an MCP to duplicate any of the activities described in this APL. However, if an MCP relies on the screening and enrollment activities conducted by another MCP, or by DHCS, the MCP must comply with all credentialing and recredentialing requirements described in this APL.

Provider Credentialing

MCPs are required to verify the credentials of their contracted medical providers, and to verify the following items, as required for the particular provider type, through a primary source,[28] as applicable:[29]

- The appropriate license and/or board certification or registration.
- Evidence of graduation or completion of any required education.
- Proof of completion of any relevant medical residency and/or specialty training.
- Satisfaction of any applicable continuing education requirements.

MCPs must also receive the following information from every network provider, but do not need to verify this information through a primary source:

- Work history.
- Hospital and clinic privileges in good standing.
- History of any suspension or curtailment of hospital and clinic privileges.
- Current Drug Enforcement Administration identification number.
- National Provider Identifier number.
- Current malpractice insurance in an adequate amount, as required for the particular provider type.
- History of liability claims against the provider.
- Provider information, if any, entered in the National Practitioner Data Bank, when applicable.[30]

[28] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.
[29] The listed requirements are not applicable to all provider types. When applicable to the provider's designation, the information must be obtained.
[30] National Practitioner Data Bank is available at: https://www ncsbn.org/418.htm.

- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List may not participate in the MCP's provider network.[31]
- History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards.

Attestations

For all medical service provider types who deliver Medi-Cal-covered medical services, the provider's application to contract with the MCP must include a signed and dated statement attesting to all the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy and completeness.[32]

Provider Recredentialing

DHCS requires each MCP to verify every three years that each network provider delivering medical services continues to possess valid credentials. MCPs must review new applications from providers and verify the items listed under the Provider Credentialing section of this APL, in the same manner, as applicable. Recredentialing must include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews. The recredentialing application must include the same attestation as contained in the provider's initial application.

MCPs must maintain a system for reporting to the appropriate oversight entities serious quality deficiencies that result in suspension or termination of a network provider. MCPs must maintain policies and procedures for disciplinary actions, including reduction, suspension, or termination of a provider's privileges, and must implement and maintain a provider appeal process.

MCPs must also conduct onsite reviews of their network provider sites. For detailed guidance, see Policy Letter (PL) 14-004, Site Reviews, Facility Site Review and Medical

[31] The Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

[32] These limited statements comply with requirements of the Americans with Disabilities Act (ADA), as discussed in the attached PL 02-03. The ADA Attachment is available at (pg. 7): http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2002/MMCDPL02003.pdf.

Record Review,[33] and any subsequent revisions to this PL. MCPs must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to the MCP's provider network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review.

Delegation of Provider Credentialing and Recredentialing

MCPs may delegate their authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the MCP remains contractually responsible for the completeness and accuracy of these activities. If an MCP delegates credential verification activities, it should establish a formal and detailed agreement with the entity performing those activities. These agreements must be revised when the parties change the agreement's terms and conditions. To ensure accountability for these activities, the MCP must establish a system that:

- Evaluates the subcontractor's ability to perform delegated activities that includes an initial review to assure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.
- Ensures that the subcontractor meets MCP and DHCS standards.
- Continuously monitors, evaluates, and approves the delegated functions.

Entities such as medical groups or independent physician organizations may conduct delegated credentialing activities and may obtain a Provider Organization Certification (POC) from the National Committee on Quality Assurance (NCQA) at their discretion. The POC focuses on the entity's role as the agent performing the credentialing functions on behalf of an MCP. The MCP may accept evidence of NCQA POC in lieu of a monitoring site visit at delegated physician organizations. If an MCP delegates credential verification activities, it should establish a formal and detailed written agreement with that entity. Such agreements need not be revised until the parties to the agreement change the agreement's terms and conditions.

Health Plan Accreditation

MCPs that receive a rating of "excellent," "commendable," or "accredited" from the NCQA will be deemed to have met DHCS' requirements for credentialing. Such MCPs will be exempt from DHCS' medical review audit of credentialing practices. MCPs; however, retain overall responsibility for ensuring that credentialing requirements are met. Credentialing accreditation from entities other than the NCQA will be considered by DHCS upon request.

[33] Policy Letter 14-004 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-004.pdf

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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 applicable APLs, PLs and Dual Plan Letters. For questions regarding this APL, please contact your MCOD contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

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Attachment 1: Provider Types and Categories of Risk[34]/Screening Requirements

(1) Limited Risk Provider Types. Physician or non-physician practitioners and medical groups or clinics:

- Ambulatory Surgical Centers (ASCs)
- End-Stage Renal Disease (ESRD) facilities
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Hospitals, including Critical Access Hospitals (CAHs)
- Indian Health Service (IHS) facilities
- Mammography screening centers
- Mass immunization roster billers
- Organ Procurement Organizations (OPOs)
- Portable x-ray suppliers
- Providers or suppliers that are publicly traded on the New York Stock Exchange (NYSE) or NASDAQ
- Public or Government-Owned Ambulance Services Suppliers
- Religious Nonmedical Health Care Institutions (RNHCIs)
- Rural Health Clinics (RHCs)
- Radiation therapy centers
- Skilled Nursing Facilities (SNFs)

(2) Moderate Risk Provider Types. Provider and supplier categories:

- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Currently enrolled (re-validating) home health agencies
  - Exception: Any such provider that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Currently enrolled (re-validating) suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)
  - Exception: Any such supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities

[34] CMS-6028-FC Tables 1–3. Federal Register / Vol. 76, No. 22 / February 2, 2011 / Rules and Regulations

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- Non-public, non-government owned or affiliated ambulance services suppliers
    - Exception: Any such provider or supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.

(3) High Risk Provider Types. Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS.

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Attachment 2: Managed Care Provider Enrollment Disclosure

Background

Beginning January 1, 2018, federal law requires that all managed care network providers must enroll in the Medi-Cal Program if they wish to provide services to Medi-Cal managed care beneficiaries. Managed care providers have two options for enrolling with the Medi-Cal Program. Providers may enroll through (1) DHCS; or (2) an MCP. If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with MCPs. If the provider enrolls through an MCP, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to fee-for-service (FFS) providers will also apply to the enrollment process for managed care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements - the "Plan Provider Agreement" and the "DHCS Provider Enrollment Agreement." The Plan Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The DHCS Provider Enrollment Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. Enrollment through an MCP. The following provides an overview of the MCP enrollment process:

- The provider will submit a provider enrollment application to the MCP using a process developed by the MCP.
- As part of the application process, the provider will be required to agree that DHCS and the MCP may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The MCP will be responsible for gathering all necessary documents and information associated with the MCP application.
- The provider should direct any questions it has regarding its MCP application to the MCP.
- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with the MCP.
- While the MCP enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment

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application may differ. In addition, MCPs will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.

- Providers will not have the right to appeal an MCP's decision to cease the enrollment process.
- The MCP will complete the enrollment process within 120 days of the provider's submission of its application. During this time, the provider may participate in the MCP's network for up to 120 days, pending approval from the MCP.
- Once the enrolling MCP places a provider on the Enrolled Provider List, the provider is eligible to contract with all MCPs. However, an MCP is not required to contract with an enrolled provider.
- Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.
- Accordingly, if the MCP receives any information that impacts the provider's enrollment, the MCP will suspend processing the provider's enrollment application and refer the provider to DHCS' FFS Provider Enrollment Division (PED) for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

B. Enrollment through DHCS.

- The provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program. (See http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx)
- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for managed care providers.
- Upon successful enrollment through DHCS, the provider will be eligible to contract with MCPs and provide services to FFS beneficiaries.

There may be other important aspects of the enrollment process that are not set forth in this information bulletin. Please check the DHCS website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Actions Related to the Regulatory Requirement for Medi-Cal Provider Enrollment by the California Department of Health Care Services

Contact

Michelle Laughlin, Executive Director Network Operations, (714) 246-8400

Recommended Actions

Authorize the following actions related to the requirement that all contracted providers be enrolled in the Medi-Cal program through the Department of Health Care Services (DHCS) by January 1, 2019:

1. Authorize CalOptima to continue to contract with non-Medi-Cal enrolled providers through June 30, 2019, subject to CalOptima's receipt of proof that each such provider's application to the State to become enrolled in the Medi-Cal program was submitted to the DHCS prior to January 1, 2019; and
2. Authorize Letters of Agreement (LOA) with non-Medi-Cal enrolled specialist providers identified by the Chief Medical Officer through December 31, 2019 as required for access to services or continuity of care.

Background

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The revised regulation included requirements that providers in Managed Care Plans (MCPs) including CalOptima be subject to the same provider enrollment and screening requirements as providers who participate in Medicaid State fee-for-service programs. Provider enrollment and screening is in addition to credentialing requirements and is meant to reduce the incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

On November 14, 2017, DHCS issued All Plan Letter (APL) 17-019, which specified MCP's responsibilities related to the screening and enrollment of all Medi-Cal network providers.

The contract between DHCS and CalOptima effective January 1, 2009, discontinued the requirement that providers be eligible for participation in the Medi-Cal Program. However, on October 7, 2010, the CalOptima Board of Directors approved the continuation of a policy which requires that providers furnishing services to CalOptima Medi-Cal members be enrolled with the State of California's Medi-Cal Program when an enrollment path with the State is available for the provider. In recognition that not all providers eligible to enroll with Medi-Cal would enroll, the Board also approved a policy allowing the Chief Medical Officer, or delegated providers in conjunction with the Chief Medical Officer, to make exceptions to this policy to satisfy access and continuity of care requirements in CalOptima's contract with DHCS.

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Although the new state mandated enrollment and screening requirements were effective January 1, 2018, DHCS guidance clarified that non-enrolled providers contracted with the MCPs prior to this date, have until December 31, 2018 to complete the process. Presumably, providers not enrolled by his date are to be terminated as a MCP participating provider for Medi-Cal services. Staff continues to review provider data to determine the number of non-enrolled providers and the potential impact to the members who are in their care should these providers no longer be available in the future due to their non-enrolled status.

DHCS specifies that provider screening and enrollment can be accomplished in two ways. MCPs may direct providers to the Medi-Cal enrollment division of DHCS for screening and enrollment, or MCPs may develop and implement an internal screening and enrollment process that meets the requirements of the APL. Due to the numerous additional requirements associated with the enrollment and screening process and the expertise required to fulfill these requirements, CalOptima staff believes it is more appropriate to continue to depend on the State's process to assure providers are properly vetted for Medi-Cal participation rather than to develop a duplicative process that would, in any case, lack the breadth of potentially relevant information available to the State, but not necessarily available to CalOptima.

Staff continues to conduct extensive outreach efforts to encourage non-enrolled providers to seek enrollment in the Medi-Cal program and continued participation with CalOptima. The outreach efforts have been successful, and Staff has identified the addition of over 900 previously non-enrolled providers since April 2018.

However, because the State's Medi-Cal enrollment process can take up to 180 days to complete, it is unlikely that all of the approximately 1,200 CalOptima providers not currently enrolled will complete this process by the end of the calendar year. Staff has gathered information on non-enrolled providers currently serving CalOptima Medi-Cal beneficiaries, identifying the number, specialty and potential member impact of terminating provider contracts. In the event that the existing contracts of all 1,200 currently non-enrolled CalOptima Medi-Cal providers were terminated, the results would be significant, affecting over 26,0000 Members' PCP assignments and more than 10,000 Members who access specialty care. To mitigate this potential disruption to the provider network and assure member's continued access to care, Staff is requesting Board approval of the recommended actions.

Discussion

Staff recommends that providers who are not currently enrolled with Medi-Cal but can provide proof that their Medi-Cal provider enrollment application and all required information has been submitted to the State prior to January 1, 2019, continue as contracted CalOptima participating providers until such a time as DHCS renders a decision on that provider's Medi-Cal enrollment application, potentially through June 30, 2019. As noted above, the Medi-Cal enrollment process with the state may take up to 180 days. This is a concern shared by many health plans state wide, with many opting for a similar approach of attempting to minimize member care disruption while the state works through the backlog of provider Medi-Cal enrollment applications, while also working to comply with the prescribed timelines.

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While the proposed approach of allowing additional time for the Medi-Cal enrollment process to be completed without reassigning Members from Providers with pending applications to those who have completed the DHCS Medi-Cal provider enrollment process potentially places CalOptima at risk for payment and for DHCS audit findings of CalOptima's non-compliance with the terms of the DHCS-CalOptima contract, as indicated, our understanding is that this is an approach being followed by numerous other plans to allow time for DHCS to work through the backlog of Medi-Cal provider enrollment applications.

Under the proposed approach, if any such provider is still not Medi-Cal enrolled by June 30, 2019, their contract with CalOptima will be not be extended thereafter. In addition, all non-enrolled PCPs will have their panels closed to new members until their Medi-Cal enrollment is complete. Should the provider still be in the enrollment process by June 30, 2019 (i.e., application submitted to the state on or before December 31, 2018, but state review process not having been finalized as of June 30, 2018), Staff will consider returning to the Board with further recommendations. This scenario would only be a possibility in the event that there were further delays in the state's enrollment process.

Apart from those providers who have indicated that they plan to submit their Medi-Cal enrollment applications on or before December 31, 2018, staff has identified members in care with non-enrolled providers who are required for access and may choose not to apply to enroll in Medi-Cal. The impact of terminating these providers could create barriers to access sensitive or highly specialized services and/or redirecting members to other providers may be disruptive to member care. Staff proposes to proactively pursue LOAs with these terminated providers to allow for uninterrupted access by Members for whom there is not a suitable alternative contracted provider at this time. DHCS has advised MCPs that MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis. COC requests would be processed in accordance with CalOptima's DHCS-approved policies on the topic. Staff plans to proactively identify members in care with non-enrolled providers required for access; subject to Board approval, Staff will enter into LOAs for members currently in care with these providers to enable members and providers to continue uninterrupted care as longer-term efforts are undertaken to ensure that, member care is being provided by Medi-Cal enrolled providers.

As indicated, implementation of these actions without DHCS approval could place potentially place CalOptima and other plans throughout the state at risk for any payments made to such non-Medi-Cal enrolled providers and may also result in audit findings from the State, the consequences of which may be corrective action plan(s) and/or sanctions. However, with a focus on ensuring member access to crucial healthcare services, staff recommends proceeding with the proposed approach.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget, approved by the Board on June 7, 2018, includes forecasted professional medical expenses. The recommended actions to continue contracts with certain non-Medi-Cal enrolled providers through June 30, 2019, and issue to certain specialist providers are not projected to result in a material change to the budgeted medical expenses. Therefore, the recommended actions are budgeted items with no additional fiscal impact assuming the State takes

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no actions related to payments made to non-enrolled providers and does not find CalOptima to be non-compliant and issue sanctions or take other related action(s).

Management will include revenue and expenses for the period of July 1, 2019, through December 31, 2019, related to the LOAs with certain specialist providers in future operating budgets.

Rationale for Recommendation

Continued access to providers in the process of being enrolled in Medi-Cal and services identified as crucial to avoid barriers in access to care will allow members to receive uninterrupted care notwithstanding the DHCS requirements that all providers enroll in the Medi-Cal program effective January 1, 2019.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS issued All Plan Letter (APL) 17-019
2. CalOptima Board Action dated October 7, 2010, Authorize Revisions to Credentialing and Provider Participation Requirements in CalOptima's Medi-Cal Program

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

10/24/2018 — **Date**

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: November 14, 2017

ALL PLAN LETTER 17-019
SUPERSEDES ALL PLAN LETTER 16-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROVIDER CREDENTIALING / RECREDENTIALING AND SCREENING / ENROLLMENT

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their responsibilities related to the screening and enrollment of all network providers pursuant to the Centers for Medicare and Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule), CMS-2390-F,[1] dated May 6, 2016. Additionally, this APL clarifies MCPs' contractual obligations related to credentialing and recredentialing as required in Title 42 Code of Federal Regulations (CFR), Section 438.214.[2] This APL supersedes APL 16-012.[3] The screening and enrollment responsibilities are located in Part: 1 and the credentialing and recredentialing responsibilities are located in Part: 2 of this APL.

All MCP network providers must enroll in the Medi-Cal Program. MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through the Department of Health Care Services (DHCS). MCPs electing to establish their own enrollment process are expected to have their infrastructure in place by January 1, 2018.

BACKGROUND:
On February 2, 2011, CMS issued rulemaking CMS-6028-FC[4] to enhance fee-for-service (FFS) provider enrollment screening requirements pursuant to the Affordable Care Act. The intent of Title 42 CFR, Part 455, Subparts B and E[5] was to reduce the

[1] CMS-2390-F is available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[2] Title 42 CFR Section 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=755076fcbadfbe6a02197ec96e0f7e16&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_1214
[3] APL 16-012 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-012.pdf
[4] CMS-6028-FC is available at: https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf
[5] Title 42 CFR, Part 455, Subparts B and E are available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=3471319414e845a757a46ec42cde2b72&mc=true&node=pt42.4.455&rgn=div5

incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

In May 2016, CMS issued rulemaking CMS-2390-F, which extended the provider screening and enrollment requirements of 42 CFR, Part 455, Subparts B and E to MCP contracted providers (Title 42 CFR, Section 438.602(b)). These requirements are designed to reduce the number of providers who do not meet CMS provider enrollment requirements from participating in the MCPs' provider networks.

MCPs are required to maintain contracts with their network providers (Plan-Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. However, prior to the Final Rule, the MCPs' network providers were not required to enroll in the Medi-Cal Program. Title 42 CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, in accordance with the requirements of Title 42 CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting network providers[6] as well as prospective network providers.

The Medi-Cal FFS delivery system currently enforces a statewide set of enrollment standards that the Medi-Cal managed care program and MCPs must now implement.[7] Although the implementation date for Title 42 CFR Section 438.602(b) is not scheduled until July 1, 2018, Section 5005(b)(2) of the 21st Century Cures Act (Cures Act),[8] requires managed care network provider enrollment to be implemented by January 1, 2018.

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes. The credentialing and recredentialing process is one component of the comprehensive quality improvement system required in all MCP contracts.[9] Credentialing is defined as the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, and/or professional association membership. The credentialing process ensures that providers are properly licensed and certified as required by state and federal law.

[6] Exhibit E, Attachment 1 Definitions. The MCP Boilerplate contracts can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[7] State-specific Medi-Cal FFS provider enrollment requirements are contained in Title 22, CCR, Section 51000 through 51051, and Welfare & Institutions Code, Division 9, Part 3, Chapter 7 (commencing with Section 14043).
[8] 42 USC § 1396u-2 (d)(6)(A)
[9] Exhibit A, Attachment 4, Credentialing and Recredentialing.

POLICY:

Part 1: Medi-Cal Managed Care Screening and Enrollment Requirements

Available Enrollment Options

MCPs may screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, MCPs may also rely on the enrollment and screening results conducted by DHCS or other MCPs. MCPs can access the California Health and Human Services' (CHHS) Open Data Portal[10] to obtain a list of currently enrolled Medi-Cal FFS providers. MCPs are required to issue network providers a "verification of enrollment" that MCPs can rely on to prevent enrollment duplication. MCPs may collaborate with each other to share provider screening and enrollment results.

Providers who enroll through the DHCS enrollment process may participate in both the Medi-Cal FFS program as well as contract with an MCP (provided the MCP chooses to contract with the provider). However, providers who only enroll through an MCP may not also participate in the Medi-Cal FFS program. Although DHCS does not require that managed care providers enroll as FFS providers, if a provider wishes to participate in, or receive reimbursement from, the Medi-Cal FFS program, the provider must enroll as a Medi-Cal FFS provider through DHCS.

MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis.

MCP Enrollment Processes

If the MCP elects to enroll a provider, the MCP must comply with the following processes:

General Requirements:

A. MCP Provider Application and Application Fee

MCPs are not required to use DHCS' provider enrollment forms. However, MCPs must ensure that they collect all the appropriate information, data elements, and supporting documentation required for each provider type.[11] In addition, MCPs must ensure that every network provider application they process is reviewed for both accuracy and

[10] The CHHS Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017

[11] Applications packages by provider type can be found at the following: http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx. For associated definitions and provider types see Title 22 CCR 51000 – 51000.26 and 51051.

completeness. MCPs must ensure that all information specified in Title 22, California Code of Regulations (CCR), including but not limited to, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60, including all required submittals and attachments to the application package have been received. The MCP must obtain the provider's consent in order for DHCS and the MCP to share information relating to the provider's application and eligibility, including but not limited to issues related to program integrity.

MCPs may collect an application fee, established by CMS from unenrolled prospective network providers, to cover the administrative costs of processing a provider's screening and enrollment application. The MCP's application fee policy must be comparable to, and must not exceed, the state's application fee.[12] The application fee for calendar year 2017 is $560. Before collecting this fee, the MCP should be certain that the network provider is not already enrolled.

B. DHCS Provider Enrollment Agreement and Plan Provider Agreement

All Medi-Cal providers are required to enter into a provider enrollment agreement with the state (DHCS Provider Enrollment Agreement) as a condition of participating in the Medi-Cal Program pursuant to Section 1902(a)(27) of the Social Security Act and Section 14043.1 of the Welfare & Institutions Code. As part of the enrollment process, MCPs are responsible for ensuring that all successfully enrolled providers execute and sign the DHCS Provider Enrollment Agreement. This provider agreement is separate and distinct from the Plan Provider Agreement (see below). MCPs must maintain the original signed DHCS Provider Enrollment Agreement for each provider and must submit a copy to DHCS, CMS, and other appropriate agencies upon request. MCPs are responsible for maintaining all provider enrollment documentation in a secure manner and place that ensures the confidentiality of each provider's personal information. These enrollment records must be made available upon request to DHCS, CMS, or other authorized governmental agencies.

The agreement between the MCP and a provider (Plan Provider Agreement) is separate and distinct from the DHCS Provider Enrollment Agreement. Both the DHCS Provider Enrollment Agreement and the Plan Provider Agreement are required for MCP network providers. The DHCS Provider Enrollment Agreement does not expand or alter the MCP's existing rights or obligations relating to its Plan Provider Agreement.

C. Review of Ownership and Control Disclosure Information

As a requirement of enrollment, providers must disclose the information required by Title 42, CFR, Sections 455.104, 455.105, and 455.106, and Title 22, CCR, Section 51000.35. Providers who are unincorporated sole-proprietors are not required to

[12] Application Fee information is available at: http://www.dhcs.ca.gov/provgovpart/Pages/AppFeeChange2017.aspx

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disclose the ownership or control information described in Title 42, CFR, Section 455.104. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by Title 42, CFR, Section 455.104.

Full disclosure throughout the enrollment process is required for participation in the Medi-Cal Program. These disclosures must be provided when:

- A prospective provider submits the provider enrollment application.
- A provider executes the DHCS Provider Enrollment Agreement.
- A provider responds to an MCP's request during the enrollment re-validation process.
- Within 35 days of any change in ownership of the network provider.

Upon MCP request, a network provider must submit within 35 days:

- Full and complete information about the ownership of any subcontractor with whom the network provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and,
- Any significant business transactions between the network provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.[13]

Additionally, MCPs must comply with the requirements contained in Title 22, CCR, Section 51000.35, Disclosure Requirements. MCPs are not required to utilize the DHCS disclosure forms (DHCS 6207 and 6216[14]); however, MCPs must collect all information and documentation required by Title 22, CCR, Section 51000.35.

D. "Limited," "Moderate," "High" Risk Assignment

MCPs must screen initial provider applications, including applications for a new practice location, and any applications received in response to a network provider's reenrollment or revalidation request to determine the provider's categorical risk level as "limited," "moderate," or "high." If a provider fits within more than one risk level, the MCP must screen the provider at the highest risk level.

The federal requirements for screening requirements and for MCPs to stratify their network providers by risk level are set forth in Attachment 1 to this APL. These federal requirements list provider types considered as limited risk, moderate risk, and high risk, and define the screening requirements for each level of risk. A provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated provider lists, and criminal background checks. MCPs are

[13] 42 CFR 455.105(b)
[14] DHCS Forms 6207 and 6216 are available at: http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

not able to enroll a provider who fails to comply with the screening criteria for that provider's assigned level of risk.

Providers are subject to screening based on verification of the following requirements:

Limited-Risk Providers:

- Meet state and federal requirements.
- Hold a license certified for practice in the state and has no limitations from other states.
- Have no suspensions or terminations on state and federal databases.

Medium-Risk Providers:

- Screening requirements of limited-risk providers.
- Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to the MCP and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

High-Risk Providers:

- Screening requirements of medium-risk providers.
- Criminal background checks based in part on a set of fingerprints.

The MCP and DHCS will adjust the categorical risk level when any of the following circumstances occur:

- The state imposes a payment suspension on a provider based on a credible allegation(s) of fraud, waste, or abuse.
- The provider has an existing Medicaid overpayment based on fraud, waste, or abuse.
- The provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten years, or when a state or federal moratorium on a provider type has been lifted.

DHCS will provide the information necessary to determine provider risk level to MCPs on a regular basis. MCPs may also obtain this information upon request from their DHCS Managed Care Operations Division (MCOD) contract manager.

E. Additional Criteria for High Risk Providers - Fingerprinting and Criminal Background Check

High-risk providers are subject to criminal background checks, including fingerprinting and the screening requirements for medium-risk providers. Regardless of whether a high-risk provider has undergone fingerprinting in the past, the requirement to submit to a criminal background check and fingerprinting remains the same. Any person with a

5% or more direct or indirect ownership in a high-risk applicant must submit to a criminal background check.[15] In addition, information discovered in the process of onsite reviews or data analysis may lead to a request for fingerprinting and criminal background checks for applicants.

DHCS will coordinate all criminal background checks. DHCS will make a pre-filled Live Scan form available to all MCPs to distribute to providers. When fingerprinting is required, MCPs must furnish the provider with the Live Scan form and instructions on where to deliver the completed form. It is critical that MCPs distribute the designated Live Scan form as this ensures the criminal history check results are forwarded directly to DHCS. The provider is responsible for paying for any Live Scan processing fees. MCPs must notify DHCS upon initiation of each criminal background check for a provider that has been designated as high risk. DHCS will provide notification of the Live Scan results directly to the MCP. The MCP must maintain the security and confidentiality of all of the information it receives from DHCS relating to the provider's high-risk designation and the results of criminal background checks.

F. Site Visits

MCPs must conduct pre- and post-enrollment site visits of medium-risk and high-risk providers to verify that the information submitted to the MCP and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements, including but not limited to, Title 22, CCR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60. In addition, all providers enrolled in the Medi-Cal Program, including providers enrolled through MCPs,[16] are subject to unannounced onsite inspections at all provider locations.

Onsite visits may be conducted for many reasons including, but not limited to, the following:

- The provider was temporarily suspended from the Medi-Cal Program.
- The provider's license was previously suspended.
- There is conflicting information in the provider's enrollment application.
- There is conflicting information in the provider's supporting enrollment documentation.
- As part of the provider enrollment process, the MCP receives information that raises a suspicion of fraud.

[15] Welfare and Institutions Code 14043.38(c)(2)
[16] 42 CFR 455.432

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G. Federal and State Database Checks

During the provider enrollment process, MCPs are required to check the following databases to verify the identity and determine the exclusion status of all providers:

- Social Security Administration's Death Master File.[17]
- National Plan and Provider Enumeration System (NPPES).[18]
- List of Excluded Individuals/Entities (LEIE).[19]
- System for Award Management (SAM).[20]
- CMS' Medicare Exclusion Database (MED).[21]
- DHCS' Suspended and Ineligible Provider List.[22]

H. Denial or Termination of Enrollment/Appeal Process

MCPs may enroll providers to participate in the Medi-Cal Managed Care Program. However, if the MCP declines to enroll a provider, it must refer the provider to DHCS for further enrollment options. If the MCP acquires information, either before or after enrollment, that may impact the provider's eligibility to participate in the Medi-Cal Program, or a provider refuses to submit to the required screening activities,[23] the MCP may decline to accept that provider's application. However, only DHCS can deny or terminate a provider's enrollment in the Medi-Cal Program.

If at any time the MCP determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, the MCP must immediately suspend the enrollment process. The MCP must inform the prospective provider that he/she may seek enrollment through DHCS.[24]

MCPs are not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.[25]

I. Provider Enrollment Disclosure

At the time of application, MCPs must inform their network providers, as well as any providers seeking to enroll with an MCP, of the differences between the MCP's and

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[17] Social Security Administration's Death Master File is available at: https://www.ssdmf.com/
[18] NPPES is available at: https://nppes.cms.hhs.gov
[19] LEIE is available at: https://oig hhs.gov/exclusions/exclusions_list.asp
[20] SAM is available at: https://www.sam.gov
[21] MED is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html
[22] Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
[23] 42 CFR 455.416
[24] Provider Enrollment information can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx.
[25] 42 CFR 455.422

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DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

DHCS has provided a disclosure statement (Attachment 2), which MCPs may use to advise providers. MCPs are not required to use this exact form, but any disclosure used must contain, at a minimum, the same information contained in Attachment 2. DHCS may periodically require MCPs to provide additional disclosures to providers relating to differences in the enrollment processes.

The provider enrollment disclosure must include, but is not limited to, the following elements:

- A statement that certain enrollment functions will not be performed by the MCP, but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.
- Notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a provider chooses to enroll through an MCP, including provisional provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal an MCP's decision to suspend the enrollment process.
- A provision informing the provider that if the MCP receives any information that impacts the provider's eligibility for enrollment, the MCP will suspend processing of the provider's enrollment application and make the provider aware of the option to apply through the DHCS' Medi-Cal FFS provider enrollment process.
- A statement clarifying that in order for the provider to participate in the Medi-Cal FFS Program, the provider must enroll through DHCS, and that enrolling through DHCS will also make the provider eligible to contract with the MCP.

J. Post Enrollment Activities

Revalidation of Enrollment

To ensure that all enrollment information is accurate and up-to-date, all providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process. MCPs may align revalidation efforts with their recredentialing efforts to reduce duplication of activities. MCPs must revalidate the enrollment of each of their limited-risk and medium-risk network providers at least every five years,[26] and their high-risk network providers every three years. MCPs are not required to revalidate providers that were enrolled through DHCS or revalidated by another MCP.

[26] 42 CFR 455.414

Data Base Checks
MCPs must review the SAM and LEIE databases on a monthly basis. All other databases must be reviewed upon a provider's reenrollment to ensure that the provider continues to meet enrollment criteria. Each MCP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal Programs; any provider terminated from the Medicare or Medicaid/Medi-Cal Program may not participate in the MCP's provider network.

Retention of Documents
MCPs are required to retain all provider screening and enrollment materials and documents for ten years.[27] Additionally, MCPs must make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

K. Miscellaneous Requirements

Timeframes
Within 120 days of receipt of a provider application, the MCP must complete the enrollment process and provide the applicant with a written determination. MCPs may allow providers to participate in their network for up to 120 days, pending the outcome of the screening process, in accordance with Title 42, CFR, Section 438.602(b)(2).

Delegation of Screening and Enrollment
MCPs may delegate their authority to perform screening and enrollment activities to a subcontractor. When doing so, the MCP remains contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor's ability to perform these activities, including an initial review to ensure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the delegated functions.

Part 2: Medi-Cal Managed Care Credentialing and Recredentialing Requirements

MCPs must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, certified, or registered. MCPs must implement the provider credentialing and recredentialing policy described below by developing and maintaining written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of their network providers. Each MCP must ensure that its governing

[27] 42 CFR 438.3(u)

body, or the designee of its governing body, reviews and approves these policies and procedures, and must ensure that the responsibility for recommendations regarding credentialing decisions rest with a credentialing committee or other peer-review body.

Some screening and enrollment requirements overlap with credentialing and recredentialing requirements. Any such overlap does not require an MCP to duplicate any of the activities described in this APL. However, if an MCP relies on the screening and enrollment activities conducted by another MCP, or by DHCS, the MCP must comply with all credentialing and recredentialing requirements described in this APL.

Provider Credentialing

MCPs are required to verify the credentials of their contracted medical providers, and to verify the following items, as required for the particular provider type, through a primary source,[28] as applicable:[29]

- The appropriate license and/or board certification or registration.
- Evidence of graduation or completion of any required education.
- Proof of completion of any relevant medical residency and/or specialty training.
- Satisfaction of any applicable continuing education requirements.

MCPs must also receive the following information from every network provider, but do not need to verify this information through a primary source:

- Work history.
- Hospital and clinic privileges in good standing.
- History of any suspension or curtailment of hospital and clinic privileges.
- Current Drug Enforcement Administration identification number.
- National Provider Identifier number.
- Current malpractice insurance in an adequate amount, as required for the particular provider type.
- History of liability claims against the provider.
- Provider information, if any, entered in the National Practitioner Data Bank, when applicable.[30]

[28] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.
[29] The listed requirements are not applicable to all provider types. When applicable to the provider's designation, the information must be obtained.
[30] National Practitioner Data Bank is available at: https://www ncsbn.org/418.htm.

- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List may not participate in the MCP's provider network.[31]
- History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards.

Attestations

For all medical service provider types who deliver Medi-Cal-covered medical services, the provider's application to contract with the MCP must include a signed and dated statement attesting to all the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy and completeness.[32]

Provider Recredentialing

DHCS requires each MCP to verify every three years that each network provider delivering medical services continues to possess valid credentials. MCPs must review new applications from providers and verify the items listed under the Provider Credentialing section of this APL, in the same manner, as applicable. Recredentialing must include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews. The recredentialing application must include the same attestation as contained in the provider's initial application.

MCPs must maintain a system for reporting to the appropriate oversight entities serious quality deficiencies that result in suspension or termination of a network provider. MCPs must maintain policies and procedures for disciplinary actions, including reduction, suspension, or termination of a provider's privileges, and must implement and maintain a provider appeal process.

MCPs must also conduct onsite reviews of their network provider sites. For detailed guidance, see Policy Letter (PL) 14-004, Site Reviews, Facility Site Review and Medical

[31] The Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

[32] These limited statements comply with requirements of the Americans with Disabilities Act (ADA), as discussed in the attached PL 02-03. The ADA Attachment is available at (pg. 7): http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2002/MMCDPL02003.pdf.

Record Review,[33] and any subsequent revisions to this PL. MCPs must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to the MCP's provider network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review.

Delegation of Provider Credentialing and Recredentialing

MCPs may delegate their authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the MCP remains contractually responsible for the completeness and accuracy of these activities. If an MCP delegates credential verification activities, it should establish a formal and detailed agreement with the entity performing those activities. These agreements must be revised when the parties change the agreement's terms and conditions. To ensure accountability for these activities, the MCP must establish a system that:

- Evaluates the subcontractor's ability to perform delegated activities that includes an initial review to assure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.
- Ensures that the subcontractor meets MCP and DHCS standards.
- Continuously monitors, evaluates, and approves the delegated functions.

Entities such as medical groups or independent physician organizations may conduct delegated credentialing activities and may obtain a Provider Organization Certification (POC) from the National Committee on Quality Assurance (NCQA) at their discretion. The POC focuses on the entity's role as the agent performing the credentialing functions on behalf of an MCP. The MCP may accept evidence of NCQA POC in lieu of a monitoring site visit at delegated physician organizations. If an MCP delegates credential verification activities, it should establish a formal and detailed written agreement with that entity. Such agreements need not be revised until the parties to the agreement change the agreement's terms and conditions.

Health Plan Accreditation

MCPs that receive a rating of "excellent," "commendable," or "accredited" from the NCQA will be deemed to have met DHCS' requirements for credentialing. Such MCPs will be exempt from DHCS' medical review audit of credentialing practices. MCPs; however, retain overall responsibility for ensuring that credentialing requirements are met. Credentialing accreditation from entities other than the NCQA will be considered by DHCS upon request.

[33] Policy Letter 14-004 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-004.pdf

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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 applicable APLs, PLs and Dual Plan Letters. For questions regarding this APL, please contact your MCOD contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

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Attachment 1: Provider Types and Categories of Risk[34]/Screening Requirements

(1) Limited Risk Provider Types. Physician or non-physician practitioners and medical groups or clinics:

- Ambulatory Surgical Centers (ASCs)
- End-Stage Renal Disease (ESRD) facilities
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Hospitals, including Critical Access Hospitals (CAHs)
- Indian Health Service (IHS) facilities
- Mammography screening centers
- Mass immunization roster billers
- Organ Procurement Organizations (OPOs)
- Portable x-ray suppliers
- Providers or suppliers that are publicly traded on the New York Stock Exchange (NYSE) or NASDAQ
- Public or Government-Owned Ambulance Services Suppliers
- Religious Nonmedical Health Care Institutions (RNHCIs)
- Rural Health Clinics (RHCs)
- Radiation therapy centers
- Skilled Nursing Facilities (SNFs)

(2) Moderate Risk Provider Types. Provider and supplier categories:

- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Currently enrolled (re-validating) home health agencies
  - Exception: Any such provider that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Currently enrolled (re-validating) suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)
  - Exception: Any such supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities

[34] CMS-6028-FC Tables 1–3. Federal Register / Vol. 76, No. 22 / February 2, 2011 / Rules and Regulations

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- Non-public, non-government owned or affiliated ambulance services suppliers
    - Exception: Any such provider or supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.

(3) High Risk Provider Types. Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS.

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Attachment 2: Managed Care Provider Enrollment Disclosure

Background

Beginning January 1, 2018, federal law requires that all managed care network providers must enroll in the Medi-Cal Program if they wish to provide services to Medi-Cal managed care beneficiaries. Managed care providers have two options for enrolling with the Medi-Cal Program. Providers may enroll through (1) DHCS; or (2) an MCP. If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with MCPs. If the provider enrolls through an MCP, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to fee-for-service (FFS) providers will also apply to the enrollment process for managed care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements - the "Plan Provider Agreement" and the "DHCS Provider Enrollment Agreement." The Plan Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The DHCS Provider Enrollment Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. Enrollment through an MCP. The following provides an overview of the MCP enrollment process:

- The provider will submit a provider enrollment application to the MCP using a process developed by the MCP.
- As part of the application process, the provider will be required to agree that DHCS and the MCP may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The MCP will be responsible for gathering all necessary documents and information associated with the MCP application.
- The provider should direct any questions it has regarding its MCP application to the MCP.
- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with the MCP.
- While the MCP enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment

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application may differ. In addition, MCPs will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.

- Providers will not have the right to appeal an MCP's decision to cease the enrollment process.
- The MCP will complete the enrollment process within 120 days of the provider's submission of its application. During this time, the provider may participate in the MCP's network for up to 120 days, pending approval from the MCP.
- Once the enrolling MCP places a provider on the Enrolled Provider List, the provider is eligible to contract with all MCPs. However, an MCP is not required to contract with an enrolled provider.
- Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.
- Accordingly, if the MCP receives any information that impacts the provider's enrollment, the MCP will suspend processing the provider's enrollment application and refer the provider to DHCS' FFS Provider Enrollment Division (PED) for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

B. Enrollment through DHCS.

- The provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program. (See http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx)
- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for managed care providers.
- Upon successful enrollment through DHCS, the provider will be eligible to contract with MCPs and provide services to FFS beneficiaries.

There may be other important aspects of the enrollment process that are not set forth in this information bulletin. Please check the DHCS website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2010
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. C. Authorize Revisions to Credentialing and Provider Participation Requirements in CalOptima's Medi-Cal Program

Contact

Gertrude S. Carter, M.D., Chief Medical Officer, (714) 246-8400
Greg Buchert, M.D., MPH, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Approve policy continuing the requirement that providers furnishing services to CalOptima Medi-Cal members be enrolled in the State of California Medi-Cal Program when enrollment is available for that type of provider;
2. Approve an exception to that Policy for providers outside of Orange, Los Angeles, San Bernardino, Riverside and San Diego Counties;
3. Approve policy that the Chief Medical Officer or delegate, and delegated providers have the ability to make exceptions to the policy identified in Recommended Action No. 1 to satisfy access and continuity of care requirements in CalOptima's contract with the California Department of Health Care Services (DHCS);
4. Approve policy that providers credentialed by CalOptima or its delegated providers that furnish services, goods or supplies to Healthy Families or OneCare members are encouraged, but not required to, enroll in the State of California Medi-Cal program;
5. Eliminate the Minimum Practitioner Standards (MPS) Policy and requirement for applicable physicians to complete the MPS form prior to credentialing; and,
6. Approve changes to CalOptima's policies to reflect the changes made in this CalOptima Board Action Agenda Referral.

Background

CalOptima contracts directly with providers, or with delegated entities to arrange for providers, to render services to its members. For CalOptima's Healthy Families and OneCare programs, the providers' qualifications are evaluated by standardized credentialing processes that are consistent with NCQA standards and if deemed qualified, can provide services and bill for those services. CalOptima requires the California Department of Health Care Services (DHCS) statutory process related to authorized categories of persons and entities that provide services, goods, and supplies to Medi-Cal recipients. The State process is intended to ensure that provider practices are consistent with sound fiscal and business practices and do not result in unnecessary cost to the State Medi-Cal program and that the State/CalOptima do not have to reimburse the State or CMS for ineligible providers. The State also requires that a provider meet federal disclosure requirements including, without limitation, those related to the provider's licensure, control and ownership interests, and health care program participation status. In reviewing

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provider applications, the State has the authority to conduct unannounced visits, pre-enrollment inspections, background checks and access government resources related to convictions, pending investigations and the status of debts and penalties, if any, owed to government entities.

The State has also established enrollment moratoriums related to specific provider types throughout the State or within specific counties in order to "safeguard public funds and maintain the fiscal integrity of the Medi-Cal program." For example, the State has a moratorium on enrollment of durable medical equipment suppliers (with exceptions) that expressly includes Orange, Los Angeles, Riverside and San Bernardino Counties. Significantly, the State provider enrollment laws incorporate the State's right to summarily deny or suspend a provider's enrollment status, for example, where there are pending allegations of fraud or abuse or investigations related to same.

Prior to January 1, 2009, CalOptima's State Medi-Cal contract with the DHCS required that "each provider who delivers Covered Services to Members shall *be eligible* for participation in the Medi-Cal program and shall meet applicable requirements established under Titles XVIII and XIX of the Social services Act unless exempted from these provisions." The State's enrollment process may take as long as twelve months for a provider to receive acknowledgement of enrollment. While most providers complied with this requirement, some providers discontinued attempting to be paid for services rendered or refused to provide future services to CalOptima members.

In addition to standard credentialing requirements for all providers and the supplemental Medi-Cal enrollment procedure for providers in certain CalOptima medical delivery systems, CalOptima initiated a requirement for providers to supply additional information in order to be paid by CalOptima – the Minimum Practitioner Standards (MPS) form based on the CalOptima Board-approved policy. This policy was adopted in part to allow for a contracted COD network and to provide a basis of denying provider participation without the necessity of a formal statutorily-required hearing for providers who could not meet the standards. All questions of this seven question form request identical information that is included on credentialing applications. Eliminating the MPS form may result in the CalOptima having to file a notice to the Medical Board of California (an "805" report) for COD or Hospital Risk providers in the Medi-Cal program for which CalOptima takes certain actions based on a medical or disciplinary cause or reason. This requirement already exists for PHCs, HMOs, and SRGs in the CalOptima Healthy Families and OneCare programs.

CalOptima entered into a new State Medi-Cal contract with DHCS on January 1, 2009. The contract *no longer* includes language requiring "each provider who delivers Covered Services to Members shall be eligible for participation in the Medi-Cal program and shall meet applicable requirements established under Titles XVIII and XIX of the Social Services Act unless exempted from these provisions." The new 2009 State Medi-Cal contract also includes the following language: "Nothing in this provision shall be construed to require that subcontracting providers be enrolled as a Medi-Cal provider." The new State Medi-Cal contract does incorporate a

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Prepaid Health Plan statute which expressly prohibits contracts between DHCS and PHPs "unless the providers and the facilities of the prepaid health plan meet the Medi-Cal program standards for participation as established by the director." Based on the contract language and communications with the State, CalOptima Staff understands that its providers do not have to enroll with the State Medi-Cal provider enrollment unit.

CalOptima continues to have obligations to ensure that providers furnishing covered items and services to CalOptima members are contracted and meet federal and state requirements through a standardized credentialing process, including providers who cannot enroll with Medi-Cal (e.g., Health Educators, Dieticians, providers subject to DHCS moratorium, and in-home service providers).

Discussion

CalOptima is responsible for providing access to qualified providers to its members through a standard credentialing process that includes evaluation of many items relevant to quality, integrity and licensure. The attached table compares the differences between those activities that are consistently performed as part of the CalOptima credentialing programs at either CalOptima or by its delegated entities with activities that may occur during the DHCS enrollment process.

Primary care providers in the CalOptima Medi-Cal program also have stringent DHCS defined facility site reviews that include both an inspection of the physical space and evaluation of adherence to certain standards, as well as an evaluation of medical record documentation practices. CalOptima's credentialing process and those of its delegated networks are audited on a routine basis by DHCS, the California Department of Managed Health Care (DMHC) and the Centers for Medicare & Medicaid Services (CMS).

For those providers that enroll with the Medi-Cal program, CalOptima benefits from that process which similarly screens potential CalOptima providers for applicable State and federal requirements and makes ultimate determinations on participation in the Medi-Cal program. Unlike the State, CalOptima does not have similar legal authority or resources to conduct the certain pre-screening and investigative activities related to provider enrollment nor does it have the same statutory authority to summarily suspend providers based on pending investigations and other matters. This responsibility and associated risk will be assumed by CalOptima for certain providers for provision of Medi-Cal services if it does not continue to require Medi-Cal enrollment for excepted providers.

While CalOptima strives to assure providers are qualified to provide services to its Medi-Cal members, it also strives to assure that its members are able to gain access to and have choice of the largest number of providers possible. While there are many CalOptima Direct providers that are currently enrolled in the Medi-Cal program, some are not, and to complete a contracted network, CalOptima needs the flexibility to make exceptions to these enrollment requirements to satisfy its access and continuity of care obligations under its contract with DHCS.

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CalOptima believes that, of the number of active licensed providers (Physicians, Podiatrists, Nurse Practitioners, Optometrists) in Orange County, approximately half are not enrolled in the Medi-Cal program although it is possible that some of these providers may not be entitled to directly bill the Medi-Cal program. The majority of providers that do not enroll in the Medi-Cal program elect to maintain that status for a variety of reasons (including desire to limit their Medi-Cal patients in their practice and avoid the lengthy application process), hence, become unavailable to serve CalOptima Direct and network members, yet they are still eligible to provide services to OneCare and Healthy Families members. Often times, providers who participate in OneCare or Healthy Families will also render services to CalOptima members because they are not aware of the different requirements for each line of business and they are frustrated by the delay or denial of payment for lack of Medi-Cal enrollment.

This policy would exempt providers outside Los Angeles, San Bernardino, Riverside, San Diego and Orange Counties from being enrolled with Medi-Cal or credentialed by CalOptima to be paid by CalOptima for rendering services to its members. It would also allow CalOptima's Chief Medical Officer, and delegated providers in conjunction with the Chief Medical Officer, to use providers who are not enrolled with Medi-Cal to satisfy CalOptima's State Contract requirements to provide proper access to, and continuity of, care for members. Examples of such exemptions may include providers in certain geographic areas which do not have adequate enrolled providers; providers that have unique needed clinical expertise; and providers who see less than five members in a calendar year. These types of providers will still be credentialed by CalOptima and may, in addition, have applications for enrollment in Medi-Cal pending.

In adopting this policy, CalOptima will assume additional responsibilities and liabilities. CalOptima must monitor anti-discrimination; be responsible for provider disciplinary matters; increase screening of providers presently done by Medi-Cal as a part of enrollment compliance; monitor federal/state requirements of its non-enrolled providers including fraud and abuse; and risk of challenge by providers not exempted from the requirement. The monitoring requirements assumed by CalOptima may present problems since DHCS will have limited jurisdiction for any fraud and abuse referrals related to non-enrolled providers. CalOptima has limited ability to investigate, and it cannot prosecute suspected fraud. CalOptima will have to rely on referring such matters to the Attorney General, District Attorney or the applicable State Licensing Board, which may lead to additional costs to investigate and additional risk of investigation or penalty to CalOptima of being out of compliance until the issue is resolved.

Notwithstanding these risks, Management makes the recommended actions outlined in this report to allow required access to providers for CalOptima Medi-Cal members while continuing to require the Medi-Cal enrollment process for the reasons stated herein. CalOptima would have to submit any changes to its provider participation requirements and related policies to DHCS for approval.

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Fiscal Impact

For both medical and administrative expenses, the fiscal impact of this action on the CalOptima budget is not known. For medical expenses, a small number of providers may currently be seeing CalOptima members but not submitting claims because they are not enrolled in the Medi-Cal program. However, neither the number of unsubmitted claims nor the associated dollars are estimated to be material. For additional administrative expenses, management anticipates that they will be absorbed into the Board-approved budget. Such expenses are dependent on several factors. For example, there may be new administrative responsibilities due to the need for CalOptima to take on additional levels of review related to provider enrollment requirements that are not currently part of CalOptima's credentialing program. Also, CalOptima's Compliance Department may have increased obligations and incur additional costs due to the DHCS' Audits & Investigations Unit (A&I) not having jurisdiction over non-enrolled providers should CalOptima identify potential fraud and/or abuse involving non-enrolled providers. Staff will monitor medical and administrative expenses and keep the Board apprised should they prove to be greater than anticipated.

Rationale for Recommendation

Notwithstanding the additional risk and possible administrative costs to CalOptima in allowing exceptions to Medi-Cal enrollment, the recommendations, if adopted, will allow CalOptima expanded access to quality health care service providers consistent with the State Contract who are not presently enrolled in the Medi-Cal program.

Concurrence

Procopio, Cory, Hargreaves & Savitch LLP

Attachment

Medi-Cal Enrollment and CalOptima Contracting and Credentialing Comparison

/s/ Richard Chambers — *10/1/2010*

Authorized Signature — **Date**

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Medi-Cal Enrollment and CalOptima Contracting and Credentialing Comparison

Category	Item	DHCS FFS	CalOptima Contracted
Information Collected	All Providers	Business Location	Business Location
		Tax ID Number	Tax ID Number
		Licenses	Licenses
		Proof of Insurance	Proof of Insurance
		Business License	*
		Seller's Permits (if req.)	*
		Fictitious Business Name Statement (if app.)	*
		Fines or Debts Owed to Govt. Healthcare Programs	*
		Felony convictions in last ten years	Felony convictions in last ten years
		Misdemeanor convictions involving fraud/abuse in last ten years	*
		Civil liability involving fraud/abuse in last ten years	*
		Settlements in lieu of conviction for fraud/abuse in last ten years	*
		Suspensions from Medi-Cal/Medicare/Medicaid	Suspensions from Medi-Cal/Medicare/Medicaid
		Suspensions/Revocations of license/certificate/approval to provide health care	Suspensions/Revocations of license/certificate/approval to provide health care
		Lost or surrendered license/certificate/approval to provide health care with discipline pending	Lost or surrendered license/certificate/approval to provide health care with discipline pending
		History of discipline re: license/certificate/approval to provide health care	History of discipline re: license/certificate/approval to provide health care
		Ownership/management/control	*
		Subcontractor information	*
		Subcontractor ownership/management/control if over $75K over five years	*
	Group Practices	Group type and specialties	Group type and specialties
		Rendering providers	Rendering providers
		Hospital privileges of rendering providers	
		Suspended or revoked hospital privileges of rendering providers	
		Voluntary resignation or surrender of hospital privileges by rendering providers	
		CLIA certificate number	
		State laboratory license/registration number	

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Category	Item	DHCS FFS	CalOptima Contracted
		Rendering provider application for providers not already enrolled	
		partnership agreement, if partnership	
	Physicians	CLIA certificate number	
		State laboratory license/registration number	
		Hospital privileges	Hospital privileges
		Suspended or revoked hospital privileges	Suspended or revoked hospital privileges
		Voluntary resignation or surrender of hospital privileges	Voluntary resignation or surrender of hospital privileges
			Other previous hospital privileges
			Premed Education
			Medical education
			Internship/PGYI
			Residencies/Fellowships
			Board Certifications
			Other Certifications
			Other state licenses
			Peer references
			Work history
			Student status relinquishment
			Professional organization discipline
			Drug-related impairment
			Disability accommodation
			Malpractice judgments/settlements
			Professional liability insurance termination/non-renewal
	Rendering Providers	Payment arrangement documents	No separate requirements
		DEA certificate	
		Anesthesia permit	
		Conscious sedation permit	
	Hospital-Based Physician	CLIA Certificate number	Exempted
		State laboratory license/registration number	

Category	Item	DHCS FFS	CalOptima Contracted
Independent Verification	As applicable	Professional licensure	Professional licensure
		Criminal history--Applicant, provider and all ownership and control persons	
		Suspensions from government programs	Suspensions from government programs
		Professional discipline	Professional discipline
		Compliance with definition (22 CCR Art. 2, Ch. 3)	
		Compliance with Standards (22 CCR Art.3, Ch. 3 and W&I Ch. 7 and Ch. 8)	
		Business licenses	
		Payment of all outstanding fines and debts to government programs	
		Current FWA investigation status of applicant, providers and all ownership and control persons	
		Onsite inspection	Onsite inspection
		No denial of enrollment in last three years	
			Hospital privileges
			Education
			Board certification
			DEA Certification
			Malpractice claim history
Enforcement Tools	All	Referral to law enforcement	Referral to law enforcement
		Contract remedies	Contract remedies
		Recoupment of Overpayments	Recoupment of Overpayments
		Civil monetary penalties	
		Peace officer status employees in Audits and Investigations	
		Summary deactivations	
		Summary terminations of provisional and preferred provisional providers	
		Sanctions (reprimand/probation/suspension)	

* CalOptima's contract with DHCS requires CalOptima to collect current, completed DHCS Disclosure Form from each subcontractor containing this information.

Credentialing and Provider Participation Requirements

Board of Directors Meeting
October 7, 2010

Gertrude S. Carter, M.D.
Chief Medical Officer

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Medi-Cal Participation History

- Requirement based on Fee-for-Service (FFS) Medi-Cal requirements

- Administrative and business focused assessment
  - Example: location, licensure status, provider's legal standing (see grid)

- FFS Medi-Cal needs:
  a. Screening mechanism to ensure minimum participation standard
  b. Means to facilitate payment
  c. Capability to monitor and enforce legal requirements

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CalOptima Participation History

- CalOptima currently requires Medi-Cal participation

- CalOptima credentialing process includes Medi-Cal participation, administrative and business requirements plus significant clinical and quality requirements.
  - Credentialing includes:
    - Education, board certification, affiliation/privileges and clinical performance
    - Facility site review and medical record review

- Former DHCS Contract stated: “Provider shall be eligible for participation in the Medi-Cal Program.”

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Current CalOptima Contract

- Current updated Medi-Cal contract language clarifies DHCS position:
  - Exhibit A, Attachment 6 (Provider Network), Provision 12 (Subcontracts)

    "Contractor shall remain accountable for all functions and responsibilities that are delegated to subcontractors. Nothing in this provision shall be construed to require that subcontracting providers be enrolled as a Medi-Cal provider."

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Issue

- What should the policy be in those cases where compliance with both requirements are in conflict, specifically when access and quality cannot be met within a Medi-Cal enrolled network?
  - ➢CalOptima has an informal process that is based on medical necessity
  - ➢The informal “exception” policy is not consistent with the current participation policy

Exceptions

- Geographic
  - Availability of service in geographic area
- Clinical service
  - Access to the most appropriate level of experience available
- Continuity of care
  - Maintaining on-going treatment plan
- Member specific need that can drive clinical outcomes
  - Culture
  - Religion
  - Gender

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Analysis 2009

- COD Prior Authorization = 30,000

- Letters of Agreement = 906
  - Ambulatory Surgery Centers = 591
  - Hospitals = 197
  - Other Facilities = 50
  - Professional Services = 56
  - Other = 12

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Analysis 2009

- Historical (Non Medi-Cal enrolled providers)
  - ➢COD (Registered) = 163 of 4,647 total contracted providers = 3.5%
  - ➢Noble = 9 of 369 total contracted providers = 2.4%
  - ➢CHOC Health Alliance = 6 of 688 total contracted providers = 0.9%
  - ➢Monarch = 72 of 1,532 total contracted providers = 4%

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Risk

- CalOptima would have to assume legal and enforcement functions without the State's police powers for those non- Medi-Cal enrolled providers, just as with all other lines of business

- Poses minimum risk because:
  1. Credentialing process
  2. Primary focus is high complex specialty directed providers who have affiliations with tertiary facilities
  3. Low utilization of exceptions
  4. CalOptima oversight activities including both compliance and peer review

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Recommendation

Align the informal process with current policy to continue Medi-Cal participation with exceptions that promote access and quality based on medical necessity review.

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CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
9. Consider Approval of Modification of CalOptima Policy and Procedure Related to CalOptima's Whole-Child Model Family Advisory Committee

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

Recommended Action
Approve modifications to Policy and Procedure AA.1271: Whole-Child Model Family Advisory Committee.

Background
The CalOptima Board of Directors approved Resolution Number 17-1102-01 on November 2, 2017 to form the Whole-Child Model Family Advisory Committee as required by the Department of Health Care Services (DHCS). As a part of the Resolution, it stated that a representative from the WCM FAC may be invited to serve on a statewide stakeholder group.

Discussion
DHCS holds quarterly California Children's Services Advisory Group (CCS AG) meetings to engage stakeholders in improving the delivery of health care to CCS children and their families, address strategies on issues such as transition for youth aging-out of CCS, improving access for Durable Medical Equipment and care coordination protocols. CalOptima was advised by DHCS on March 29, 2019, that a member of CalOptima's WCM FAC committee had been selected to serve on the CCS AG.

CalOptima staff proposes modification of policy AA.1271: Whole-Child Model Family Advisory Committee to include reimbursement for eligible expenses and a clarification on receiving stipends related to a WCM FAC committee member attendance at a quarterly CCS AG meeting.

Fiscal Impact
The fiscal impact to reimburse eligible travel expenses for a WCM FAC committee member to attend the CCS AG meeting is up to $500 per quarterly meeting. Management will include $2,000 in annual expenditures for this purpose in future CalOptima operating budgets.

Rationale for Recommendation
To ensure CalOptima meets all requirements of the Whole-Child Model program, approval of the requested action is recommended.

Concurrence
Gary Crockett, Chief Counsel

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Attachment
Revised CalOptima Policy AA.1271: Whole-Child Model Family Advisory Committee (Redline and Clean)

/s/ Michael Schrader — *4/24/2019*
Authorized Signature — **Date**

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Policy #:	AA.1271
Title:	**Whole -Child Model Family Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/2018
~~Last Review Date:~~	~~Not Applicable~~
~~Last~~ Revised Date:	~~Not Applicable~~05/02/2019

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole -Child Model (**WCM**) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the **Whole -Child Model** Family Advisory Committee (**WCM** FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the **WCM** FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regard to **California Children's Services (CCS)** provided by CalOptima Medi-Cal's implementation of the **WCM**.

B. CalOptima's Board encourages **Member** and community involvement in CalOptima programs.

C. **WCM** FAC **Members** shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the ***WCM*** FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the **WCM** FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. **WCM** FAC **Members** shall have direct or indirect contact with CalOptima **Members**.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the **WCM** FAC shall be comprised of eleven (11) voting members representing **CCS** family members, as well as consumer advocates representing **CCS** families. Except as noted below, each voting member shall serve a two (2)-year term with no limits on the number of terms a representative may serve. The initial appointments of **WCM** FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The **WCM** FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

DRAFT

a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima **Member** who is a current recipient of ***CCS*** services;

b. CalOptima **Members** eighteen (18)-twenty-one (21) years of age who are current recipients of ***CCS*** services; or

c. Current CalOptima **Members** over the age of twenty-one (21) who transitioned from **CCS** services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving **CCS** services, including:

a. Community-based organizations; or

b. Consumer advocates.

3. While two (2) of the **WCM** FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) **WCM** FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a **WCM** FAC member or family member representative.

5. A family representative, in accordance with Section II.F.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group~~.~~. CalOptima shall reimburse eligible expenses associated with attending the statewide stakeholder advisory group quarterly meetings in accordance with CalOptima Policy GA.5004: Travel Policy.

G. Stipends

1. ~~Subject to approval by the CalOptima Board,~~ CalOptima may provide a reasonable per diem payment of up to $50 per meeting to a member or family representative serving on the **WCM** FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

2. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The **WCM** FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. **WCM** FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the **WCM** FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new **WCM** FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, **WCM** FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The **WCM** FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The **WCM** FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The **WCM** FAC chair or vice chair shall ask for three (3) to four (4) members from the **WCM** FAC to serve on a nomination ad hoc subcommittee. **WCM** FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The **WCM** FAC nomination ad hoc subcommittee shall:

a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

b. Forward the prospective chair, vice chair, and slate of candidate(s) to the **WCM** FAC for review and approval.

2. Following approval from the **WCM** FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the **WCM** FAC.

M. Upon appointment to **WCM** FAC and annually thereafter, **WCM** FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the **WCM** FAC.

N. **WCM** FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a **WCM** FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the **WCM** FAC members' attendance at **WCM** FAC meetings. As the attendance log is a public record, any request from a member of the public, the **WCM** FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the **WCM** FAC chair or vice chair shall contact any committee member who has three (3) consecutive unexcused absences.

1. **WCM** FAC members**'** attendance shall be considered as a criterion upon reapplication.

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III. PROCEDURE

A. **WCM** FAC meeting frequency

1. **WCM** FAC shall meet at least quarterly.

2. **WCM** FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. **WCM** FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in **CCS** which are or are expected to transition to CalOptima's Whole -Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving **CCS**;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in **Threshold Languages**.

3. Prospective candidates must submit a **WCM** Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the **WCM** FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first **WCM** FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. **WCM** FAC nomination evaluation process

1. The **WCM** FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the ~~nominations~~nomination's ad hoc subcommittee. For the first nomination process, **Member Advisory Committee (MAC)** members shall serve on the nominations ad hoc subcommittee to review candidates for **WCM** FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to **WCM** FAC nomination ad hoc subcommittee meeting (including the initial **WCM** FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. **WCM** FAC selection and approval process for prospective chair, vice chair, and **WCM** FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to **WCM** FAC (or in the first year, the **MAC**) for review and approval. Following **WCM** FAC's approval (or in the first year, the **MAC**), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The **WCM** FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following **WCM** FAC meeting.

3. **WCM** FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENT(S)

A. Whole -Child Model Member Advisory Committee Application
B. Whole -Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole -Child Model Community Advisory Committee Application
D. Whole -Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)
E. CalOptima Policy GA.5004: Travel Policy

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VI. REGULATORY AGENCY APPROVAL(S)

A. 09/07/18: Department of Health Care Services

VII. BOARD ACTION(S)

A. 06/07/18: Regular Meeting of the CalOptima Board of Directors
B. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number#~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	06/07/2018	AA.1271	Whole -Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	05/02/2019	AA.1271	Whole -Child Model Family Advisory Committee	Medi-Cal Administrative

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IX. GLOSSARY

Term	Definition
California Children's Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole -Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole -Child Model (WCM)	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

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Policy #:	AA.1271
Title:	**Whole Child Model Family Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/2018
Revised Date:	05/02/2019

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (**WCM**) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the **Whole Child Model** Family Advisory Committee (**WCM** FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the **WCM** FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regard to **California Children's Services (CCS)** provided by CalOptima Medi-Cal's implementation of the **WCM**.

B. CalOptima's Board encourages **Member** and community involvement in CalOptima programs.

C. **WCM** FAC **Members** shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the ***WCM*** FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the **WCM** FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. **WCM** FAC **Members** shall have direct or indirect contact with CalOptima **Members**.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the **WCM** FAC shall be comprised of eleven (11) voting members representing **CCS** family members, as well as consumer advocates representing **CCS** families. Except as noted below, each voting member shall serve a two (2)-year term with no limits on the number of terms a representative may serve. The initial appointments of **WCM** FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The **WCM** FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

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* Terms in **bold** are defined in the Glossary

a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima **Member** who is a current recipient of ***CCS*** services;

b. CalOptima **Members** eighteen (18)-twenty-one (21) years of age who are current recipients of ***CCS*** services; or

c. Current CalOptima **Members** over the age of twenty-one (21) who transitioned from **CCS** services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving **CCS** services, including:

a. Community-based organizations; or

b. Consumer advocates.

3. While two (2) of the **WCM** FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) **WCM** FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a **WCM** FAC member or family member representative.

5. A family representative, in accordance with Section II.F.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group. CalOptima shall reimburse eligible expenses associated with attending the statewide stakeholder advisory group quarterly meetings in accordance with CalOptima Policy GA.5004: Travel Policy.

G. Stipends

1. CalOptima may provide a reasonable per diem payment of up to $50 per meeting to a member or family representative serving on the **WCM** FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

2. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The **WCM** FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. **WCM** FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the **WCM** FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new **WCM** FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, **WCM** FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The **WCM** FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The **WCM** FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The **WCM** FAC chair or vice chair shall ask for three (3) to four (4) members from the **WCM** FAC to serve on a nomination ad hoc subcommittee. **WCM** FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The **WCM** FAC nomination ad hoc subcommittee shall:

a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

b. Forward the prospective chair, vice chair, and slate of candidate(s) to the **WCM** FAC for review and approval.

2. Following approval from the **WCM** FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the **WCM** FAC.

M. Upon appointment to **WCM** FAC and annually thereafter, **WCM** FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the **WCM** FAC.

N. **WCM** FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a **WCM** FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the **WCM** FAC members' attendance at **WCM** FAC meetings. As the attendance log is a public record, any request from a member of the public, the **WCM** FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the **WCM** FAC chair or vice chair shall contact any committee member who has three (3) consecutive unexcused absences.

1. **WCM** FAC members**'** attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. **WCM** FAC meeting frequency

1. **WCM** FAC shall meet at least quarterly.

2. **WCM** FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. **WCM** FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in **CCS** which are or are expected to transition to CalOptima's Whole Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving **CCS**;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in **Threshold Languages**.

3. Prospective candidates must submit a **WCM** Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the **WCM** FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first **WCM** FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. **WCM** FAC nomination evaluation process

1. The **WCM** FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nomination's ad hoc subcommittee. For the first nomination process, **Member Advisory Committee (MAC)** members shall serve on the nominations ad hoc subcommittee to review candidates for **WCM** FAC.

   a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to **WCM** FAC nomination ad hoc subcommittee meeting (including the initial **WCM** FAC nomination ad hoc subcommittee).

    a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

    b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

    c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. **WCM** FAC selection and approval process for prospective chair, vice chair, and **WCM** FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to **WCM** FAC (or in the first year, the **MAC**) for review and approval. Following **WCM** FAC's approval (or in the first year, the **MAC**), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The **WCM** FAC members' terms shall be effective upon approval by the CalOptima Board.

    a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following **WCM** FAC meeting.

3. **WCM** FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENT(S)

A. Whole Child Model Member Advisory Committee Application
B. Whole Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole Child Model Community Advisory Committee Application
D. Whole Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)
E. CalOptima Policy GA.5004: Travel Policy

VI. REGULATORY AGENCY APPROVAL(S)

A. 09/07/18: Department of Health Care Services

VII. BOARD ACTION(S)

A. 06/07/18: Regular Meeting of the CalOptima Board of Directors
B. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	06/07/2018	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	05/02/2019	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative

IX. GLOSSARY

Term	Definition
California Children's Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model (WCM)	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole Child Model Family Advisory Committee (WCM FAC)
Member Application Fiscal Year 2019-2020

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-347-5785**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below: *

Seven (7) to nine (9) seats shall be member/family representatives for a one or two-year term. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children's Services/Whole Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children's Services/Whole Child Model member.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

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Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

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Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): **Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.**
Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of the CalOptima Whole Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for.**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free **1-800-735-2929**.

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RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

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CalOptima
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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

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Whole Child Model Family Advisory Committee (WCM FAC)
Community Application Fiscal Year 2019-2020

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-347-5785.

Name: _____ Work Phone: _____

Address: _____ Mobile Phone: _____

City, State ZIP: _____ Fax Number: _____

Date: _____ Email: _____

Please see the eligibility criteria below:

Two (2) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

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3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State ZIP: _____	City, State ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Cheryl Simmons
Email: mailto:csimmons@caloptima.org
For questions, call **1-714-347-5785**

Applications must be received by April 1, 2019.

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Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken May 2, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Appointment to the CalOptima Board of Directors' Member Advisory Committee

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

Recommended Action
The CalOptima Member Advisory Committee (MAC) recommends appointment of Pamela Pimentel as the MAC Children Representative for a term ending June 30, 2020.

Background
The CalOptima Board of Directors established the Member Advisory Committee (MAC) by resolution on February 14, 1995 to provide input to the Board. The MAC is comprised of fifteen voting members. Pursuant to the resolution, MAC members serve two-year terms with the exception of the two standing seats, which are representatives from the Social Services Agency (SSA) and the Health Care Agency (HCA). The CalOptima Board is responsible for the appointment of all MAC members. In September 2018, MAC incurred a vacancy for the Children Representative due to the resignation of Luisa Santa.

Discussion
CalOptima conducted a special recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, including targeting community-based organizations (CBOs) and outreach to agencies serving the open positions. CalOptima staff received applications from interested candidates and submitted them to the Nominations Ad Hoc Subcommittee for review.

Prior to the Nominations Ad Hoc Subcommittee meeting on February 25, 2017, subcommittee members evaluated each of the applications. Subcommittee Members Sally Molnar, Sandra Finestone and Christine Tolbert met and made a recommendation to the MAC for consideration.

At its March 14, 2019 meeting, the MAC agreed to recommend the candidate the Nominations Ad Hoc had recommended.

Two candidates applied for the open position:

Children Representative Candidates
Pamela Pimentel, RN*
Mario Parada

Pamela Pimentel, RN is the Chief Executive Officer of MOMS Orange County. MOMS Orange County provides access to prenatal care, health screenings, infant development screenings, health education and referral services through home visits and group classes. Ms. Pimentel serves on several committees through the OC community, among them the National Children's Health Study Regional Community

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Engagement Committee and the Children's Outcomes Project Committee for the Nemours Foundation. She is a former member of the CalOptima Provider Advisory Committee (PAC) having served for nine consecutive years in various seats most recently as the Nurse representative. She has also served as PAC Chair.

Mario Parada is a Union Field Organizer for United Domestic Workers of America (UDWA), the Homecare Providers Union serving low-income seniors and people with disabilities as their caregivers. In his current position, Mr. Parada helps develop the organizing skills of member organizers as well as identify, recruit, train and develop union leaders. He also works to build coalitions with community groups and organizations.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As requested by the CalOptima Board of Directors, the MAC established a Nominations Ad Hoc to review potential candidates for vacancies on the Committee. The MAC met to discuss the Ad Hoc's recommended slate of candidates and concurred with the Subcommittee's recommendations. The MAC forwards the recommended slate of candidates to the Board of Directors for consideration.

Concurrence
Member Advisory Committee Nominations Ad Hoc
Member Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *4/24/2019*
Authorized Signature **Date**

*Indicates MAC recommendation

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Actions Related to the Provision of Behavioral Health Services for CalOptima OneCare Connect (Medicare-Medicaid) and OneCare Programs (HMO-SNP) Members

Contact

David Ramirez, M.D., Chief Medical Officer, 714-246-8400
Ladan Khamseh, Chief Operating Officer, 714-246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to:

1. Integrate OneCare Connect (Medicare-Medicaid Plan) and OneCare (HMO Special Need Population) covered Behavioral Health (BH) services within CalOptima internal operations effective January 1, 2020;
2. Establish a standard CalOptima provider fee schedule for BH services based on Medi-Cal and Medicare fee schedules; and
3. With the assistance of Legal Counsel, enter into new contracts or amend existing contracts, with BH providers.

Background

In June 2016, CalOptima issued a request for proposal (RFP) for the management of Medi-Cal, OneCare (OC), and OneCare Connect (OCC) BH services. The primary focus of the RFP was to identify and engage a single entity capable of managing CalOptima BH benefit for all lines of business. On September 1, 2016, the CalOptima Board of Directors (Board) authorized CalOptima to contract with Human Affairs International of California, Inc., dba Magellan Healthcare (Magellan), to be the single Managed Behavioral Health Organization (MBHO) for all lines of business effective January 1, 2017.

On August 3, 2017, the Board authorized an amendment to the Magellan contract which defined the terms and conditions for the end of the Medi-Cal contract between CalOptima and Magellan effective December 31, 2017. At its September 7, 2017 meeting, the CalOptima Board authorized staff to bring the administration of the Medi-Cal BH benefit in-house starting January 1, 2018. Further recommendations regarding management of the OC and OCC benefit were postponed to a future date. CalOptima continues to contract with Magellan as the MBHO for CalOptima's OC and OCC. This contract expires on December 31, 2019.

Under the current MBHO contract, Magellan is responsible for providing inpatient and outpatient BH professional services for all OC and OCC members. Included is coverage for all Medicare Part B covered services for BH, and reimbursement to the County and County agencies or Full-Service Partnerships for serious persistent mental illness and other Medicare covered professional services. OC and OCC members may receive additional carved out benefits through the Orange County Health Care Agency including Drug Medi-Cal Organized Delivery System.

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Discussion

Effective January 1, 2017, CalOptima contracted with Magellan for Medi-Cal, OC, and OCC members. CalOptima's primary purpose for contracting with a single MBHO was to achieve consistency and efficiency in how BH services were managed across all lines of business. BH services for Medi-Cal, OC and OCC are primarily open access, meaning a member can obtain the care without the need of prior authorization. It is important that all CalOptima members experience the same consistent level of care and support when accessing BH services. Beginning January 1, 2018, administration of Medi-Cal BH services was transitioned to CalOptima. Since the Magellan contract for OC and OCC expires on December 31, 2019, CalOptima staff proposes to integrate the OC and OCC BH benefit within CalOptima internal operations effective January 1, 2020. This transition is expected to be an incremental addition of approximately 14,000 OC and OCC members to the existing CalOptima infrastructure, which currently manages the BH services for 765,000 Medi-Cal members.

In order to integrate Medicare BH services into CalOptima operations, staff plans to leverage the clinical and operational work plan utilized for the January 2018 Medi-Cal transition. Current infrastructure and resources will be utilized to meet key milestones as well as ensure compliance with legislative, regulatory, and accreditation requirements.

Since transitioning the Medi-Cal BH benefit on January 1, 2018, CalOptima staff has developed internal operational processes and dedicated resources to manage the Medi-Cal BH benefits which include member support, utilization management, claims processing, contracting, and provider relations. A dedicated team of Customer Service Representatives (CSR), Licensed BH Clinicians, and Member Liaison Specialists (MLS) currently provide care management support for Medi-Cal members calling the CalOptima BH Line. In 2018, the BH Line received a total of 47,012 calls from members with a daily average of 187 calls. The BH call center consistently met its key performance indicators (KPI) standards during the year. The team will build on the success of the Medi-Cal BH call center for OC and OCC members.

CalOptima has also developed a robust network of BH providers for Medi-Cal members. As of March 2019, 410 BH providers contract with CalOptima. Magellan's OC/OCC network consists of 540 BH providers. Of the 540 Magellan BH providers, 168 served OC/OCC members in 2018 and 68 of them are already contracted with CalOptima for Medi-Cal services, accounting for approximately 52% of all 2018 OC/OCC BH encounters. Staff plans to amend existing Medi-Cal contracts to include the OC and OCC lines of business to maintain continuity of care for members currently receiving BH services. CalOptima staff also plans to pursue contracts with providers currently serving OC and OCC members who are not part of the Medi-Cal provider network.

If the proposed transition of BH to internal operations is approved, budgetary resources required for this transition will be included in the annual FY 2019-20 budget. Additionally, CalOptima staff will identify, develop and/or revise policy and procedures, and utilization program descriptions as appropriate. Further transition plans, updated policies and programs will be presented at subsequent Board meetings for approval as required.

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Fiscal Impact

The recommended action to integrate the management of OC and OCC covered BH services within CalOptima' internal operations is projected to be budget neutral. To maintain existing network adequacy standards, CalOptima staff plans to establish a standard provider fee schedule for BH services similar to current rates, thereby minimizing disruption to both members and providers. In addition, CalOptima does not anticipate a material change in utilization resulting from the transition. Staff projects that the total costs of claims and administration for the BH benefit will not exceed the capitation amount currently paid to Magellan for these services. Management plans to include projected expenses associated with the internal administration of the OCC and OC behavioral health benefit in the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

It is critical to ensure continuity of care and access to services for OC and OCC members with behavioral health. Management believes that the best option is to integrate administration of mental health into CalOptima operations, with the services continuing to be provided by private sector providers. This approach has proven to be successful with the Medi-Cal line of business. It 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.

Currently, CalOptima delegates the management of OC and OCC BH benefits to MBHO. Given the successful implementation and direct management of Medi-Cal BH benefits by CalOptima, and in accordance with the original Board approved action to establish a single entity to manage all behavioral health benefits, management is seeking Board consideration to bring the administration of the OC and OCC BH benefits under CalOptima's operations and management.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Actions referenced:
   a. 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 with College Health Independent Practice Association and Windstone Behavioral Health
   b. Board Action dated September 7, 2017, Consider Further Actions Related to the Provision of Behavioral Health Services for CalOptima Medi-Cal Members

/s/ Michael Schrader — *4/24/2019*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

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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

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- 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.

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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**

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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.

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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**

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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

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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**

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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

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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

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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

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- 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**

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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.

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;

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- 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.);

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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.

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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.

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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

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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.

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

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
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

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

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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"

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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

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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,

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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.

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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.

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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**

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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.

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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 — **Authorized Signature**

01/29/2016 — **Date**

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Attachment to:
February 4, 2016
Agenda Item 7

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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.

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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**

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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

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Today's Agenda

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

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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

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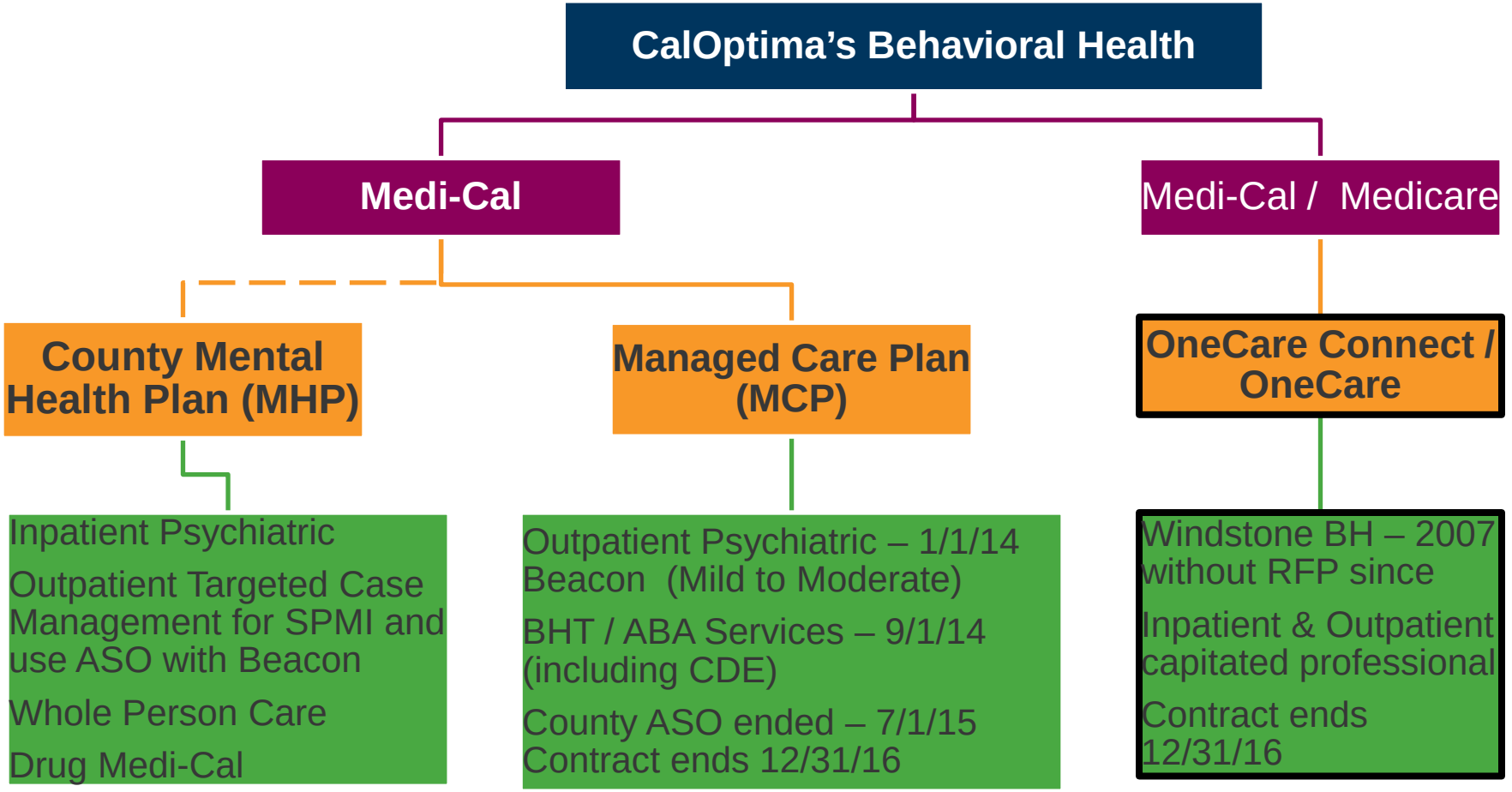
Behavioral Health Services at CalOptima



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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

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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

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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

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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"

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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

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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

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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

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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

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* 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

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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

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MBHO Selection Process – Additional Steps

- **Contract Language**
  - ➢Proposed changes reviewed
- **References**
  - ➢Reference checks completed and support the RFP scoring
- **Financial Review**
  - ➢Magellan and Envolve proposals were reviewed with Finance and determined to have a reasonable pricing model

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Rationale for Recommendation

- 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
  - All delegated functions related to the Behavioral Health benefits: Customer Service, Care Management, Utilization Management, Credentialing, Quality Improvement, Claims Processing and Payment, Provider Dispute Resolution, Compliance and first level Provider Appeals

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Rationale for Recommendation

- CalOptima staff believes contracting with Magellan will meet CalOptima's goal of continuing to provide a comprehensive provider network and Behavioral Health and ASD services for CalOptima's Medi-Cal and Duals programs with:
  - Efficient and effective assessment, diagnosis, integrated care planning, strength based and person centered treatment implementation, support services and outcomes evaluation
  - Cultural responsiveness to our diverse membership, to develop a full picture of the various needs of the person and support goals and strategies to help members achieve and maintain recovery

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Next Steps

- Authorize the CEO to:
  - Enter into contract within 30 days with Magellan Health Inc.
  - Contract with a consultant(s) for up to $50,000 to assist with implementation
  - Extend the current CHIPA and Windstone contracts for up to six months, if necessary, to ensure no gap in coverage during the transition
- Direct CEO to return to the Board with further recommendations if contract is not finalized with Magellan within 30 days.

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CalOptima's Mission

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

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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

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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.

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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**

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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

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Agenda

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

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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

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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)

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

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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

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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

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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

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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)

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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

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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

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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

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**	

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BCBA = Board Certified Behavior Analyst

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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

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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

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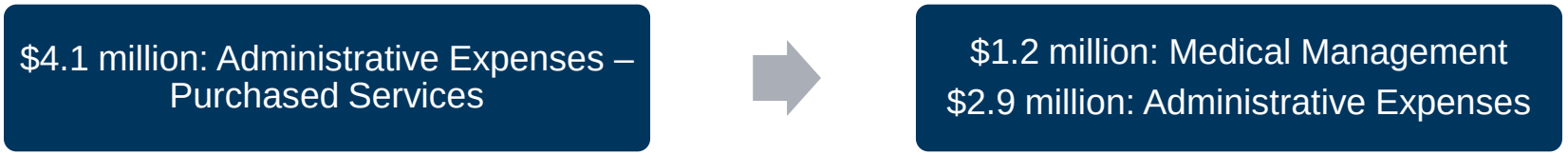
Fiscal Impact

- 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

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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.

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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.

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CalOptima's Mission

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

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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

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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

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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.

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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

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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**

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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

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Agenda

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

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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

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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)

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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

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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

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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)

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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

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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;

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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.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

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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

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- 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.

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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**

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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.

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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**

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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

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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

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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

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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

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- 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**

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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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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;

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- 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.);

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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.

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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.

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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

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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.

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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

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Department of Health Care Services

TOBY DOUGLAS
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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

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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"

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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.

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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.

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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**

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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.

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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

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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.

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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**

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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

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Today's Agenda

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

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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

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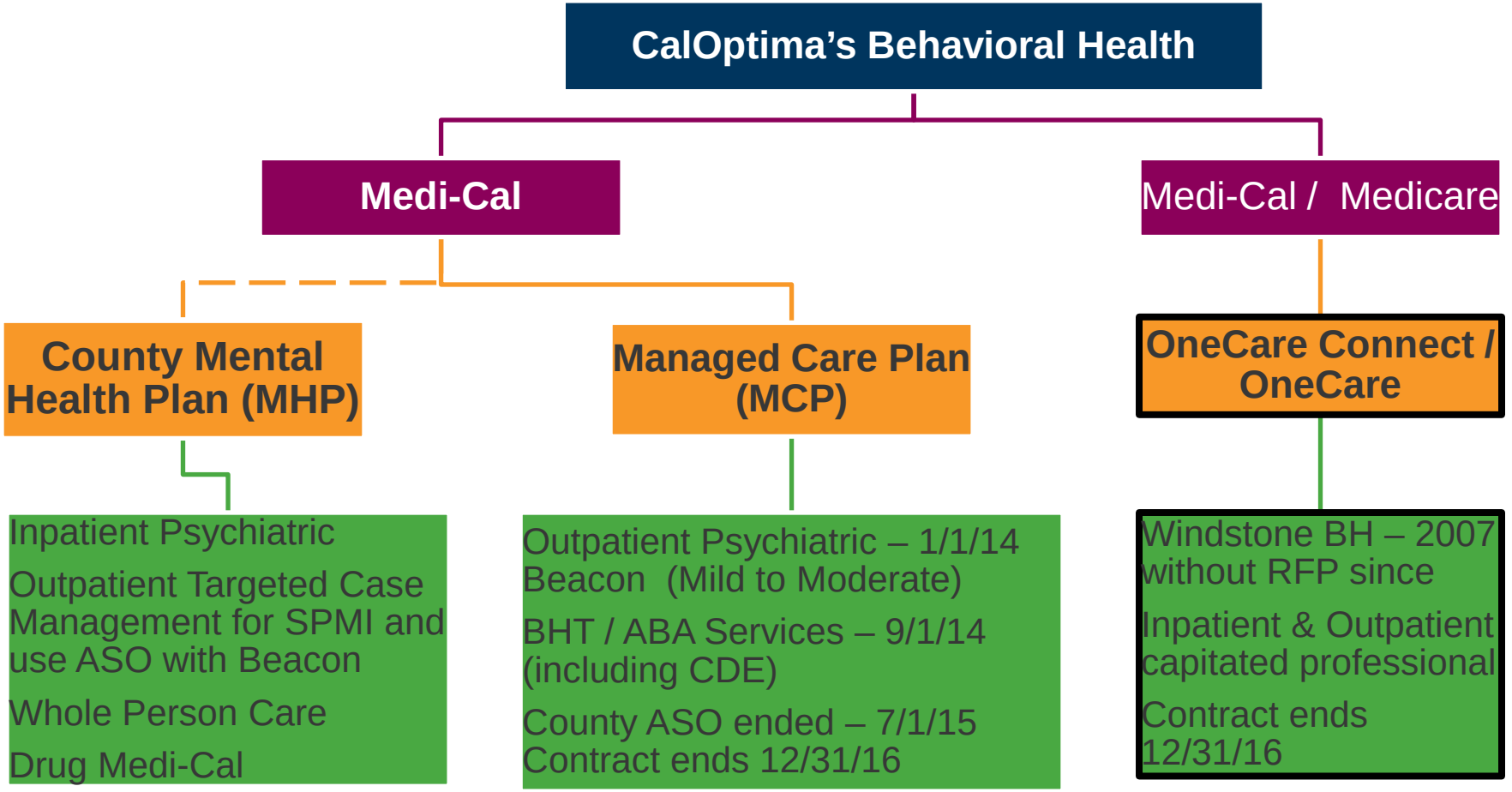
Behavioral Health Services at CalOptima



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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

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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

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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

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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"

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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

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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

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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

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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

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* 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

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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

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MBHO Selection Process – Additional Steps

- **Contract Language**
  - ➢Proposed changes reviewed
- **References**
  - ➢Reference checks completed and support the RFP scoring
- **Financial Review**
  - ➢Magellan and Envolve proposals were reviewed with Finance and determined to have a reasonable pricing model

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Rationale for Recommendation

- 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
  - All delegated functions related to the Behavioral Health benefits: Customer Service, Care Management, Utilization Management, Credentialing, Quality Improvement, Claims Processing and Payment, Provider Dispute Resolution, Compliance and first level Provider Appeals

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Rationale for Recommendation

- CalOptima staff believes contracting with Magellan will meet CalOptima's goal of continuing to provide a comprehensive provider network and Behavioral Health and ASD services for CalOptima's Medi-Cal and Duals programs with:
  - Efficient and effective assessment, diagnosis, integrated care planning, strength based and person centered treatment implementation, support services and outcomes evaluation
  - Cultural responsiveness to our diverse membership, to develop a full picture of the various needs of the person and support goals and strategies to help members achieve and maintain recovery

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Next Steps

- Authorize the CEO to:
  - Enter into contract within 30 days with Magellan Health Inc.
  - Contract with a consultant(s) for up to $50,000 to assist with implementation
  - Extend the current CHIPA and Windstone contracts for up to six months, if necessary, to ensure no gap in coverage during the transition
- Direct CEO to return to the Board with further recommendations if contract is not finalized with Magellan within 30 days.

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CalOptima's Mission

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

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AGENDA ITEM 12 *TO FOLLOW CLOSED SESSION*

Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2020 and Execute Contract with the Centers for Medicare & Medicaid Services; Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement

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AGENDA ITEM 13 *TO FOLLOW CLOSED SESSION*

Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Connect Bid for Calendar Year 2020 and Execute Three-way Contract with the Centers for Medicare & Medicaid Services and the Department of the Health Care Services; Authorize the CEO to Amend/Execute OneCare Connect Health Network Contracts and Take Other Actions as Necessary to Implement

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Board of Directors Meeting
May 2, 2019

Provider Advisory Committee (PAC) Update

April 11, 2019 PAC Meeting

Ladan Khamseh, Chief Operations Officer, provided an update on the Qualified Medicare Beneficiary (QMB) program annual outreach which ended on March 31, 2019, and noted CalOptima received a 36% response rate from the outreach. Ms. Khamseh also provided an update on open positions for the Member Advisory Committee (MAC) and the recruitment extension to allow more time for committee applications to be submitted.

Candice Gomez, Executive Director Program Implementation provided an update on the Whole-Child Model and noted that the 90-day notices had been approved by the Department of Health Care Services (DHCS) and sent on March 29, 2019 and the 60-day notices have also been approved and will be sent to the affected members on May 1, 2019. Ms. Gomez advised the committee that CalOptima was not required to mail a 30-day notice and instead would be followed up by a phone to each member affected by the transition.

PAC also received a Behavioral Health Update from Donald Sharps, M.D., Behavioral Health Medical Director and a comprehensive presentation from Isabel Becerra, Chief Executive Officer of the Coalition of Community Health Centers.

Michael Schrader, Chief Executive Officer, provided the PAC with a verbal Homeless Health update. Mr. Schrader noted that the Board allocated $100M towards Homeless Health and that CalOptima would be partnering with the Federally Qualified Health Centers (FQHCs) to assist CalOptima in providing medical care within the community. CalOptima began outreach to the homeless population on April 10, 2019.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's current activities.

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AGENDA ITEM 15 - STRATEGIC PLAN UPDATE

This agenda item is a verbal presentation by staff.

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Introduction to the FY 2019-20 CalOptima Budget: Part 2

Board of Directors Meeting
May 2, 2019

Nancy Huang
Interim Chief Financial Officer

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Overview

- Enrollment Forecast
  - Medi-Cal
  - OneCare Connect
  - OneCare
  - PACE
- Public Plan Comparison
  - Medical Loss Ratio (MLR)
  - Administrative Loss Ratio (ALR)
- DHCS Rate Development Process
- FY 2019-20 Outlook
  - Program Update
  - Internal Resource Needs
- Board Deliverables
- Budget Timeline

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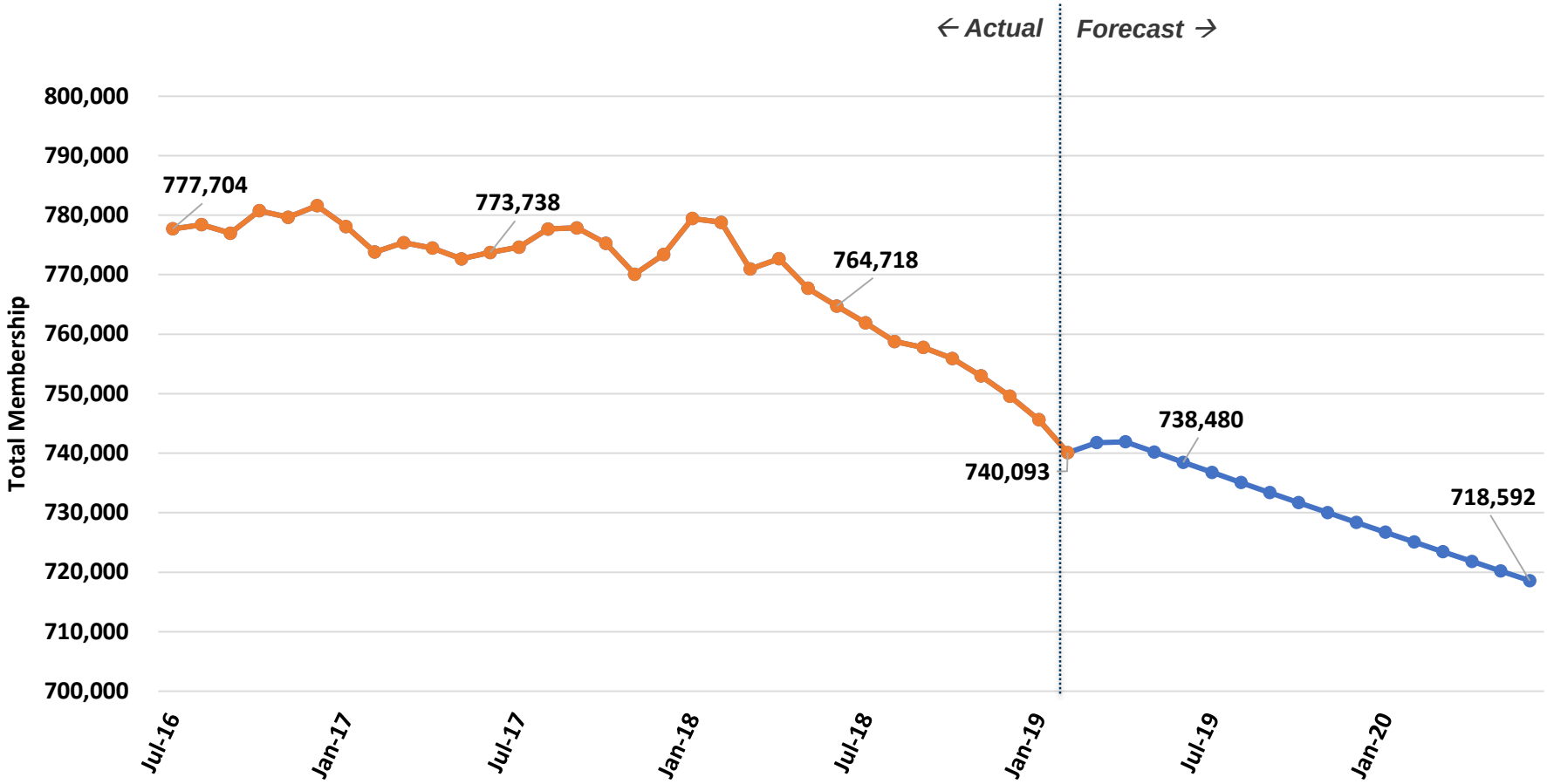
Enrollment: Total Medi-Cal



Notes: Total Medi-Cal enrollment includes Medi-Cal Classic and Medi-Cal Expansion members
Medi-Cal Expansion enrollment is ~30% of Total Medi-Cal enrollment

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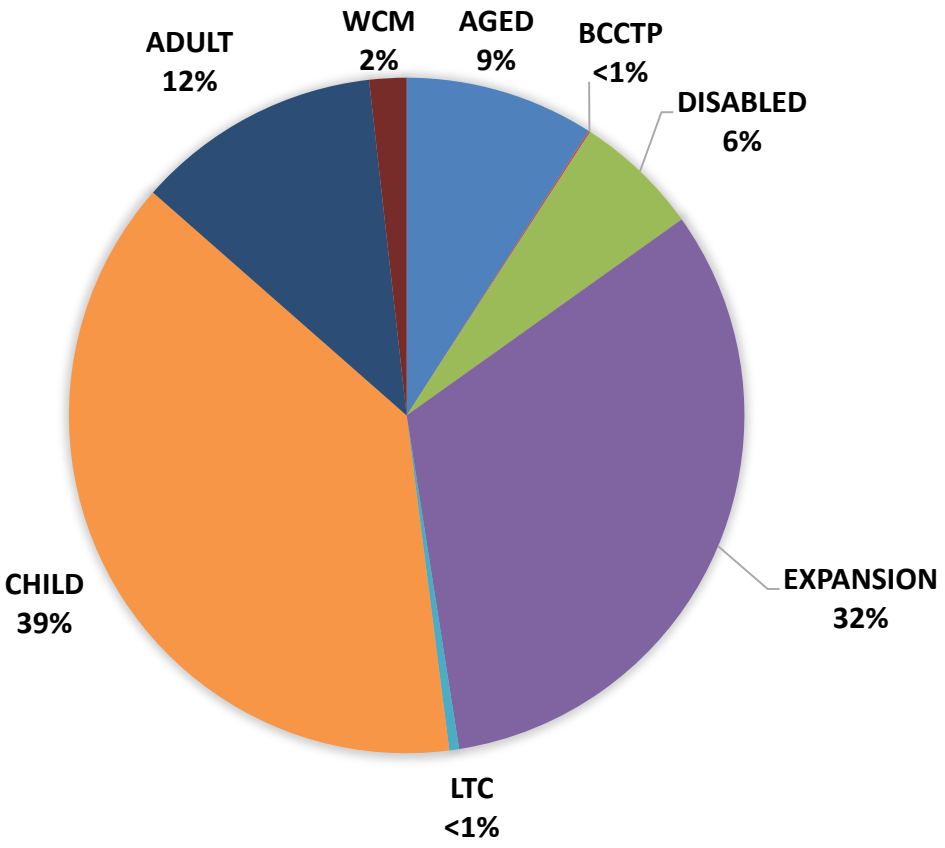
Enrollment: Medi-Cal Aid Category



WCM – Whole Child Model
BCCTP – Breast and Cervical Cancer Treatment Program
LTC – Long-Term Care

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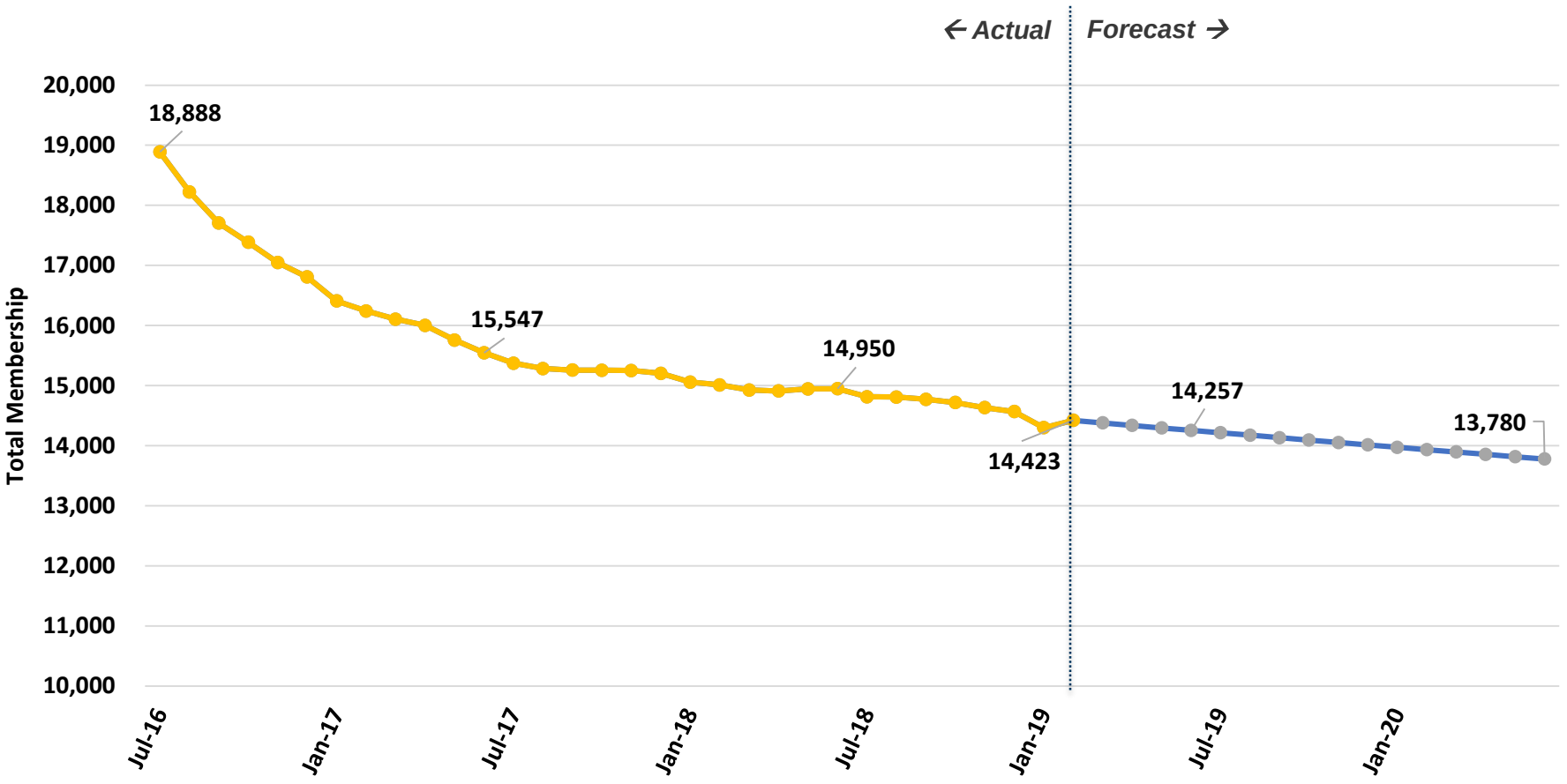
Enrollment: OneCare Connect



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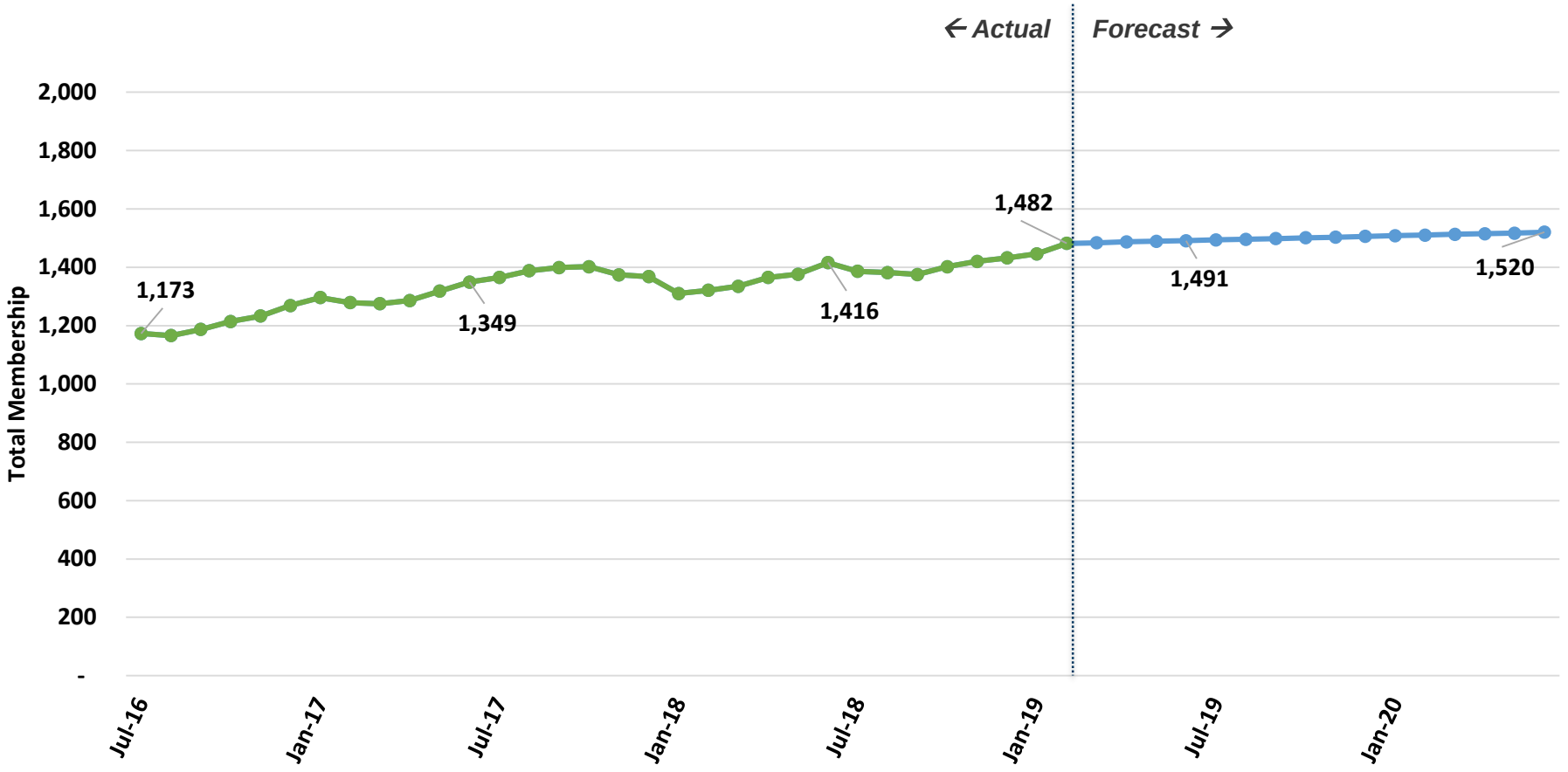
Enrollment: OneCare



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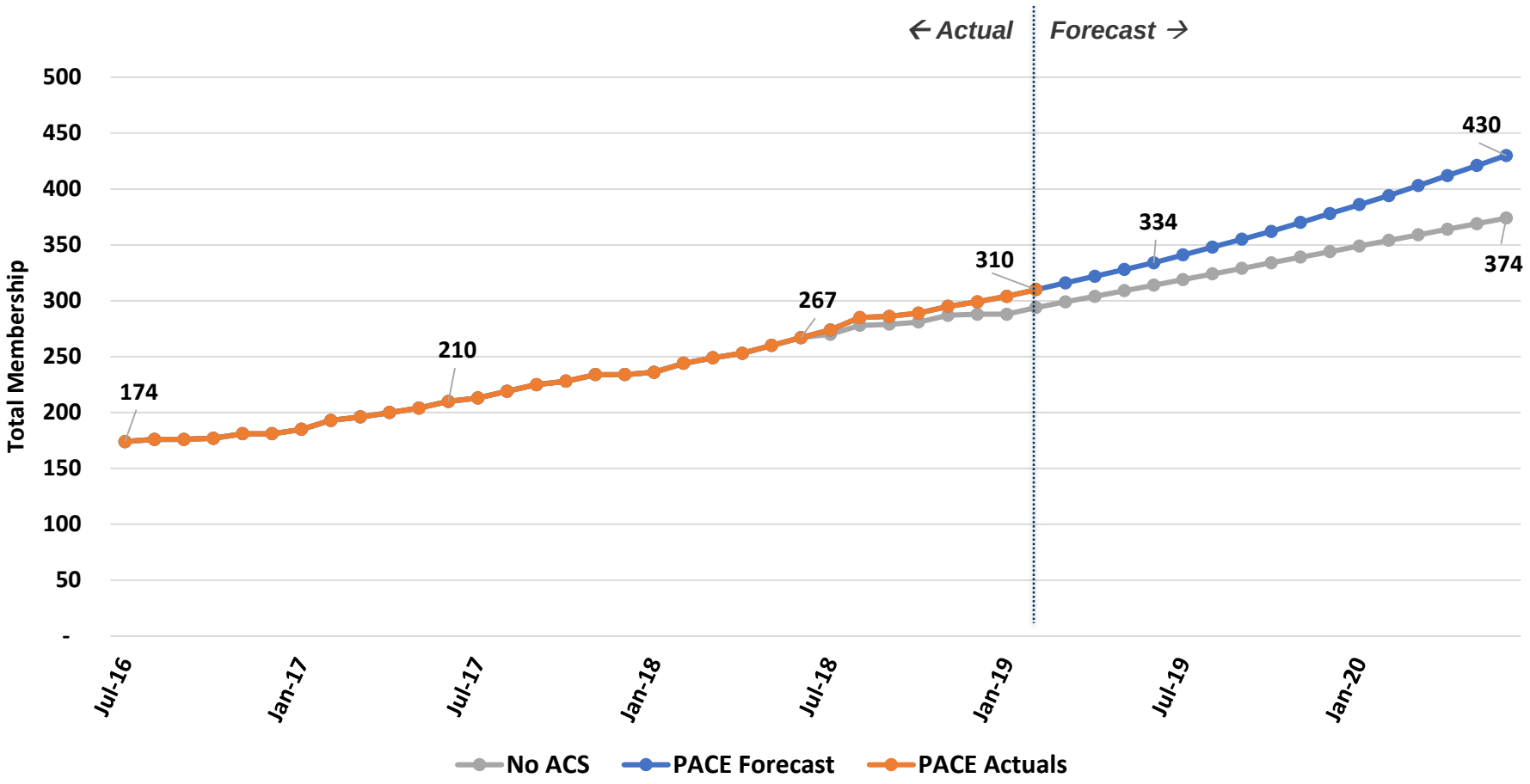
Enrollment: PACE



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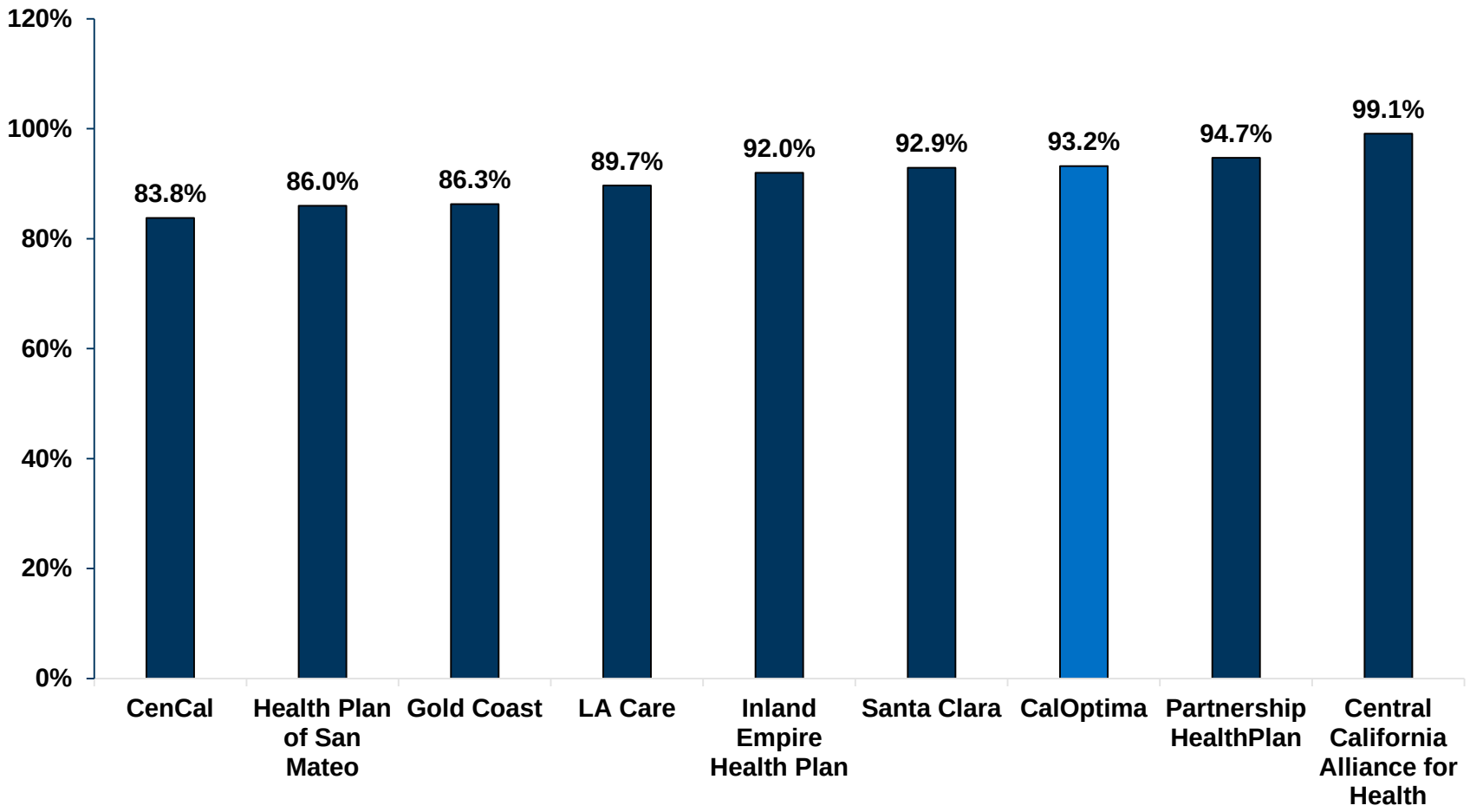
Public Plan Comparison: MLR



Source: DMHC Public Plan Comparison (Financials as of December 31, 2018, YTD)

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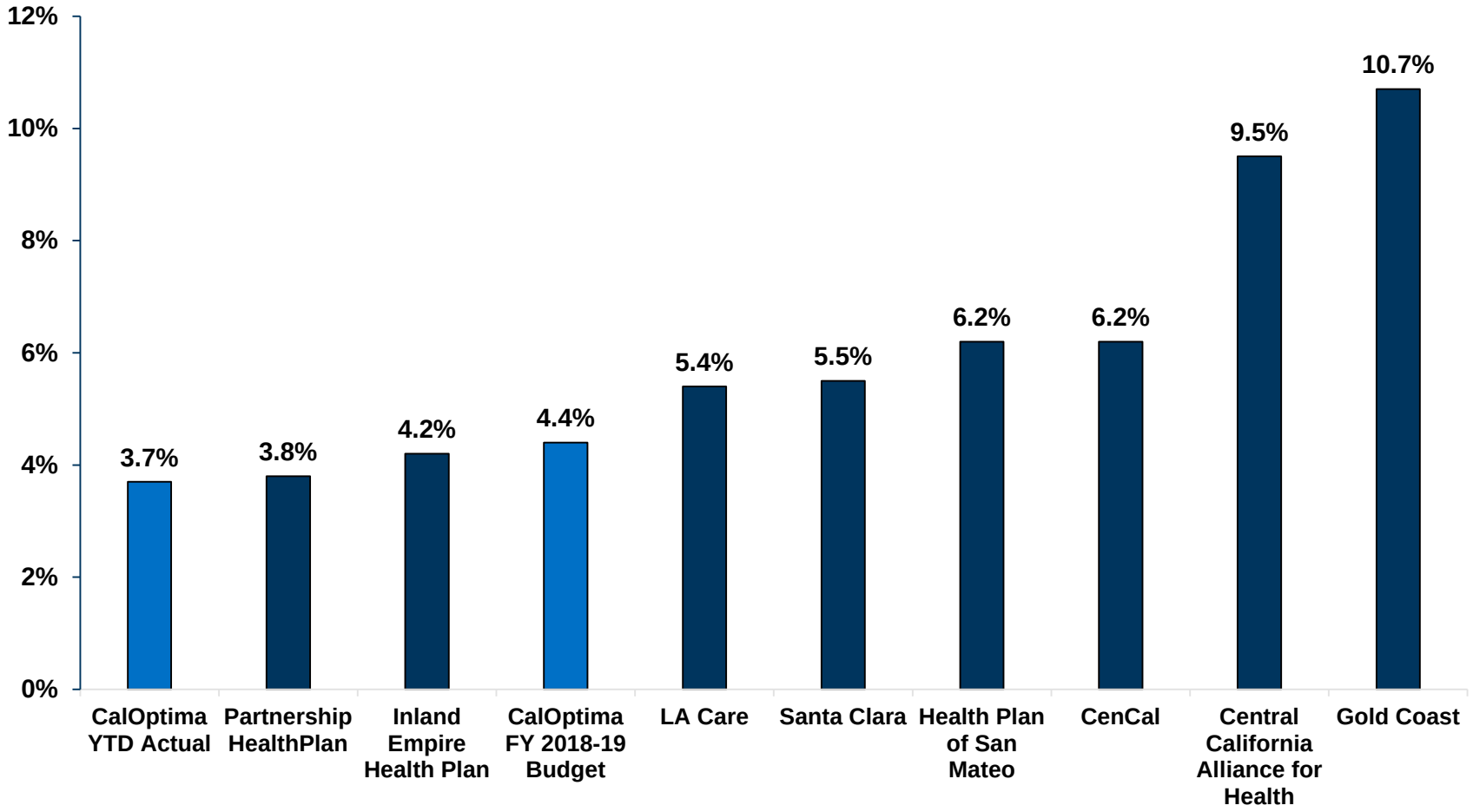
Public Plan Comparison: ALR



Source: DMHC Public Plan Comparison (Financials as of December 31, 2018, YTD)

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DHCS Rate Development Process

CalOptima submits Calendar Year 2017 data

- Reports experience to DHCS through Rate Development Template (RDT)

DHCS adjusts data to develop FY 2019-20 Base Data

- Makes adjustments to CalOptima's Calendar Year 2017 data to develop FY 2019-20 Base Data

DHCS applies FY 2019-20 adjustments

- Applies FY 2019-20 trends and program adjustments to the FY 2019-20 Base Data

DHCS creates FY 2019-20 Final Rates

- Sends rates to CalOptima in draft form; expected in early May
- Needs CMS approval to implement

- Expense data has 2.5 years trending
- Takes a prolonged period for DHCS to account for operational changes (e.g., 4% provider rate increase implemented by CalOptima in July 2017 will not be reflected in rate until FY 2019-20)

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FY 2019-20 Outlook: Program Update

- Medi-Cal Classic rate
  - New FY 2019-20 rates effective July 1, 2019
    - FY 2019-20 draft rates are expected from DHCS in early May
  - Expectation of a small increase for FY 2019-20 based on rate development submissions
  - In FY 2018-19, rates increased 3.9% from previous year

- Medi-Cal Expansion rate
  - New FY 2019-20 rates effective July 1, 2019
    - FY 2019-20 draft rates are expected from DHCS in early May
  - Expectation of FY 2019-20 rate change
    - Revenue: 10% to 20% decrease (i.e., $130 million to $260 million)
    - FY 2018-19 MCE capitation rate is 47% higher than the Adult rate
  - In FY 2018-19, rates increased 5.2% from previous year

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FY 2019-20 Outlook: Program Update

- OneCare Connect
  - Program changes:
    - January 2019: Disenrollment rate penalties will be applied
    - January 2020: Quality withhold will increase from 3% to 4%
  - No formal bid process
    - Part C and Part D revenue based on county FFS benchmark rates.

- California Children's Services (CCS) transition to Whole Child Model (WCM) program
  - Revised implementation date: July 1, 2019
  - Member impact: Estimated 12,500 members are CCS-eligible
  - Budget assumptions based on DHCS rate estimates

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FY 2019-20 Outlook: Internal Resource Needs

- New initiatives will increase internal resource needs
  - Homeless initiatives
  - WCM program additional requirements
  - Transition of behavioral health benefits for OneCare and OneCare Connect from Magellan to internal operations
  - Health Homes Program
    - Projected start date: January 1, 2020
- Goal: Consistent with previous years, maintain ALR at no greater than 4.5%

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Board Deliverables

- FY 2019-20 Operating Budget
  - Board Report
  - Attachment A: FY 2019-20 Budget for all Lines of Business
  - Attachment B: Administrative Budget Details
    - Medi-Cal
    - OneCare Connect
    - OneCare
    - PACE
    - Facilities (505 Building)

- FY 2019-20 Capital Budget
  - Board Report
  - Attachment A: FY 2019-20 Capital Budget by Project

Budget Timeline

Budget Preparation

- Late February to early March: Departments prepare budgets
- Mid to late March: Finance meets with Departments on budget proposals
- Early April: CFO reviews proposed budget
- 4/4: Board Information Item on Budget: Part 1

Budget Review

- Early to mid April: Executives review proposed budget; Hold additional department meetings, if needed
- 4/23: Finalize budget and sign-off from Executives

Budget Approval

- End April to mid-May: Prepare May FAC and June BOD materials
- 5/2: Board Information Item on Budget: Part 2
- 5/16: FAC meeting
- 6/6: Board meeting

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Financial Summary

March 2019

Board of Directors Meeting

May 2, 2019

Nancy Huang

Interim Chief Financial Officer

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FY 2018-19: Consolidated Enrollment

March 2019 MTD

Overall enrollment was 767,279 member months

- Actual lower than budget 16,088 members or 2.1%
  - Medi-Cal unfavorable variance of 15,520 members
    - Whole Child Model (WCM) unfavorable variance of 12,502 members
      - WCM members will remain in their original aid codes until the program begins 7/1/19
    - Medi-Cal Expansion (MCE) unfavorable variance of 4,796 members
    - Temporary Assistance for Needy Families (TANF) unfavorable variance of 206 members
    - Long-Term Care (LTC) unfavorable variance of 145 members
    - Seniors and Persons with Disabilities (SPD) favorable variance of 2,129 members
  - OneCare Connect unfavorable variance of 725 members
- 6,077 increase from February
  - Medi-Cal increase of 6,130
  - OneCare Connect decrease of 81
  - OneCare increase of 16
  - PACE increase of 12

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FY 2018-19: Consolidated Enrollment (cont.)

March 2019 YTD

Overall enrollment was 6,929,458 member months

- Actual lower than budget 128,332 members or 1.8%
  - Medi-Cal unfavorable variance of 125,747 members or 1.8%
    - MCE unfavorable variance of 45,827 members
    - TANF unfavorable variance of 45,132 members
    - WCM unfavorable variance of 37,506 members
      - WCM members will remain in their original aid codes until the program begins 7/1/19
    - LTC unfavorable variance of 795 members
    - SPD favorable variance of 3,513 members
  - OneCare Connect unfavorable variance of 3,474 members or 2.6%
  - OneCare favorable variance of 908 members or 7.6%
  - PACE unfavorable variance of 19 members or 0.7%

FY 2018-19: Consolidated Revenues

March 2019 MTD

- Actual higher than budget $8.5 million or 19.5%
  - ➢ Medi-Cal favorable to budg5et $57.1 million or 21.2%
    - o Unfavorable volume variance of $5.4 million
    - o Favorable price variance of $62.6 million
      - $43.8 million due to Proposition 56 rate true-up
      - $42.8 million of Intergovernmental Transfer (IGT) 2018 revenue
      - Offset by $22.9 million of WCM revenue due to delay of program start
  - ➢ OneCare Connect favorable to budget $1.0 million or 3.9%
    - o Unfavorable volume variance of $1.3 million
    - o Favorable price variance of $2.3 million due to $3.5 million of calendar year (CY) 2017 Hierarchical Condition Category (HCC) and risk adjustments offset by unfavorable rates

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FY 2018-19: Consolidated Revenues (cont.)

March 2019 MTD

- OneCare favorable to budget $0.2 million or 11.7%
  - Favorable volume variance of $0.2 million
  - Unfavorable price variance of $0.01 million
- PACE favorable to budget $0.2 million or 6.4%
  - Unfavorable volume variance of $0.1 million
  - Favorable price variance of $0.2 million

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FY 2018-19: Consolidated Revenues (cont.)

March 2019 YTD

- Actual higher than budget $6.2 million or 0.2%
  - ➢ Medi-Cal favorable to budget $8.2 million or 0.4%
    - o Unfavorable volume variance of $41.8 million
    - o Favorable price variance of $50.0 million due to:
      - $42.9 million of Proposition 56 revenue
      - $42.8 million of IGT 8 revenue
      - $24.7 million due to prior year revenue
      - $14.4 million due to favorable MCE rates
      - $10.1 million of prior year non-LTC revenue from non-LTC aid codes
      - Offset by unfavorable variance due to:
        - $68.3 million of WCM revenue
        - $5.9 million of Coordinated Care Initiative (CCI) revenue
        - $11.3 million of fiscal year (FY) 2019 non-LTC revenue from non-LTC aid codes

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FY 2018-19: Consolidated Revenues (cont.)

March 2019 YTD

- OneCare Connect unfavorable to budget $2.5 million or 1.1%
  - Unfavorable volume variance of $5.9 million
  - Favorable price variance of $3.5 million
- OneCare favorable to budget $0.2 million or 1.6%
  - Favorable volume variance of $1.1 million
  - Unfavorable price variance of $0.9 million
- PACE favorable to budget $0.3 million or 1.5%
  - Unfavorable volume variance of $0.1 million
  - Favorable price variance of $0.4 million

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FY 2018-19: Consolidated Medical Expenses

March 2019 MTD

- Actual higher than budget $40.4 million or 14.0%
  - ➢ Medi-Cal unfavorable variance of $38.9 million
    - o Favorable volume variance of $5.2 million
    - o Unfavorable price variance of $44.2 million
      - Provider Capitation expenses unfavorable variance of $32.2 million due to:
        - $42.0 million from Proposition 56 capitation expense
        - $2.0 million from Child Health and Disability Prevention Program (CHDP) claims budgeted in Professional claims
        - Offset by $12.0 million due to the delay of WCM program
      - Facilities expenses unfavorable variance of $10.0 million due to increase in Incurred But Not Reported (IBNR) claims
      - Prescription Drug expenses favorable variance of $9.1 million mainly due to delay of WCM program
      - Professional Claim expenses unfavorable variance of $7.3 million due to:
        - $11.7 million of Proposition 56 expense
        - Offset by $2.0 million of CHDP expenses

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FY 2018-19: Consolidated Medical Expenses (cont.)

March 2019 MTD

- OneCare Connect unfavorable variance of $1.4 million or 5.4%
  - Favorable volume variance of $1.2 million
  - Unfavorable price variance of $2.6 million
- OneCare unfavorable variance of $0.1 million or 7.0%
  - Unfavorable volume variance of $0.2 million
  - Favorable price variance of $0.1 million
- PACE favorable variance of $1,527 or 0.1%
  - Favorable volume variance of $47,095
  - Unfavorable price variance of $45,567

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FY 2018-19: Consolidated Medical Expenses (cont.)

March 2019 YTD

- Actual lower than budget $44.8 million or 1.8%
  - ➢ Medi-Cal favorable variance of $42.5 million
    - o Favorable volume variance of $39.7 million
    - o Favorable price variance of $2.8 million
      - Provider Capitation expenses unfavorable variance of $45.7 million
      - Professional Claim expenses favorable variance of $38.5 million
      - Prescription Drug expenses favorable variance of $30.4 million
      - Facilities expenses unfavorable variance of $29.2 million
  - ➢ OneCare Connect favorable variance of $0.9 million
    - o Favorable volume variance of $5.7 million
    - o Unfavorable price variance of $4.8 million

Medical Loss Ratio (MLR)

- March 2019 MTD: Actual: 91.6% Budget: 96.0%
- March 2019 YTD: Actual: 93.1% Budget: 95.0%

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FY 2018-19: Consolidated Administrative Expenses

March 2019 MTD

- Actual lower than budget $1.4 million or 10.6%
  - Salaries, wages and benefits: favorable variance of $0.3 million
  - Other categories: favorable variance of $1.0 million

March 2019 YTD

- Actual lower than budget $18.6 million or 16.3%
  - Salaries, wages & benefits: favorable variance of $9.3 million
  - Other categories: favorable variance of $9.3 million

Administrative Loss Ratio (ALR)

- March 2019 MTD: Actual: 3.2% Budget: 4.3%
- March 2019 YTD: Actual: 3.7% Budget: 4.4%

FY 2018-19: Change in Net Assets

March 2019 MTD

- $23.6 million surplus
- $24.1 million favorable to budget
  - Higher than budgeted revenue of $58.5 million
  - Higher than budgeted medical expenses of $40.4 million
  - Lower than budgeted administrative expenses of $1.4 million
  - Higher than budgeted investment and other income of $4.7 million

March 2019 YTD

- $111.9 million surplus
- $95.2 million favorable to budget
  - Higher than budgeted revenue of $6.2 million
  - Lower than budgeted medical expenses of $44.8 million
  - Lower than budgeted administrative expenses of $18.6 million
  - Higher than budgeted investment and other income of $25.6 million

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Enrollment Summary: March 2019

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
64,814	65,562	(748)	(1.1%)	Aged	577,814	581,990	(4,176)	(0.7%)
591	620	(29)	(4.7%)	BCCTP	5,424	5,580	(156)	(2.8%)
47,040	44,134	2,906	6.6%	Disabled	422,966	415,122	7,844	1.9%
305,505	303,825	1,680	0.6%	TANF Child	2,775,029	2,805,507	(30,478)	(1.1%)
91,038	92,924	(1,886)	(2.0%)	TANF Adult	834,922	849,576	(14,654)	(1.7%)
3,391	3,536	(145)	(4.1%)	LTC	30,633	31,428	(795)	(2.5%)
238,964	243,760	(4,796)	(2.0%)	MCE	2,136,769	2,182,596	(45,827)	(2.1%)
-	12,502	(12,502)	(100.0%)	WCM*	-	37,506	(37,506)	(100.0%)
751,343	**766,863**	**(15,520)**	**(2.0%)**	**Medi-Cal**	**6,783,557**	**6,909,304**	**(125,747)**	**(1.8%)**
14,128	**14,853**	**(725)**	**(4.9%)**	**OneCare Connect**	**130,417**	**133,891**	**(3,474)**	**(2.6%)**
1,488	**1,324**	**164**	**12.4%**	**OneCare**	**12,824**	**11,916**	**908**	**7.6%**
320	**327**	**(7)**	**(2.1%)**	**PACE**	**2,660**	**2,679**	**(19)**	**(0.7%)**
767,279	**783,367**	**(16,088)**	**(2.1%)**	**CalOptima Total**	**6,929,458**	**7,057,790**	**(128,332)**	**(1.8%)**

*Note: WCM members will remain in their original aid codes until the program begins 7/1/19

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Financial Highlights: March 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
767,279	783,367	(16,088)	(2.1%)	Member Months	6,929,458	7,057,790	(128,332)	(1.8%)
358,427,492	299,909,761	58,517,731	19.5%	Revenues	2,566,275,921	2,560,070,576	6,205,346	0.2%
328,343,228	287,919,054	(40,424,174)	(14.0%)	Medical Expenses	2,388,407,986	2,433,192,729	44,784,743	1.8%
11,557,918	12,931,007	1,373,089	10.6%	Administrative Expenses	95,339,977	113,896,846	18,556,870	16.3%
18,526,347	**(940,299)**	**19,466,646**	**2070.3%**	**Operating Margin**	**82,527,959**	**12,981,000**	**69,546,959**	**535.8%**
5,090,406	416,667	4,673,739	1121.7%	Non Operating Income (Loss)	29,385,817	3,750,000	25,635,817	683.6%
23,616,753	**(523,633)**	**24,140,386**	**4610.2%**	**Change in Net Assets**	**111,913,776**	**16,731,000**	**95,182,776**	**568.9%**
91.6%	96.0%	4.4%		Medical Loss Ratio	93.1%	95.0%	2.0%	
3.2%	4.3%	1.1%		Administrative Loss Ratio	3.7%	4.4%	0.7%	
5.2%	(0.3%)	5.5%		Operating Margin Ratio	3.2%	0.5%	2.7%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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Consolidated Performance Actual vs. Budget: March 2019 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
19.0	(0.2)	19.2	Medi-Cal	87.2	20.6	66.6
(0.7)	(0.6)	(0.1)	OCC	(6.7)	(7.1)	0.4
0.0	(0.1)	0.1	OneCare	(0.0)	(0.5)	0.5
0.2	(0.0)	0.2	PACE	2.1	0.1	2.0
18.5	**(0.9)**	**19.4**	**Operating**	**82.6**	**13.1**	**69.5**
5.1	0.4	4.7	Inv./Rental Inc, MCO tax	29.4	3.8	25.6
5.1	**0.4**	**4.7**	**Non-Operating**	**29.4**	**3.8**	**25.6**
23.6	**(0.5)**	**24.1**	**TOTAL**	**111.9**	**16.7**	**95.2**

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Consolidated Revenue & Expense: March 2019 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	512,379	238,964	751,343	14,128	1,488	320	767,279
REVENUES							
Capitation Revenue	$ 160,085,291	$ 166,301,126	$ 326,386,417	$ 27,666,877	$ 1,843,064	$ 2,531,135	$ 358,427,492
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	160,085,291	166,301,126	326,386,417	27,666,877	1,843,064	2,531,135	358,427,492
MEDICAL EXPENSES							
Provider Capitation	55,528,120	70,941,155	126,469,275	13,375,163	486,668		140,331,106
Facilities	25,849,141	30,948,305	56,797,446	4,172,596	657,029	546,728	62,173,799
Ancillary	-	-	-	1,070,659	35,879	-	1,106,538
Professional Claims	26,022,095	10,717,499	36,739,593	-	-	599,409	37,339,003
Prescription Drugs	17,206,620	19,120,697	36,327,318	4,957,339	453,259	213,848	41,951,763
MLTSS	33,212,270	3,001,641	36,213,911	1,543,824	17,060	64,152	37,838,947
Medical Management	2,176,515	890,547	3,067,062	1,135,637	54,584	608,376	4,865,659
Quality Incentives	757,957	413,430	1,171,387	273,620		3,200	1,448,207
Reinsurance & Other	319,454	614,428	933,881	203,565	(12,000)	162,760	1,288,206
Total Medical Expenses	161,072,172	136,647,702	297,719,873	26,732,403	1,692,478	2,198,474	328,343,228
Medical Loss Ratio	100.6%	82.2%	91.2%	96.6%	91.8%	86.9%	91.6%
GROSS MARGIN	**(986,881)**	**29,653,424**	**28,666,543**	**934,474**	**150,586**	**332,661**	**30,084,265**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			7,093,072	733,707	31,054	110,039	7,967,872
Professional fees			292,255	7,340	14,667	123	314,384
Purchased services			694,060	190,246	19,396	13,648	917,351
Printing & Postage			383,315	23,513	(11)	8,742	415,559
Depreciation & Amortization			435,073			2,089	437,161
Other expenses			1,125,401	56,950	277	3,298	1,185,925
Indirect cost allocation & Occupancy			(320,106)	581,690	41,461	16,620	319,665
Total Administrative Expenses			9,703,071	1,593,445	106,843	154,559	11,557,918
Admin Loss Ratio			3.0%	5.8%	5.8%	6.1%	3.2%
INCOME (LOSS) FROM OPERATIONS			18,963,473	(658,971)	43,743	178,103	18,526,347
INVESTMENT INCOME							5,090,405
CHANGE IN NET ASSETS			**$ 18,963,473**	**$ (658,971)**	**$ 43,743**	**$ 178,103**	**$ 23,616,753**
BUDGETED CHANGE IN NET ASSETS			(221,333)	(649,414)	(63,781)	(5,771)	(523,633)
VARIANCE TO BUDGET - FAV (UNFAV)			$ 19,184,806	$ (9,557)	$ 107,524	$ 183,873	$ 24,140,386

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Consolidated Revenue & Expense: March 2019 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	4,646,788	2,136,769	6,783,557	130,417	12,824	2,660	6,929,458
REVENUES							
Capitation Revenue	$ 1,258,257,889	$ 1,046,975,202	$ 2,305,233,092	$ 226,606,201	$ 14,702,921	$ 19,733,707	$ 2,566,275,921
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	1,258,257,889	1,046,975,202	2,305,233,092	226,606,201	14,702,921	19,733,707	2,566,275,921
MEDICAL EXPENSES							
Provider Capitation	341,776,058	473,020,763	814,796,821	104,218,871	4,097,854		923,113,547
Facilities	204,218,255	217,169,249	421,387,504	32,738,235	4,112,212	3,651,949	461,889,899
Ancillary	-	-	-	6,213,225	355,598	-	6,568,824
Professional Claims	153,616,394	60,801,247	214,417,641	-	-	4,068,471	218,486,112
Prescription Drugs	154,443,794	174,678,166	329,121,960	47,869,147	4,177,397	1,566,831	382,735,335
MLTSS	287,929,089	25,519,687	313,448,776	12,626,830	428,557	98,063	326,602,226
Medical Management	18,960,851	8,952,376	27,913,226	10,033,995	549,315	5,619,762	44,116,298
Quality Incentives	6,898,037	3,686,268	10,584,304	2,652,000		26,600	13,262,904
Reinsurance & Other	4,916,193	3,233,911	8,150,104	1,983,810	37,298	1,461,629	11,632,841
Total Medical Expenses	1,172,758,670	967,061,666	2,139,820,336	218,336,114	13,758,231	16,493,305	2,388,407,986
Medical Loss Ratio	93.2%	92.4%	92.8%	96.4%	93.6%	83.6%	93.1%
GROSS MARGIN	**85,499,219**	**79,913,536**	**165,412,755**	**8,270,087**	**944,690**	**3,240,402**	**177,867,935**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			55,204,224	6,794,774	295,701	894,534	63,189,233
Professional fees			1,534,810	225,661	132,000	6,614	1,899,085
Purchased services			6,654,902	1,634,140	140,338	86,494	8,515,874
Printing & Postage			2,889,097	576,430	70,024	56,265	3,591,816
Depreciation & Amortization			3,933,106			18,731	3,951,836
Other expenses			10,724,537	405,447	653	23,808	11,154,446
Indirect cost allocation & Occupancy			(2,743,352)	5,380,112	349,079	51,848	3,037,686
Total Administrative Expenses			78,197,324	15,016,565	987,794	1,138,294	95,339,977
Admin Loss Ratio			3.4%	6.6%	6.7%	5.8%	3.7%
INCOME (LOSS) FROM OPERATIONS			87,215,432	(6,746,478)	(43,104)	2,102,109	82,527,959
INVESTMENT INCOME							29,385,016
OTHER INCOME			801				801
CHANGE IN NET ASSETS			**$ 87,216,233**	**$ (6,746,478)**	**$ (43,104)**	**$ 2,102,109**	**$ 111,913,776**
BUDGETED CHANGE IN NET ASSETS			20,570,079	(7,125,983)	(520,142)	57,045	16,731,000
VARIANCE TO BUDGET - FAV (UNFAV)			$ 66,646,154	$ 379,505	$ 477,037	$ 2,045,063	$ 95,182,776

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CalOptima A Public Agency Better. Together.

Balance Sheet:
As of March 2019

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$640,608,268	Accounts Payable	$40,132,045
Investments	487,961,165	Medical Claims liability	1,081,745,716
Capitation receivable	472,217,779	Accrued Payroll Liabilities	12,101,684
Receivables - Other	24,720,145	Deferred Revenue	53,657,665
Prepaid expenses	5,584,844	Deferred Lease Obligations	63,588
		Capitation and Withholds	127,132,188
Total Current Assets	**1,631,092,200**	**Total Current Liabilities**	**1,314,832,886**
Capital Assets			
Furniture & Equipment	38,297,211		
Building/Leasehold Improvements	6,032,369		
505 City Parkway West	50,289,440		
	94,619,020		
Less: accumulated depreciation	(46,758,863)		
Capital assets, net	47,860,156	Other (than pensions) post employment benefits liability	25,673,365
Other Assets		Net Pension Liabilities	23,602,064
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Board-designated assets			
Cash and Cash Equivalents	25,194,513	**TOTAL LIABILITIES**	**1,364,108,315**
Long-term Investments	527,576,174		
Total Board-designated Assets	552,770,687	Deferred Inflows	
		Change in Assumptions	4,747,505
Total Other Assets	553,070,687	Excess Earnings	156,330
TOTAL ASSETS	**2,232,023,044**	TNE	83,441,682
		Funds in Excess of TNE	790,103,661
Deferred Outflows			
Pension Contributions	686,962		
Difference in Experience	3,419,328	Net Assets	873,545,343
Excess Earning	-		
Changes in Assumptions	6,428,159		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,242,557,493**	**TOTAL LIABILITIES & FUND BALANCES**	**2,242,557,493**

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Board Designated Reserve and TNE Analysis
As of March 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	151,281,498				
	Tier 1 - Logan Circle	150,816,354				
	Tier 1 - Wells Capital	150,650,843				
Board-designated Reserve		452,748,694	318,222,862	490,364,810	134,525,832	(37,616,115)
TNE Requirement	Tier 2 - Logan Circle	100,021,993	83,441,682	83,441,682	16,580,311	16,580,311
	Consolidated:	**552,770,687**	**401,664,544**	**573,806,491**	**151,106,143**	**(21,035,804)**
	Current reserve level	*1.93*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

March 2019

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CalOptima - Consolidated
Financial Highlights
For the Nine Months Ended March 31, 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
767,279	783,367	(16,088)	(2.1%)	Member Months	6,929,458	7,057,790	(128,332)	(1.8%)
358,427,492	299,909,761	58,517,731	19.5%	Revenues	2,566,275,921	2,560,070,576	6,205,346	0.2%
328,343,228	287,919,054	(40,424,174)	(14.0%)	Medical Expenses	2,388,407,986	2,433,192,729	44,784,743	1.8%
11,557,918	12,931,007	1,373,089	10.6%	Administrative Expenses	95,339,977	113,896,846	18,556,870	16.3%
18,526,347	**(940,299)**	**19,466,646**	**2070.3%**	**Operating Margin**	**82,527,959**	**12,981,000**	**69,546,959**	**535.8%**
5,090,406	416,667	4,673,739	1121.7%	Non Operating Income (Loss)	29,385,817	3,750,000	25,635,817	683.6%
23,616,753	**(523,633)**	**24,140,386**	**4610.2%**	**Change in Net Assets**	**111,913,776**	**16,731,000**	**95,182,776**	**568.9%**
91.6%	96.0%	4.4%		Medical Loss Ratio	93.1%	95.0%	2.0%	
3.2%	4.3%	1.1%		Administrative Loss Ratio	3.7%	4.4%	0.7%	
5.2%	(0.3%)	5.5%		Operating Margin Ratio	3.2%	0.5%	2.7%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima
Financial Dashboard
For the Nine Months Ended March 31, 2019

MONTH - TO - DATE

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	751,343	766,863	(15,520)	(2 0%)
OneCare Connect	14,128	14,853	(725)	(4 9%)
OneCare	1,488	1,324	164	12 4%
PACE	320	327	(7)	(2 1%)
Total	767,279	783,367	(16,088)	(2 1%)

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 18,963	$ (221)	$ 19,184	8680 5%
OneCare Connect	(659)	(649)	(10)	(1 5%)
OneCare	44	(64)	108	168 8%
PACE	178	(6)	184	3066 7%
505 Bldg	-	-	-	0 0%
Investment Income & Other	5,090	417	4,673	1120 6%
Total	$ 23,616	$ (523)	$ 24,139	4615 5%

MLR	Actual	Budget	% Point Var
Medi-Cal	91 2%	96 1%	4 9
OneCare Connect	96 6%	95 3%	(1 4)
OneCare	91 8%	95 8%	4 0

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,703	$ 10,706	$ 1,003	9 4%
OneCare Connect	1,593	1,908	315	16 5%
OneCare	107	133	26	19 6%
PACE	155	184	29	15 8%
Total	$ 11,558	$ 12,931	$ 1,373	10 6%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,000	1,089	90
OneCare Connect	225	234	9
OneCare	5	6	1
PACE	70	88	17
Total	1,300	1,417	117

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	752	704	48
OneCare Connect	63	63	(1)
OneCare	297	221	76
PACE	5	4	1
Total	1,116	992	124

YEAR - TO - DATE

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	6,783,557	6,909,304	(125,747)	(1 8%)
OneCare Connect	130,417	133,891	(3,474)	(2 6%)
OneCare	12,824	11,916	908	7 6%
PACE	2,660	2,679	(19)	(0 7%)
Total	6,929,458	7,057,790	(128,332)	(1 8%)

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 87,216	$ 20,570	$ 66,646	324 0%
OneCare Connect	(6,746)	(7,126)	380	5 3%
OneCare	(43)	(520)	477	91 7%
PACE	2,102	57	2,045	3587 7%
505 Bldg	-	-	-	0 0%
Investment Income & Other	29,386	3,750	25,636	683 6%
Total	$ 111,915	$ 16,731	$ 95,184	568 9%

MLR	Actual	Budget	% Point Var
Medi-Cal	92 8%	95 0%	2 2
OneCare Connect	96 4%	95 7%	(0 7)
OneCare	93 6%	95 4%	1 8

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 78,197	$ 94,181	$ 15,983	17 0%
OneCare Connect	15,017	16,977	1,960	11 5%
OneCare	988	1,187	199	16 8%
PACE	1,138	1,553	414	26 7%
Total	$ 95,340	$ 113,897	$ 18,557	16 3%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	8,622	9,622	1,000
OneCare Connect	1,989	2,106	118
OneCare	44	54	10
PACE	581	729	148
Total	11,236	12,511	1,275

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	787	718	69
OneCare Connect	66	64	2
OneCare	290	221	70
PACE	5	4	1
Total	1,147	1,006	141

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended March 31, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	767,279		783,367		(16,088)	
REVENUE						
Medi-Cal	$ 326,386,417	$ 434.40	$ 269,256,500	$ 351.11	$ 57,129,917	$ 83.29
OneCare Connect	27,666,877	1,958.30	26,625,074	1,792.57	1,041,803	165.73
OneCare	1,843,064	1,238.62	1,650,376	1,246.51	192,688	(7.89)
PACE	2,531,135	7,909.80	2,377,812	7,271.60	153,323	638.20
Total Operating Revenue	358,427,492	467.14	299,909,761	382.85	58,517,731	84.29
MEDICAL EXPENSES						
Medi-Cal	297,719,873	396.25	258,771,424	337.44	(38,948,449)	(58.81)
OneCare Connect	26,732,403	1,892.16	25,366,285	1,707.82	(1,366,118)	(184.34)
OneCare	1,692,478	1,137.42	1,581,344	1,194.37	(111,134)	56.95
PACE	2,198,474	6,870.23	2,200,001	6,727.83	1,527	(142.40)
Total Medical Expenses	328,343,228	427.93	287,919,054	367.54	(40,424,174)	(60.39)
GROSS MARGIN	30,084,265	39.21	11,990,707	15.31	18,093,557	23.90
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,967,872	10.38	8,302,369	10.60	334,498	0.22
Professional fees	314,384	0.41	433,009	0.55	118,625	0.14
Purchased services	917,351	1.20	1,286,438	1.64	369,087	0.44
Printing & Postage	415,559	0.54	485,645	0.62	70,085	0.08
Depreciation & Amortization	437,161	0.57	464,167	0.59	27,005	0.02
Other expenses	1,185,925	1.55	1,587,146	2.03	401,220	0.48
Indirect cost allocation & Occupancy expense	319,665	0.42	372,234	0.48	52,569	0.06
Total Administrative Expenses	11,557,918	15.06	12,931,007	16.51	1,373,089	1.45
INCOME (LOSS) FROM OPERATIONS	18,526,347	24.15	(940,299)	(1.20)	19,466,646	25.35
INVESTMENT INCOME						
Interest income	2,983,599	3.89	416,667	0.53	2,566,932	3.36
Realized gain/(loss) on investments	(62,558)	(0.08)	-	-	(62,558)	(0.08)
Unrealized gain/(loss) on investments	2,169,364	2.83	-	-	2,169,364	2.83
Total Investment Income	5,090,405	6.63	416,667	0.53	4,673,739	6.10
CHANGE IN NET ASSETS	**23,616,753**	**30.78**	**(523,633)**	**(0.67)**	**24,140,386**	**31.45**
MEDICAL LOSS RATIO	**91.6%**		**96.0%**		**4.4%**	
ADMINISTRATIVE LOSS RATIO	**3.2%**		**4.3%**		**1.1%**	

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the Nine Months Ended March 31, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	6,929,458		7,057,789		(128,331)	
REVENUE						
Medi-Cal	$ 2,305,233,092	$ 339.83	$ 2,297,068,019	$ 332.46	$ 8,165,073	$ 7.37
OneCare Connect	226,606,201	1,737.55	229,083,623	1,710.98	(2,477,422)	26.57
OneCare	14,702,921	1,146.52	14,476,178	1,214.85	226,743	(68.33)
PACE	19,733,707	7,418.69	19,442,756	7,257.47	290,951	161.22
Total Operating Revenue	2,566,275,921	370.34	2,560,070,576	362.73	6,205,346	7.61
MEDICAL EXPENSES						
Medi-Cal	2,139,820,336	315.44	2,182,317,296	315.85	42,496,960	0.41
OneCare Connect	218,336,114	1,674.14	219,232,657	1,637.41	896,543	(36.73)
OneCare	13,758,231	1,072.85	13,809,743	1,158.92	51,512	86.07
PACE	16,493,305	6,200.49	17,833,033	6,656.60	1,339,728	456.11
Total Medical Expenses	2,388,407,986	344.67	2,433,192,729	344.75	44,784,743	0.08
GROSS MARGIN	177,867,935	25.67	126,877,846	17.98	50,990,089	7.69
ADMINISTRATIVE EXPENSES						
Salaries and benefits	63,189,233	9.12	72,456,897	10.27	9,267,664	1.15
Professional fees	1,899,085	0.27	3,734,175	0.53	1,835,090	0.26
Purchased services	8,515,874	1.23	11,180,811	1.58	2,664,937	0.35
Printing & Postage	3,591,816	0.52	4,750,808	0.67	1,158,993	0.15
Depreciation & Amortization	3,951,836	0.57	4,177,496	0.59	225,660	0.02
Other expenses	11,154,446	1.61	14,246,558	2.02	3,092,112	0.41
Indirect cost allocation & Occupancy expense	3,037,686	0.44	3,350,101	0.47	312,415	0.03
Total Administrative Expenses	95,339,977	13.76	113,896,846	16.14	18,556,870	2.38
INCOME (LOSS) FROM OPERATIONS	82,527,959	11.91	12,981,000	1.84	69,546,959	10.07
INVESTMENT INCOME						
Interest income	24,454,783	3.53	3,750,000	0.53	20,704,782	3.00
Realized gain/(loss) on investments	(1,877,901)	(0.27)	-	-	(1,877,901)	(0.27)
Unrealized gain/(loss) on investments	6,808,134	0.98	-	-	6,808,134	0.98
Total Investment Income	29,385,016	4.24	3,750,000	0.53	25,635,016	3.71
OTHER INCOME	801	-	-	-	801	-
CHANGE IN NET ASSETS	**111,913,776**	**16.15**	**16,731,000**	**2.37**	**95,182,776**	**13.78**
MEDICAL LOSS RATIO	**93.1%**		**95.0%**		**2.0%**	
ADMINISTRATIVE LOSS RATIO	**3.7%**		**4.4%**		**0.7%**	

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended March 31, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	512,379	238,964	751,343	14,128	1,488	320	767,279
REVENUES							
Capitation Revenue	$ 160,085,291	$ 166,301,126	$ 326,386,417	$ 27,666,877	$ 1,843,064	$ 2,531,135	$ 358,427,492
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	160,085,291	166,301,126	326,386,417	27,666,877	1,843,064	2,531,135	358,427,492
MEDICAL EXPENSES							
Provider Capitation	55,528,120	70,941,155	126,469,275	13,375,163	486,668		140,331,106
Facilities	25,849,141	30,948,305	56,797,446	4,172,596	657,029	546,728	62,173,799
Ancillary	-	-	-	1,070,659	35,879	-	1,106,538
Professional Claims	26,022,095	10,717,499	36,739,593	-	-	599,409	37,339,003
Prescription Drugs	17,206,620	19,120,697	36,327,318	4,957,339	453,259	213,848	41,951,763
MLTSS	33,212,270	3,001,641	36,213,911	1,543,824	17,060	64,152	37,838,947
Medical Management	2,176,515	890,547	3,067,062	1,135,637	54,584	608,376	4,865,659
Quality Incentives	757,957	413,430	1,171,387	273,620		3,200	1,448,207
Reinsurance & Other	319,454	614,428	933,881	203,565	(12,000)	162,760	1,288,206
Total Medical Expenses	161,072,172	136,647,702	297,719,873	26,732,403	1,692,478	2,198,474	328,343,228
Medical Loss Ratio	100.6%	82.2%	91.2%	96.6%	91.8%	86.9%	91.6%
GROSS MARGIN	**(986,881)**	**29,653,424**	**28,666,543**	**934,474**	**150,586**	**332,661**	**30,084,265**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			7,093,072	733,707	31,054	110,039	7,967,872
Professional fees			292,255	7,340	14,667	123	314,384
Purchased services			694,060	190,246	19,396	13,648	917,351
Printing & Postage			383,315	23,513	(11)	8,742	415,559
Depreciation & Amortization			435,073			2,089	437,161
Other expenses			1,125,401	56,950	277	3,298	1,185,925
Indirect cost allocation & Occupancy			(320,106)	581,690	41,461	16,620	319,665
Total Administrative Expenses			9,703,071	1,593,445	106,843	154,559	11,557,918
Admin Loss Ratio			3.0%	5.8%	5.8%	6.1%	3.2%
INCOME (LOSS) FROM OPERATIONS			18,963,473	(658,971)	43,743	178,103	18,526,347
INVESTMENT INCOME							5,090,405
CHANGE IN NET ASSETS			**$ 18,963,473**	**$ (658,971)**	**$ 43,743**	**$ 178,103**	**$ 23,616,753**
BUDGETED CHANGE IN NET ASSETS			(221,333)	(649,414)	(63,781)	(5,771)	(523,633)
VARIANCE TO BUDGET - FAV (UNFAV)			$ 19,184,806	$ (9,557)	$ 107,524	$ 183,873	$ 24,140,386

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Nine Months Ended March 31, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	4,646,788	2,136,769	6,783,557	130,417	12,824	2,660	6,929,458
REVENUES							
Capitation Revenue	$ 1,258,257,889	$ 1,046,975,202	$ 2,305,233,092	$ 226,606,201	$ 14,702,921	$ 19,733,707	$ 2,566,275,921
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	1,258,257,889	1,046,975,202	2,305,233,092	226,606,201	14,702,921	19,733,707	2,566,275,921
MEDICAL EXPENSES							
Provider Capitation	341,776,058	473,020,763	814,796,821	104,218,871	4,097,854		923,113,547
Facilities	204,218,255	217,169,249	421,387,504	32,738,235	4,112,212	3,651,949	461,889,899
Ancillary	-	-	-	6,213,225	355,598	-	6,568,824
Professional Claims	153,616,394	60,801,247	214,417,641	-	-	4,068,471	218,486,112
Prescription Drugs	154,443,794	174,678,166	329,121,960	47,869,147	4,177,397	1,566,831	382,735,335
MLTSS	287,929,089	25,519,687	313,448,776	12,626,830	428,557	98,063	326,602,226
Medical Management	18,960,851	8,952,376	27,913,226	10,033,995	549,315	5,619,762	44,116,298
Quality Incentives	6,898,037	3,686,268	10,584,304	2,652,000		26,600	13,262,904
Reinsurance & Other	4,916,193	3,233,911	8,150,104	1,983,810	37,298	1,461,629	11,632,841
Total Medical Expenses	1,172,758,670	967,061,666	2,139,820,336	218,336,114	13,758,231	16,493,305	2,388,407,986
Medical Loss Ratio	93 2%	92 4%	92 8%	96 4%	93 6%	83 6%	93 1%
GROSS MARGIN	**85,499,219**	**79,913,536**	**165,412,755**	**8,270,087**	**944,690**	**3,240,402**	**177,867,935**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			55,204,224	6,794,774	295,701	894,534	63,189,233
Professional fees			1,534,810	225,661	132,000	6,614	1,899,085
Purchased services			6,654,902	1,634,140	140,338	86,494	8,515,874
Printing & Postage			2,889,097	576,430	70,024	56,265	3,591,816
Depreciation & Amortization			3,933,106			18,731	3,951,836
Other expenses			10,724,537	405,447	653	23,808	11,154,446
Indirect cost allocation & Occupancy			(2,743,352)	5,380,112	349,079	51,848	3,037,686
Total Administrative Expenses			78,197,324	15,016,565	987,794	1,138,294	95,339,977
Admin Loss Ratio			3 4%	6 6%	6 7%	5 8%	3 7%
INCOME (LOSS) FROM OPERATIONS			87,215,432	(6,746,478)	(43,104)	2,102,109	82,527,959
INVESTMENT INCOME							29,385,016
OTHER INCOME			801				801
CHANGE IN NET ASSETS			**$ 87,216,233**	**$ (6,746,478)**	**$ (43,104)**	**$ 2,102,109**	**$ 111,913,776**
BUDGETED CHANGE IN NET ASSETS			20,570,079	(7,125,983)	(520,142)	57,045	16,731,000
VARIANCE TO BUDGET - FAV (UNFAV)			$ 66,646,154	$ 379,505	$ 477,037	$ 2,045,063	$ 95,182,776

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March 31, 2019 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $23.6 million, $24.1 million favorable to budget
- Operating surplus is $18.5 million, with a surplus in non-operating income of $5.1 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $111.9 million, $95.2 million favorable to budget
- Operating surplus is $82.5 million, with a surplus in non-operating income of $29.4 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
19.0	(0.2)	19.2	Medi-Cal	87.2	20.6	66.6
(0.7)	(0.6)	(0.1)	OCC	(6.7)	(7.1)	0.4
0.0	(0.1)	0.1	OneCare	(0.0)	(0.5)	0.5
0.2	(0.0)	0.2	PACE	2.1	0.1	2.0
18.5	**(0.9)**	**19.4**	**Operating**	**82.6**	**13.1**	**69.5**
5.1	0.4	4.7	Inv./Rental Inc, MCO tax	29.4	3.8	25.6
5.1	**0.4**	**4.7**	**Non-Operating**	**29.4**	**3.8**	**25.6**
23.6	**(0.5)**	**24.1**	**TOTAL**	**111.9**	**16.7**	**95.2**

CalOptima - Consolidated
Enrollment Summary
For the Nine Months Ended March 31, 2019

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
64,814	65,562	(748)	(1.1%)	Aged	577,814	581,990	(4,176)	(0.7%)
591	620	(29)	(4.7%)	BCCTP	5,424	5,580	(156)	(2.8%)
47,040	44,134	2,906	6.6%	Disabled	422,966	415,122	7,844	1.9%
305,505	303,825	1,680	0.6%	TANF Child	2,775,029	2,805,507	(30,478)	(1.1%)
91,038	92,924	(1,886)	(2.0%)	TANF Adult	834,922	849,576	(14,654)	(1.7%)
3,391	3,536	(145)	(4.1%)	LTC	30,633	31,428	(795)	(2.5%)
238,964	243,760	(4,796)	(2.0%)	MCE	2,136,769	2,182,596	(45,827)	(2.1%)
-	12,502	(12,502)	(100.0%)	WCM*	-	37,506	(37,506)	(100.0%)
751,343	**766,863**	**(15,520)**	**(2.0%)**	**Medi-Cal**	**6,783,557**	**6,909,304**	**(125,747)**	**(1.8%)**
14,128	**14,853**	**(725)**	**(4.9%)**	**OneCare Connect**	**130,417**	**133,891**	**(3,474)**	**(2.6%)**
1,488	**1,324**	**164**	**12.4%**	**OneCare**	**12,824**	**11,916**	**908**	**7.6%**
320	**327**	**(7)**	**(2.1%)**	**PACE**	**2,660**	**2,679**	**(19)**	**(0.7%)**
767,279	**783,367**	**(16,088)**	**(2.1%)**	**CalOptima Total**	**6,929,458**	**7,057,790**	**(128,332)**	**(1.8%)**

* Whole Child Model (WCM) was budgeted based on initial implementation date. Enrollment for WCM was transferred from the other seven aid categories.

				Enrollment (By Network)				
165,917	167,071	(1,154)	(0.7%)	HMO	1,498,427	1,510,151	(11,724)	(0.8%)
214,163	221,858	(7,695)	(3.5%)	PHC	1,949,699	1,999,024	(49,325)	(2.5%)
192,350	187,696	4,654	2.5%	Shared Risk Group	1,734,019	1,718,308	15,711	0.9%
178,913	190,239	(11,326)	(6.0%)	Fee for Service	1,601,412	1,681,822	(80,410)	(4.8%)
751,343	**766,863**	**(15,520)**	**(2.0%)**	**Medi-Cal**	**6,783,557**	**6,909,304**	**(125,747)**	**(1.8%)**
14,128	**14,853**	**(725)**	**(4.9%)**	**OneCare Connect**	**130,417**	**133,891**	**(3,474)**	**(2.6%)**
1,488	**1,324**	**164**	**12.4%**	**OneCare**	**12,824**	**11,916**	**908**	**7.6%**
320	**327**	**(7)**	**(2.1%)**	**PACE**	**2,660**	**2,679**	**(19)**	**(0.7%)**
767,279	**783,367**	**(16,088)**	**(2.1%)**	**CalOptima Total**	**6,929,458**	**7,057,790**	**(128,332)**	**(1.8%)**

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CalOptima - Consolidated
Enrollment Trend by Network Type
Fiscal Year 2019

Network Type	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	YTD
HMO													
Aged	3,844	3,866	3,841	3,841	3,854	3,842	3,837	3,821	3,783				34,529
BCCTP	1	1	1	1	1	1	1	1	1				9
Disabled	6,744	6,789	6,789	6,811	6,838	6,813	6,807	6,824	6,835				61,250
TANF Child	58,435	58,267	58,162	58,110	57,723	56,929	56,504	56,327	56,636				517,093
TANF Adult	29,473	29,373	29,404	29,529	29,392	29,131	28,926	28,716	28,656				262,600
LTC	2	2	3	4	1	1	2	2	3				20
MCE	68,597	68,602	68,919	69,646	69,547	69,385	69,020	69,207	70,003				622,926
WCM	-	-	-	-	-	-	-	-	-				-
	167,096	**166,900**	**167,119**	**167,942**	**167,356**	**166,102**	**165,097**	**164,898**	**165,917**				**1,498,427**
PHC													
Aged	1,600	1,621	1,620	1,673	1,673	1,645	1,593	1,565	1,535				14,525
BCCTP	-	-	-	-	-	-	-	-	-				-
Disabled	7,243	7,239	7,230	7,212	7,226	7,231	7,190	7,187	7,225				64,983
TANF Child	157,157	156,755	157,444	158,169	157,483	156,497	155,299	154,625	155,297				1,408,726
TANF Adult	12,731	12,684	12,787	12,785	12,596	12,476	12,049	11,890	11,851				111,849
LTC	-	1	-	-	-	1	1	-	-				3
MCE	39,060	38,992	39,234	39,568	39,402	39,204	37,896	38,002	38,255				349,613
WCM	-	-	-	-	-	-	-	-	-				-
	217,791	**217,292**	**218,315**	**219,407**	**218,380**	**217,054**	**214,028**	**213,269**	**214,163**				**1,949,699**
Shared Risk Group													
Aged	3,593	3,605	3,621	3,642	3,610	3,589	3,635	3,614	3,632				32,541
BCCTP	-	-	-	-	-	-	-	-	-				-
Disabled	7,626	7,554	7,486	7,473	7,493	7,463	7,409	7,419	7,426				67,349
TANF Child	67,471	67,226	67,159	67,251	66,739	66,119	65,717	65,144	65,328				598,154
TANF Adult	30,936	30,567	30,622	30,670	30,417	30,217	29,947	29,702	29,756				272,834
LTC	2	-	1	1	-	2	-	-	1				7
MCE	83,554	83,443	84,008	85,253	85,270	84,916	85,218	85,265	86,207				763,134
WCM	-	-	-	-	-	-	-	-	-				-
	193,182	**192,395**	**192,897**	**194,290**	**193,529**	**192,306**	**191,926**	**191,144**	**192,350**				**1,734,019**
Fee for Service (Dual)													
Aged	49,903	50,943	50,657	50,741	51,018	51,265	51,130	51,194	51,296				458,147
BCCTP	16	15	18	14	13	11	11	10	11				119
Disabled	20,706	20,863	20,741	20,761	20,812	20,921	20,739	20,879	20,732				187,154
TANF Child	2	3	2	2	1	2	2	2	2				18
TANF Adult	1,081	1,083	1,064	1,055	1,038	1,029	1,028	992	1,014				9,384
LTC	3,025	3,019	3,007	3,077	3,079	3,096	3,062	3,027	3,054				27,446
MCE	2,327	2,367	2,416	2,388	2,237	2,141	2,086	2,141	2,216				20,319
WCM	-	-	-	-	-	-	-	-	-				-
	77,060	**78,293**	**77,905**	**78,038**	**78,198**	**78,465**	**78,058**	**78,245**	**78,325**				**702,587**
Fee for Service (Non-Dual)													
Aged	4,702	3,727	4,153	4,118	4,018	4,128	4,311	4,347	4,568				38,072
BCCTP	613	596	601	581	589	574	584	579	579				5,296
Disabled	4,802	4,672	4,617	4,678	5,209	4,676	4,068	4,686	4,822				42,230
TANF Child	30,166	31,801	28,765	26,649	25,545	26,010	27,672	26,188	28,242				251,038
TANF Adult	20,308	20,588	20,198	19,628	19,315	19,401	19,614	19,442	19,761				178,255
LTC	353	360	367	347	356	340	351	350	333				3,157
MCE	44,399	44,410	43,161	40,810	40,393	41,103	42,153	42,065	42,283				380,777
WCM	-	-	-	-	-	-	-	-	-				-
	105,343	**106,154**	**101,862**	**96,811**	**95,425**	**96,232**	**98,753**	**97,657**	**100,588**				**898,825**
MEDI-CAL TOTAL													
Aged	63,642	63,762	63,892	64,015	64,173	64,469	64,506	64,541	64,814				577,814
BCCTP	630	612	620	596	603	586	596	590	591				5,424
Disabled	47,121	47,117	46,863	46,935	47,578	47,104	46,213	46,995	47,040				422,966
TANF Child	313,231	314,052	311,532	310,181	307,491	305,557	305,194	302,286	305,505				2,775,029
TANF Adult	94,529	94,295	94,075	93,667	92,758	92,254	91,564	90,742	91,038				834,922
LTC	3,382	3,382	3,378	3,429	3,436	3,440	3,416	3,379	3,391				30,633
MCE	237,937	237,814	237,738	237,665	236,849	236,749	236,373	236,680	238,964				2,136,769
WCM	-	-	-	-	-	-	-	-	-				-
	760,472	**761,034**	**758,098**	**756,488**	**752,888**	**750,159**	**747,862**	**745,213**	**751,343**				**6,783,557**
OneCare Connect	16,399	13,137	14,681	14,665	14,610	14,301	14,287	14,209	14,128				130,417
OneCare	1,390	1,384	1,375	1,404	1,423	1,435	1,453	1,472	1,488				12,824
PACE	273	286	286	289	295	299	304	308	320				2,660
TOTAL	**778,534**	**775,841**	**774,440**	**772,846**	**769,216**	**766,194**	**763,906**	**761,202**	**767,279**				**6,929,458**

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ENROLLMENT:

Overall March enrollment was 767,279

- Unfavorable to budget 16,088 or 2.1%
- Increased 6,077 or 0.8% from prior month (February 2019)
- Decreased 21,421 or 2.7% from prior year (March 2018)

Medi-Cal enrollment was 751,343

- Unfavorable to budget 15,520 or 2.0%
  - Whole Child Model (WCM) unfavorable 12,502
    - WCM members will remain in their original aid codes until the program begins 7/1/19
  - Medi-Cal Expansion (MCE) unfavorable 4,796
  - Temporary Assistance for Needy Families (TANF) unfavorable 206
  - Long-Term Care (LTC) unfavorable 145
  - Seniors and Persons with Disabilities (SPD) favorable 2,129
- Increased 6,130 from prior month

OneCare Connect enrollment was 14,128

- Unfavorable to budget 725 or 4.9%
- Decreased 81 from prior month

OneCare enrollment was 1,488

- Favorable to budget 164 or 12.4%
- Increased 16 from prior month

PACE enrollment was 320

- Unfavorable to budget 7 or 2.1%
- Increased 12 from prior month

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Nine Months Ending March 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
751,343	**766,863**	**(15,520)**	**(2.0%)**	**Member Months**	**6,783,557**	**6,909,304**	**(125,747)**	**(1.8%)**
				Revenues				
326,386,417	269,256,500	57,129,917	21 2%	Capitation revenue	2,305,233,092	2,297,068,019	8,165,073	0 4%
-	-	-	0 0%	Other income	-	-	-	0 0%
326,386,417	**269,256,500**	**57,129,917**	**21.2%**	**Total Operating Revenue**	**2,305,233,092**	**2,297,068,019**	**8,165,073**	**0.4%**
				Medical Expenses				
127,640,662	95,414,605	(32,226,057)	(33 8%)	Provider capitation	825,381,125	794,110,374	(31,270,751)	(3 9%)
56,797,446	46,837,804	(9,959,642)	(21 3%)	Facilities	421,387,504	399,492,168	(21,895,336)	(5 5%)
36,739,593	29,452,980	(7,286,614)	(24 7%)	Professional Claims	214,417,641	257,609,610	43,191,969	16 8%
36,327,318	45,439,995	9,112,678	20 1%	Prescription drugs	329,121,960	366,191,547	37,069,586	10 1%
36,213,911	37,170,661	956,750	2 6%	MLTSS	313,448,776	326,559,107	13,110,331	4 0%
3,067,062	3,924,745	857,683	21 9%	Medical management	27,913,226	33,578,785	5,665,559	16 9%
933,881	530,634	(403,247)	(76 0%)	Reinsurance & other	8,150,104	4,775,706	(3,374,398)	(70 7%)
297,719,873	**258,771,424**	**(38,948,449)**	**(15.1%)**	**Total Medical Expenses**	**2,139,820,336**	**2,182,317,296**	**42,496,960**	**1.9%**
28,666,543	**10,485,075**	**18,181,468**	**173.4%**	**Gross Margin**	**165,412,755**	**114,750,722**	**50,662,033**	**44.1%**
				Administrative Expenses				
7,093,072	7,225,851	132,779	1 8%	Salaries, wages & employee benefits	55,204,224	63,073,413	7,869,190	12 5%
292,255	370,326	78,071	21 1%	Professional fees	1,534,810	3,170,025	1,635,215	51 6%
694,060	996,571	302,510	30 4%	Purchased services	6,654,902	8,572,010	1,917,108	22 4%
383,315	375,809	(7,507)	(2 0%)	Printing and postage	2,889,097	3,762,285	873,188	23 2%
435,073	462,076	27,003	5 8%	Depreciation and amortization	3,933,106	4,158,680	225,574	5 4%
1,125,401	1,499,367	373,966	24 9%	Other operating expenses	10,724,537	13,456,551	2,732,014	20 3%
(320,106)	(223,591)	96,515	43 2%	Indirect cost allocation, Occupancy Expense	(2,743,352)	(2,012,321)	731,031	36 3%
9,703,071	**10,706,408**	**1,003,338**	**9.4%**	**Total Administrative Expenses**	**78,197,324**	**94,180,644**	**15,983,320**	**17.0%**
				Operating Tax				
11,383,062	10,934,485	448,577	4 1%	Tax Revenue	102,761,120	97,463,753	5,297,366	5 4%
11,383,062	10,934,485	(448,577)	(4 1%)	Premium tax expense	102,761,120	86,679,615	(16,081,504)	(18 6%)
-	-	-	0 0%	Sales tax expense	-	10,784,138	10,784,138	100 0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
				Grant Income				
24,056	249,874	(225,818)	(90 4%)	Grant Revenue	379,791	2,248,866	(1,869,075)	(83 1%)
16,575	223,107	206,532	92 6%	Grant expense - Service Partner	251,600	2,007,963	1,756,363	87 5%
7,481	26,767	19,286	72 1%	Grant expense - Administrative	128,191	240,903	112,712	46 8%
-	-	-	**0.0%**	**Total Grant Income**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Other income**	**801**	-	**801**	**0.0%**
18,963,473	**(221,333)**	**19,184,806**	**8667.8%**	**Change in Net Assets**	**87,216,233**	**20,570,079**	**66,646,154**	**324.0%**
91.2%	***96.1%***	***4.9%***	***5.1%***	***Medical Loss Ratio***	***92.8%***	***95.0%***	***2.2%***	***2.3%***
3.0%	***4.0%***	***1.0%***	***25.2%***	***Admin Loss Ratio***	***3.4%***	***4.1%***	***0.7%***	***17.3%***

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MEDI-CAL INCOME STATEMENT - MARCH MONTH:

REVENUES of $326.4 million are favorable to budget $57.1 million driven by:

- Unfavorable volume related variance of $5.4 million
- Favorable price related variance of $62.6 million due to:
  - $43.8 million due to Proposition 56 rate true-up
  - $42.8 million of Intergovernmental Transfer (IGT) fiscal year (FY) 2018 revenue
  - Offset by $22.9 WCM revenue due to delay of program start

MEDICAL EXPENSES of $297.7 million are unfavorable to budget $38.9 million driven by:

- **Provider Capitation** expense is unfavorable to budget $32.2 million due to:
  - $42.0 million of capitation expense for Proposition 56
  - $2.0 million of Child Health and Disability Prevention Program (CHDP)
  - Offset by $12.0 million of WCM expense due to delay of program start
- **Facilities** expense is unfavorable to budget $10.0 million due to increase Incurred But Not Reported (IBNR) claims
- **Prescription Drug** expense is favorable to budget $9.1 million, in part due to delay of WCM program start
- **Professional Claims** expense is unfavorable to budget $7.3 million due to:
  - $11.7 million of Proposition 56 expenses, offset by:
  - $2.0 million of CHDP expenses

ADMINISTRATIVE EXPENSES of $9.7 million are favorable to budget $1.0 million driven by:

- Salaries & Benefit expenses are favorable to budget $0.1 million
- Other Non-Salary expenses are favorable to budget $0.9 million

CHANGE IN NET ASSETS is $19.0 million for the month, favorable to budget $19.2 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Nine Months Ending March 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,128	**14,853**	**(725)**	**(4.9%)**	**Member Months**	**130,417**	**133,891**	**(3,474)**	**(2.6%)**
				Revenues				
2,637,470	3,177,330	(539,860)	(17.0%)	Medi-Cal Capitation revenue	24,720,586	29,480,649	(4,760,063)	(16 1%)
19,909,574	18,606,687	1,302,887	7.0%	Medicare Capitation revenue part C	155,986,217	156,916,651	(930,434)	(0.6%)
5,119,833	4,841,057	278,776	5.8%	Medicare Capitation revenue part D	45,899,399	42,686,323	3,213,076	7.5%
-	-	-	0.0%	Other Income	-	-	-	0.0%
27,666,877	**26,625,074**	**1,041,803**	**3 9%**	**Total Operating Revenue**	**226,606,201**	**229,083,623**	**(2,477,422)**	**(1.1%)**
				Medical Expenses				
13,648,783	12,370,388	(1,278,395)	(10.3%)	Provider capitation	106,870,871	105,353,375	(1,517,496)	(1.4%)
4,172,596	3,788,430	(384,166)	(10.1%)	Facilities	32,738,235	32,648,493	(89,742)	(0 3%)
1,070,659	717,983	(352,676)	(49.1%)	Ancillary	6,213,225	5,987,750	(225,475)	(3.8%)
1,543,824	1,597,424	53,600	3.4%	Long Term Care	12,626,830	14,735,979	2,109,149	14.3%
4,957,339	5,429,860	472,521	8.7%	Prescription drugs	47,869,147	47,543,502	(325,645)	(0.7%)
1,135,637	1,323,535	187,898	14.2%	Medical management	10,033,995	11,671,361	1,637,366	14.0%
203,565	138,665	(64,900)	(46.8%)	Other medical expenses	1,983,810	1,292,197	(691,613)	(53 5%)
26,732,403	**25,366,285**	**(1,366,118)**	**(5.4%)**	**Total Medical Expenses**	**218,336,114**	**219,232,657**	**896,543**	**0.4%**
934,474	**1,258,789**	**(324,315)**	**(25.8%)**	**Gross Margin**	**8,270,087**	**9,850,966**	**(1,580,879)**	**(16.0%)**
				Administrative Expenses				
733,707	893,239	159,532	17.9%	Salaries, wages & employee benefits	6,794,774	7,842,273	1,047,499	13.4%
7,340	42,917	35,577	82.9%	Professional fees	225,661	386,250	160,589	41.6%
190,246	251,415	61,169	24.3%	Purchased services	1,634,140	2,262,736	628,596	27.8%
23,513	86,202	62,689	72.7%	Printing and postage	576,430	775,815	199,385	25.7%
-	-	-	0.0%	Depreciation & amortization	-	-	-	0.0%
56,950	77,037	20,086	26.1%	Other operating expenses	405,447	693,329	287,881	41.5%
581,690	557,394	(24,296)	(4.4%)	Indirect cost allocation	5,380,112	5,016,546	(363,566)	(7 2%)
1,593,445	**1,908,203**	**314,758**	**16 5%**	**Total Administrative Expenses**	**15,016,565**	**16,976,949**	**1,960,384**	**11.5%**
(658,971)	**(649,414)**	**(9,557)**	**(1.5%)**	**Change in Net Assets**	**(6,746,478)**	**(7,125,983)**	**379,505**	**5.3%**
96.6%	***95.3%***	***(1.4%)***	***(1.4%)***	***Medical Loss Ratio***	***96.4%***	***95.7%***	***(0.7%)***	***(0.7%)***
5.8%	***7.2%***	***1.4%***	***19.6%***	***Admin Loss Ratio***	***6.6%***	***7.4%***	***0.8%***	***10.6%***

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ONECARE CONNECT INCOME STATEMENT - MARCH MONTH:

REVENUES of $27.7 million are favorable to budget $1.0 million driven by:

- Unfavorable volume related variance of $1.3 million
- Favorable price related variance of $2.3 million due to $3.5 million of calendar year (CY) 2017 Hierarchical Condition Category (HCC) and risk adjustments offset by unfavorable rates

MEDICAL EXPENSES of $26.7 million are unfavorable to budget $1.4 million driven by:

- Favorable volume related variance of $1.2 million
- Unfavorable price related variance of $2.6 million due to $2.3 million of CY 2017 HCC capitation expense

ADMINISTRATIVE EXPENSES of $1.6 million are favorable to budget $0.3 million

C**HANGE IN NET ASSETS** is ($0.7) million, in line with budget

CalOptima
OneCare
Statement of Revenues and Expenses
For the Nine Months Ending March 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,488	**1,324**	**164**	**12.4%**	**Member Months**	**12,824**	**11,916**	**908**	**7.6%**
				Revenues				
1,303,011	1,141,043	161,967	14.2%	Medicare Part C revenue	9,969,722	10,000,400	(30,678)	(0.3%)
540,054	509,332	30,721	6.0%	Medicare Part D revenue	4,733,199	4,475,778	257,421	5.8%
1,843,064	**1,650,376**	**192,688**	**11.7%**	**Total Operating Revenue**	**14,702,921**	**14,476,178**	**226,743**	**1.6%**
				Medical Expenses				
486,668	452,663	(34,005)	(7.5%)	Provider capitation	4,097,854	4,057,301	(40,553)	(1.0%)
657,029	544,404	(112,625)	(20.7%)	Inpatient	4,112,212	4,672,563	560,351	12.0%
35,879	60,764	24,886	41.0%	Ancillary	355,598	507,790	152,192	30.0%
17,060	26,857	9,798	36.5%	Skilled nursing facilities	428,557	237,384	(191,173)	(80.5%)
453,259	452,587	(672)	(0.1%)	Prescription drugs	4,177,397	3,959,361	(218,036)	(5.5%)
54,584	34,301	(20,283)	(59.1%)	Medical management	549,315	306,662	(242,653)	(79.1%)
(12,000)	9,768	21,768	222.8%	Other medical expenses	37,298	68,681	31,384	45.7%
1,692,478	**1,581,344**	**(111,134)**	**(7.0%)**	**Total Medical Expenses**	**13,758,231**	**13,809,743**	**51,512**	**0.4%**
150,586	**69,032**	**81,554**	**118.1%**	**Gross Margin**	**944,690**	**666,435**	**278,255**	**41.8%**
				Administrative Expenses				
31,054	40,734	9,680	23.8%	Salaries, wages & employee benefits	295,701	357,863	62,162	17.4%
14,667	19,600	4,934	25.2%	Professional fees	132,000	176,400	44,400	25.2%
19,396	17,425	(1,971)	(11.3%)	Purchased services	140,338	156,825	16,487	10.5%
(11)	13,206	13,217	100.1%	Printing and postage	70,024	118,853	48,830	41.1%
277	6,883	6,607	96.0%	Other operating expenses	653	61,950	61,297	98.9%
41,461	34,965	(6,496)	(18.6%)	Indirect cost allocation, occupancy expense	349,079	314,685	(34,394)	(10.9%)
106,843	**132,813**	**25,970**	**19.6%**	**Total Administrative Expenses**	**987,794**	**1,186,576**	**198,782**	**16.8%**
43,743	**(63,781)**	**107,524**	**168.6%**	**Change in Net Assets**	**(43,104)**	**(520,142)**	**477,037**	**91.7%**
91.8%	***95.8%***	***4.0%***	***4.2%***	***Medical Loss Ratio***	***93.6%***	***95.4%***	***1.8%***	***1.9%***
5.8%	***8.0%***	***2.3%***	***28.0%***	***Admin Loss Ratio***	***6.7%***	***8.2%***	***1.5%***	***18.0%***

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CalOptima
PACE
Statement of Revenues and Expenses
For the Nine Months Ending March 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
320	**327**	**(7)**	**(2.1%)**	**Member Months**	**2,660**	**2,679**	**(19)**	**-0.7%**
				Revenues				
1,940,670	1,830,226	110,444	6 0%	Medi-Cal capitation revenue	15,011,591	14,995,975	15,616	0 1%
454,308	441,586	12,722	2 9%	Medicare Part C revenue	3,704,575	3,583,425	121,150	3 4%
136,157	106,000	30,157	28 4%	Medicare Part D revenue	1,017,541	863,356	154,185	17 9%
2,531,135	**2,377,812**	**153,323**	**6.4%**	**Total Operating Revenue**	**19,733,707**	**19,442,756**	**290,951**	**1.5%**
				Medical Expenses				
608,376	794,236	185,860	23 4%	Medical Management	5,619,762	6,545,211	925,449	14 1%
546,728	507,560	(39,168)	(7 7%)	Claims payments to hospitals	3,651,949	4,061,921	409,972	10 1%
599,409	529,223	(70,186)	(13 3%)	Professional claims	4,068,471	4,305,275	236,804	5 5%
162,760	145,773	(16,987)	(11 7%)	Patient transportation	1,461,629	1,194,271	(267,358)	(22 4%)
213,848	192,396	(21,452)	(11 1%)	Prescription drugs	1,566,831	1,556,838	(9,993)	(0 6%)
64,152	27,713	(36,439)	(131 5%)	MLTSS	98,063	143,417	45,354	31 6%
3,200	3,100	(100)	(3 2%)	Other Expenses	26,600	26,100	(500)	(1 9%)
2,198,474	**2,200,001**	**1,527**	**0.1%**	**Total Medical Expenses**	**16,493,305**	**17,833,033**	**1,339,728**	**7.5%**
332,661	**177,811**	**154,850**	**87.1%**	**Gross Margin**	**3,240,402**	**1,609,723**	**1,630,679**	**101.3%**
				Administrative Expenses				
110,039	142,545	32,507	22 8%	Salaries, wages & employee benefits	894,534	1,183,348	288,813	24 4%
123	167	43	25 9%	Professional fees	6,614	1,500	(5,114)	(341 0%)
13,648	21,027	7,378	35 1%	Purchased services	86,494	189,240	102,746	54 3%
8,742	10,428	1,686	16 2%	Printing and postage	56,265	93,855	37,590	40 1%
2,089	2,091	2	0 1%	Depreciation & amortization	18,731	18,816	85	0 5%
3,298	3,859	561	14 5%	Other operating expenses	23,808	34,728	10,920	31 4%
16,620	3,466	(13,154)	(379 6%)	Indirect cost allocation, Occupancy Expense	51,848	31,191	(20,657)	(66 2%)
154,559	**183,582**	**29,023**	**15.8%**	**Total Administrative Expenses**	**1,138,294**	**1,552,678**	**414,384**	**26.7%**
				Operating Tax				
4,749	-	4,749	0 0%	Tax Revenue	37,954	-	37,954	0 0%
4,749	-	(4,749)	0 0%	Premium tax expense	37,954	-	(37,954)	0 0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
178,103	**(5,771)**	**183,873**	**3186.2%**	**Change in Net Assets**	**2,102,109**	**57,045**	**2,045,063**	**3585.0%**
86.9%	***92.5%***	***5.7%***	***6.1%***	***Medical Loss Ratio***	***83.6%***	***91.7%***	***8.1%***	***8.9%***
6.1%	***7.7%***	***1.6%***	***20.9%***	***Admin Loss Ratio***	***5.8%***	***8.0%***	***2.2%***	***27.8%***

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CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Nine Months Ending March 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
34,112	22,982	(11,130)	(48.4%)	Purchase services	302,706	206,835	(95,871)	(46.4%)
163,419	162,935	(484)	(0.3%)	Depreciation & amortization	1,467,756	1,466,411	(1,345)	(0.1%)
15,816	15,916	100	0.6%	Insurance expense	142,342	143,250	908	0.6%
87,778	173,136	85,358	49.3%	Repair and maintenance	870,940	1,558,224	687,284	44.1%
24,345	1,635	(22,710)	(1389.0%)	Other Operating Expense	384,451	14,715	(369,736)	(2512.7%)
(325,470)	(376,604)	(51,134)	(13.6%)	Indirect allocation, Occupancy	(3,168,196)	(3,389,435)	(221,239)	(6.5%)
(0)	**-**	**0**	**0.0%**	**Total Administrative Expenses**	**(0)**	**-**	**0**	**0.0%**
0	**-**	**0**	**0.0%**	**Change in Net Assets**	**0**	**-**	**0**	**0.0%**

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OTHER INCOME STATEMENTS - MARCH MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $43.7 thousand, $107.5 thousand favorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $178.1 thousand, $183.9 thousand favorable to budget

CalOptima
Balance Sheet
March 31, 2019

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$640,608,268	Accounts Payable	$40,132,045
Investments	487,961,165	Medical Claims liability	1,081,745,716
Capitation receivable	472,217,779	Accrued Payroll Liabilities	12,101,684
Receivables - Other	24,720,145	Deferred Revenue	53,657,665
Prepaid expenses	5,584,844	Deferred Lease Obligations	63,588
		Capitation and Withholds	127,132,188
Total Current Assets	**1,631,092,200**	**Total Current Liabilities**	**1,314,832,886**
Capital Assets			
Furniture & Equipment	38,297,211		
Building/Leasehold Improvements	6,032,369		
505 City Parkway West	50,289,440		
	94,619,020		
Less: accumulated depreciation	(46,758,863)		
Capital assets, net	47,860,156	Other (than pensions) post	
		employment benefits liability	25,673,365
Other Assets		Net Pension Liabilities	23,602,064
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Board-designated assets			
Cash and Cash Equivalents	25,194,513	**TOTAL LIABILITIES**	**1,364,108,315**
Long-term Investments	527,576,174		
Total Board-designated Assets	552,770,687	Deferred Inflows	
		Change in Assumptions	4,747,505
Total Other Assets	553,070,687	Excess Earnings	156,330
TOTAL ASSETS	**2,232,023,044**	TNE	83,441,682
		Funds in Excess of TNE	790,103,661
Deferred Outflows			
Pension Contributions	686,962		
Difference in Experience	3,419,328	Net Assets	873,545,343
Excess Earning	-		
Changes in Assumptions	6,428,159		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,242,557,493**	**TOTAL LIABILITIES & FUND BALANCES**	**2,242,557,493**

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CalOptima
Board Designated Reserve and TNE Analysis
as of March 31, 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	151,281,498				
	Tier 1 - Logan Circle	150,816,354				
	Tier 1 - Wells Capital	150,650,843				
Board-designated Reserve		452,748,694	318,222,862	490,364,810	134,525,832	(37,616,115)
TNE Requirement	Tier 2 - Logan Circle	100,021,993	83,441,682	83,441,682	16,580,311	16,580,311
	Consolidated:	**552,770,687**	**401,664,544**	**573,806,491**	**151,106,143**	**(21,035,804)**
	Current reserve level	*1.93*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
March 31, 2019

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	23,616,753	111,913,776
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	600,580	5,419,592
Changes in assets and liabilities:		
Prepaid expenses and other	1,217,714	712,503
Catastrophic reserves		
Capitation receivable	(28,672,425)	(175,786,907)
Medical claims liability	330,659,872	249,126,103
Deferred revenue	462,865	(60,045,284)
Payable to providers	46,695,812	30,683,297
Accounts payable	12,080,280	33,576,638
Other accrued liabilities	(1,583,507)	(547,621)
Net cash provided by/(used in) operating activities	385,077,943	195,052,096
GASB 68 CalPERS Adjustments	2,173,056	2,173,056
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	1,814,591	92,337,783
Change in Property and Equipment	(290,368)	(2,521,499)
Change in Board designated reserves	(3,156,206)	(14,523,015)
Net cash provided by/(used in) investing activities	(1,631,983)	75,293,269
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	385,619,017	272,518,421
CASH AND CASH EQUIVALENTS, beginning of period	254,989,251	368,089,847
CASH AND CASH EQUIVALENTS, end of period	**640,608,268**	**640,608,268**

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BALANCE SHEET - MARCH MONTH:

ASSETS of $2.2 billion increased $413.5 million from February or 22.6%

- Operating Cash increased $385.6 million primarily due to Quality Assurance Fee (QAF) and Proposition 56 receipts
- Capitation Receivables increased $27.0 million or 6.1% due to IGT FY 2018 receipts and timing of Department of Healthcare Services (DHCS) capitation payments

LIABILITIES increased $388.3 million from February or 39.8%

- Claims Liability increased $330.7 million due to QAF liabilities accrued
- Capitation and Withholds increased $46.7 million due to Proposition 56 rate adjustments
- Accounts Payable increased $11.9 million due to quarterly Managed Care Organization (MCO) tax liability

NET ASSETS of $873.5 million, increased $23.6 million from February or 2.8%

CalOptima Foundation
Statement of Revenues and Expenses
For the Nine Months Ended March 31, 2019

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	55,658	55,658	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	26,863	26,863	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%
4,666	229,840	225,174	98.0%	Other	12,000	2,068,557	2,056,557	99.4%
4,666	**239,009**	**234,343**	**98%**	**Total Operating Expenditures**	**12,000**	**2,151,078**	**2,139,078**	**99.4%**
4,926	**0**	**4,926**	**0.0%**	**Investment Income**	**26,401**	**0**	**26,401**	**0.0%**
260	**(239,009)**	**239,268**	**100.1%**	**Program Income**	**14,401**	**(2,151,078)**	**2,165,479**	**100.7%**

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CalOptima Foundation
Balance Sheet
March 31, 2019

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,869,540	Accounts payable-Current	12,000
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**2,869,540**	Grants-Foundation	0
		Total Current Liabilities	**12,000**
		Total Liabilities	**12,000**
		Net Assets	**2,857,540**
TOTAL ASSETS	**2,869,540**	**TOTAL LIABILITIES & NET ASSETS**	**2,869,540**

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CALOPTIMA FOUNDATION FINANCIAL STATEMENTS – MARCH MONTH AND YTD:

OVERVIEW - CalOptima Foundation was formed as a not-for-profit corporation in 2010 and is dedicated to the betterment of public health care services in Orange County. The activities of the Foundation are presented in the financial statements. CalOptima Foundation is in the process of winding down by the end of fiscal year (FY) 2019

INCOME STATEMENT

REVENUES - no activity for the month of March or YTD FY 2019

OPERATING EXPENSES

- March - $4,666 for the month, favorable to budget $234.3 thousand
- YTD - $12,000 for the year, favorable to the budget $2.1 million

INVESTMENT INCOME

- March - $4.9 thousand for the month
- YTD - $26.4 thousand for the year

CHANGE IN NET INCOME

- March - $260 for the month, favorable to budget $239.3 thousand
- YTD – $14.4 thousand, favorable to budget $2.2 million

BALANCE SHEET

ASSETS

- Cash - $2.9 million remains from the FY 2014 $3.0 million transferred by CalOptima for grants and programs in support of providers and community

LIBILITIES

- Accounts Payable - $12,000 for audit fees

Budget Allocation Changes
Reporting Changes for February 2019

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
November	Medi-Cal	Facilities - Capital Project (8th Floor HR Remodel)	Facilities - Capital Project (Replace Master Control Center)	$22,500	Reallocate $22,500 from Capital Project (8th Floor hr. Remodel) to Capital Project (Replace Master Control Center)	2019
December	Medi-Cal	Facilities - Office Supplies	Facilities - Computer Supply/Minor Equipment	$60,000	Reallocate $60,000 from Office Supplies to Computer Supplies/Minor Equipment to furniture needs of the staff	2019
December	Medi-Cal	Strategic Development - Professional Fees (Covered CA Consulting)	Strategic Development - Professional Fees (Strategic Planning Consulting)	$50,000	Repurpose $50,000 from Professional Fees (Covered CA Consulting) to Professional Fees (Strategic Planning Consulting)	2019
January	Medi-Cal	IS Application Development - Training & Seminars	IS Application Development - Maintenance HW/SW	$11,000	Reallocate $11,000 from training & seminars to maintenance HW/SW to pay for additional Tableau licenses	2019
February	No Reported Changes					
March	No Reported Changes					

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.

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Board of Directors Meeting
May 2, 2019

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

- CY 2018 CMS Timeliness Monitoring Project:

  On December 21, 2018, the Centers for Medicare & Medicaid Services (CMS) announced its efforts to collect data for organization determinations, appeals and grievances (ODAG) and coverage determinations, appeals and grievances (CDAG) for the review period of February 1, 2018 – April 30, 2018. CMS will run a timeliness analysis on all validated universes and determine a rate of timeliness for each case type. Any findings may result in compliance actions, if necessary, and may have implications for the Star Ratings data integrity reviews for the four (4) appeals measures.

  On March 4, 2019, CMS notified CalOptima of its participation in the Timeliness Monitoring Project. CMS conducted the ODAG and CDAG validation webinars on April 2, 2019 and April 9, 2019, respectively. Based on preliminary feedback from CMS, there appears to be no findings or deficiencies identified during the validation webinars. CMS expected to provide the final results in the coming weeks.

- CY 2017 Medicare Part C National Risk Adjustment Data Validation (RADV) Audit:

  On December 28, 2018, CMS notified CalOptima that its OneCare program has been selected to participate in the CY 2017 Medicare Part C National Risk Adjustment Data Validation (RADV) audit. On February 28, 2019, the CMS submission window opened and CalOptima was notified that only one (1) enrollee with six (6) hierarchical condition categories (HCCs) was selected for validation. The deadline for submission of medical records for the selected enrollee is June 20, 2019.

- Notification of Three-Year Provider Network Adequacy Review:

  On January 15, 2019, CMS notified CalOptima that its OneCare program has been selected for its three-year provider network adequacy review. On February 4, 2019, CMS requested that CalOptima upload its provider and facility network for an informal review. CalOptima

will have between February and May 2019 to remediate any deficiencies before the formal submission is due in June 2019. In June 2019, CalOptima will receive instructions on how to upload the entire network for its OneCare program for CMS to begin the formal review.

- Medicare Data Validation Audit (OneCare and OneCare Connect):

  On an annual basis, CMS requires all plan sponsors to engage an independent consultant to conduct a validation audit of all Medicare Parts C and D data reported for the prior calendar year. In preparation for the audit, CalOptima has collected the required Parts C and D reporting data and worked with all impacted business areas to ensure the accuracy of the data prior to submission in February 2019. The validation audit is expected to take place starting in March and conclude in June 2019. The audit includes an onsite audit and source documentation review for the following Medicare Parts C and D measures:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations
  - Medication Therapy Management (MTM) Program
  - Special Needs Plan (SNP) Care Management
  - Improving Drug Utilization Review Controls

  CMS has scheduled the virtual audit to take place on April 17, 2019.

- CY 2014 Part C Contract-Level Risk Adjustment Data Validation (RADV) Audit:

  On February 26, 2019, CMS notified CalOptima of its selection to participate in the CY 2014 Contract-Level Risk Adjustment Data Validation (RADV) audit. CMS will be conducting a medical records review to validate the accuracy of the CY 2014 Medicare Part C risk adjustment data and payments. The collection of medical records and medical director/review approval will begin April 3 through August 9, 2019. The deadline for submission of medical records for the selected enrollees is August 20, 2019.

- CMS Program Audit Readiness (OneCare and OneCare Connect):

  CalOptima anticipates receiving an audit engagement letter from CMS for its OneCare and OneCare Connect programs as early as March of 2019. If engaged for this audit, CMS will be performing a full-scale program audit using the Medicare Parts C and D Audit Protocols and the Program Audit Protocols for Medicare-Medicaid Plans (MMPs). In preparation, the Office of Compliance has created a workplan outlining audit activities, deliverables and responsible parties. CMS indicates that it will be sending scheduled program audit engagement letters to selected plans from March through July 2019.

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. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.
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2. OneCare Connect

- CY 2017 Medicare Part D Prescription Drug Event (PDE) Validation:

  On January 10, 2019, CMS informed CalOptima that its OneCare Connect program has been selected to participate in the Calendar Year (CY) 2017 Medicare Part D PDE validation. CMS will validate the accuracy of PDE data submitted by Medicare Part D sponsors for CY 2017 payments. On January 31, 2019, CMS hosted the first training teleconference in preparation for the validation audit, with a second teleconference held in March 2019. CalOptima has gathered the supporting documentation for this audit and submitted it for CMS review on March 4, 2019. CalOptima is pending a response from CMS for any additional information. All documentation must be submitted by the final deadline of April 19, 2019.

3. Medi-Cal

- 2019 Medi-Cal Audit:

  The Department of Health Care Services (DHCS) conducted its annual audit of CalOptima from February 4, 2019 through February 15, 2019. The audit covered the review period of February 1, 2018 through January 31, 2019, and consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member's rights, quality management, and administrative and organizational capacity. CalOptima expects to receive a preliminary report and an exit conference in the coming months.

- CMS Medicaid Expansion Medical Loss Ratio (MLR) Examination:

  On April 1, 2019, CMS informed CalOptima that it will perform a comprehensive examination and validation of California Medicaid managed care plans' MLR reporting for the reporting periods January 1, 2014 to June 30, 2015 and July 1, 2015 to June 30, 2016. The overall purpose of the examinations is to ensure that the financial information submitted by the Medicaid managed care plans and used by the DHCS to perform the MLR calculations is consistent with contractual obligations and matches each Medicaid managed care plan's internal data and accounting systems. CMS has engaged a contractor to review and assist with these examinations. CMS expects that the review will be completed within six (6) months after all the data have been received by the reviewing contractor. The commencement date of the examination has yet to be established, but CalOptima expects to begin receiving data requests soon.

B. Regulatory Notices of Non-Compliance

1. CalOptima did not receive any notices of non-compliance from its regulators for the month of March 2019.

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. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

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C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring: Medi-Cal [a\]

- Medi-Cal: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2018	97%	100%	100%	100%
December 2018	100%	100%	97%	100%
January 2019	67%	100%	100%	97%

- The lower compliance score of 67% for paid claims timeliness for January 2019 was due to multiple untimely claims.
- The lower compliance score of 97% for denied claims accuracy for January 2019 was due to one (1) inaccurate claim.
- CalOptima's Audit & Oversight (A&O) department issued a request for corrective action plan (CAP) for deficiencies identified during the review of paid and denied claims. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Paper PDRs Acknowledged within ≤ 15 Business Days	PDRs Resolved within ≤ 45 Business Days	Accurate PDR Determinations	Clear and Specific PDR Resolution Language	Interest Accuracy and Timeliness within ≤ 5 Business Days
November 2018	100%	83%	100%	100%	100%
December 2018	100%	80%	100%	100%	95%
January 2019	100%	43%	98%	100%	100%

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- The lower compliance score of 43% for resolution timeliness of PDRs for January 2019 was due to multiple PDRs not processed within forty-five (45) business days of the PDR receipt date.

- The lower compliance score of 98% for accuracy of PDRs for January 2019 was due to one (1) incorrect documentation.

- CalOptima's Audit & Oversight (A&O) department issued a request for corrective action plan (CAP) for deficiencies identified during the review of paid and denied claims. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of PDRs within regulatory requirements.

- Medi-Cal Pharmacy: Pharmacy Standard Appeals

Month	Timeliness	Clinical Decision Making	Categorization/ Classification	Language Preference	Member Notice	Provider Notice	Authorization
November 2018	100%	100%	100%	100%	100%	100%	100%
December 2018	100%	100%	100%	100%	100%	100%	100%
January 2019	100%	100%	100%	100%	100%	100%	100%

- No significant trends to report.

2. Internal Monitoring: OneCare [a\]

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2018	100%	100%	100%	90%
December 2018	100%	90%	100%	100%
January 2019	100%	100%	100%	100%

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- No significant trends to report.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Resolution Timeliness	Accurate PDR Determinations	Clear and Specific PDR Resolution Language
November 2018	Nothing to Report	Nothing to Report	Nothing to Report
December 2018	Nothing to Report	Nothing to Report	Nothing to Report
January 2019	100%	100%	100%

- No significant trends to report.

3. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2018	100%	100%	100%	100%
December 2018	100%	100%	100%	100%
January 2019	100%	100%	100%	100%

- No significant trends to report.

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- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Resolution Timeliness	Letter Accuracy	Check Lag
November 2018	100%	100%	100%	N/A
December 2018	100%	67%	100%	N/A
January 2019	100%	79%	100%	N/A

  - The compliance score of 79% for resolution timeliness for January 2019 was due to untimely processing of PDRs.

4. Internal Monitoring: PACE [a\]

- PACE Claims: Professional Claims

Month	Paid Claims Accuracy	Paid Claims Timeliness	Denied Claims Accuracy	Denied Claims Timeliness
November 2018	100%	100%	100%	100%
December 2018	100%	100%	100%	100%
January 2019	100%	100%	100%	100%

  - No significant trends to report.

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- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Resolution Timeliness	Check Lag
November 2018	100%	100%	100%	N/A
December 2018	100%	100%	100%	N/A
January 2019	100%	100%	0%	N/A

- The lower compliance score of 0% for timeliness of PDRs for January 2019 was due to one (1) PDR not processed within thirty (30) days of the PDR receipt date. Only one (1) PDR was received for January 2019.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for the deficiency identified during the review of paid and denied claims. The A&O department continues to work with the Claims department to remediate the deficiency by identifying an accurate root cause and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of PDRs within regulatory requirements.

5. Health Network Monitoring: Medi-Cal

- 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
November 2018	55%	78%	80%	73%	70%	75%	90%	83%	83%	85%	42%	60%	66%
December 2018	71%	78%	87%	81%	64%	88%	91%	56%	91%	87%	38%	35%	53%
January 2019	79%	73%	74%	90%	93%	85%	87%	89%	87%	89%	54%	61%	75%

- The lower scores for clinical decision making were due to the following reasons:
  - Failure to obtain adequate clinical information

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- Failure to have appropriate professional make decision
- Failure to cite criteria for decision

➢ The lower letter scores were due to the following reasons:
- Failure to provide member with information on how to file a grievance
- Failure to provide letter in member's primary language
- Failure to provide language assistance program (LAP) insert in approved threshold languages
- Failure to provide letter with description of services in lay language
- Failure to describe why the request did not meet criteria in lay language
- Failure to include name and contact information for health care professional responsible for the decision to deny or modify
- Failure to provide notification to enrollee of delayed decision and anticipated final decision date
- Failure to provide notification to provider of delayed decision and anticipated final decision date
- Failure to provide peer-to-peer discussion of the decision with medical reviewer

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of UM prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2018	100%	87%	100%	91%
December 2018	100%	86%	99%	77%
January 2019	100%	91%	99%	81%

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

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6. Health Network Monitoring: OneCare

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
November 2018	93%	67%	91%	100%	98%	100%	75%	89%
December 2018	93%	100%	87%	90%	91%	100%	84%	92%
January 2019	94%	Nothing to Report	91%	96%	94%	100%	78%	92%

  - The lower scores for clinical decision making were due to the following reasons:
    - Failure to obtain adequate clinical information
    - Failure to cite criteria for decision

  - CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2018	89%	100%	100%	94%
December 2018	92%	85%	100%	89%
January 2019	100%	100%	100%	100%

  - No significant trends to report.

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7. Health Network Monitoring: OneCare Connect

- OneCare Connect Utilization Management: Prior Authorization 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
November 2018	75%	84%	82%	63%	95%	43%	72%	77%	38%	89%	69%
December 2018	83%	79%	84%	84%	88%	44%	57%	58%	68%	89%	78%
January 2019	82%	72%	80%	95%	82%	98%	75%	80%	67%	68%	75%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent - 72 hours)
  - Failure to meet timeframe for member notification (2 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)

- The lower scores for clinical decision making were due to the following reasons:
  - Failure to obtain adequate clinical information
  - Failure to cite criteria for decision

- The lower letter scores were due to the following reasons:
  - Failure to provide letter in member's primary language
  - Failure to provide language assistance program (LAP) insert in approved threshold languages
  - Failure to provide letter with description of services in lay language
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide referral back to primary care provider (PCP) on denial letter
  - Failure to include name and contact information for health care professional responsible for the decision to deny
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

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- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2018	81%	96%	98%	90%
December 2018	87%	93%	100%	94%
January 2019	90%	99%	96%	88%

- The compliance rate for denied claims timeliness decreased from 100% in December 2018 to 96% in January 2019 due to untimely processing of multiple claims.

- The compliance rate for denied claims accuracy decreased from 94% in December 2018 to 88% in January 2019 due to missing documents that are required for processing accurate payment on claims.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

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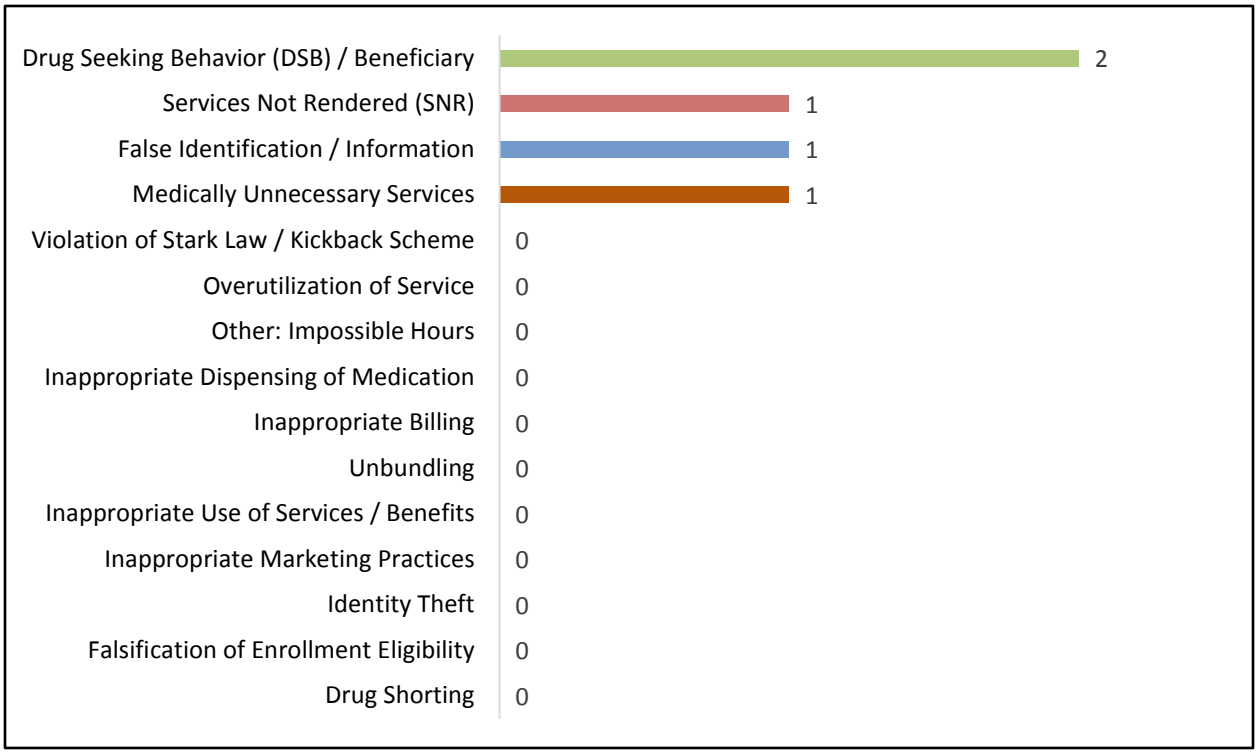
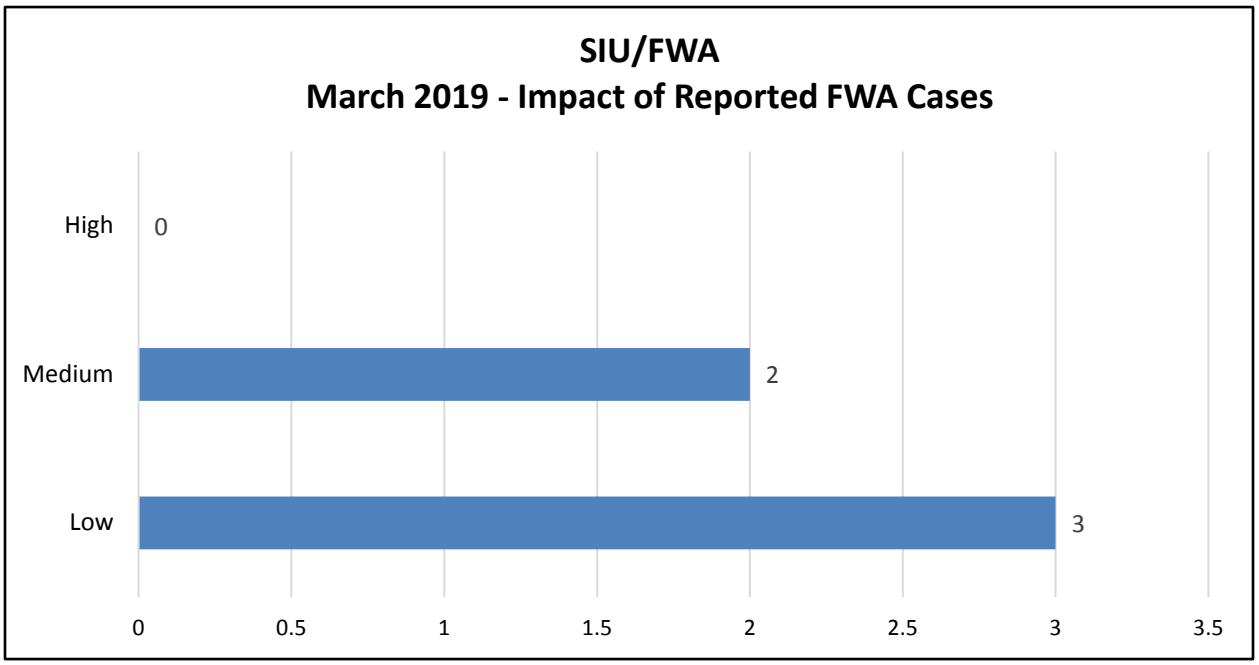
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in March 2019)





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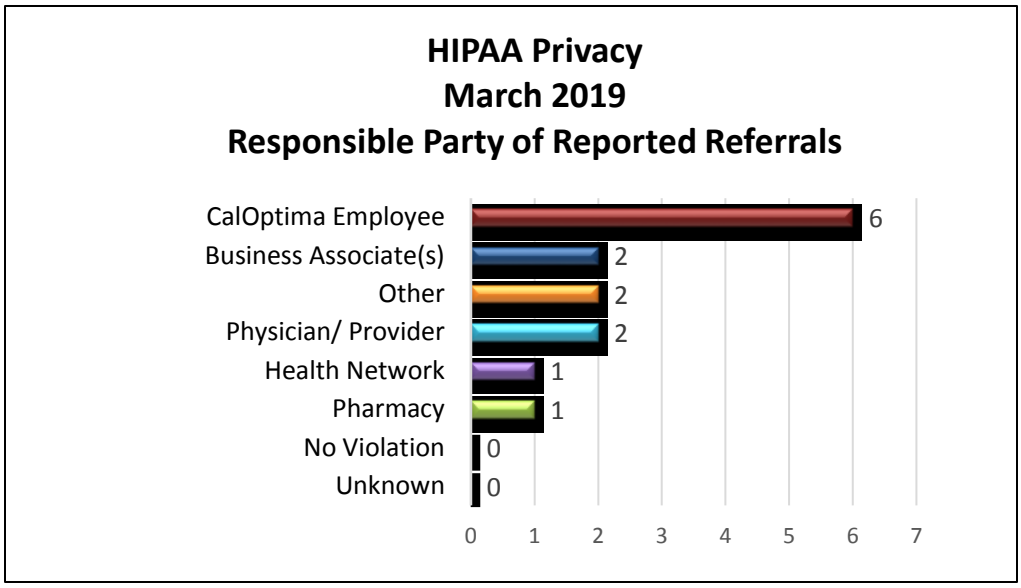
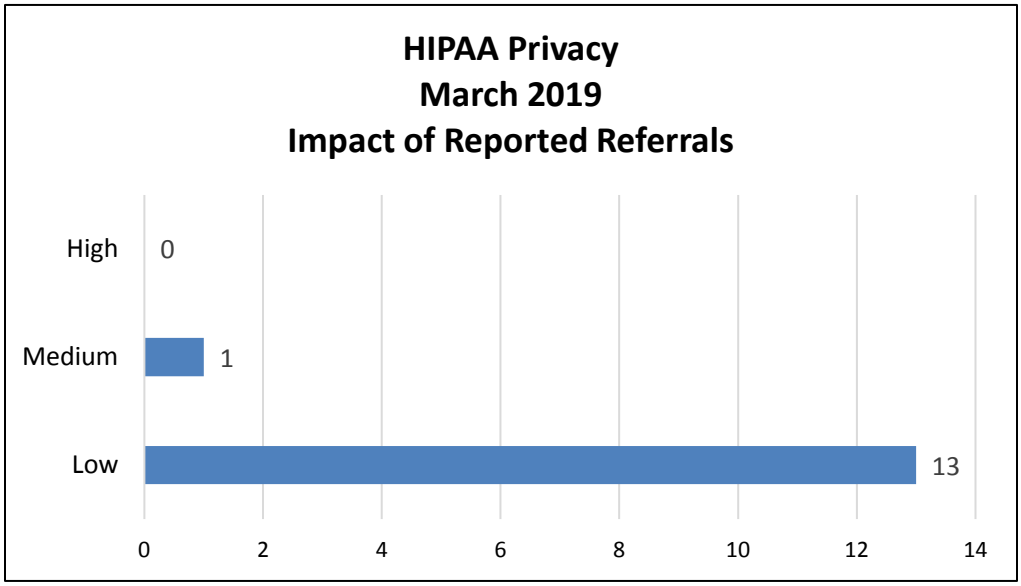
E. Privacy Update (March 2019)





PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	13
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	1
Total Number of Referrals Reported	**14**

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CalOptima
A Public Agency
Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting
May 2, 2019

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

April 8, 2019

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: April Board of Directors Report

Negotiations continue on a deal to raise Fiscal Year (FY) 2020 spending caps, with concern that the President's demand for strict limits could drag out the appropriations process. Meanwhile, Congress passed Medicaid extender legislation while House committees continue to move on drug pricing issues. This report provides an update on legislative activities through April 8, 2019.

FY 2020 Budget and Appropriations

The Fiscal Year (FY) 2020 appropriations cycle continues following the release of the President's Budget Request last month. Health and Human Services (HHS) Secretary Alex Azar has testified before several committees so far on the 2020 HHS Budget, calling attention to the Department's proposals related to opioid response and drug pricing. Democrats have been especially critical, however, of the Budget's dramatic cuts to Medicaid and the proposed repeal of the Affordable Care Act (ACA) along with the Medicaid expansion. Members of the Senate Appropriations Committee Labor-HHS-Education Subcommittee indicated that they are likely to reject the proposed funding reductions for HHS. Indeed, Subcommittee Chairman Roy Blunt (R-MO) said he is sure that the proposed 12.6 percent cut for the National Institutes of Health (NIH) is "not going to happen."

Meanwhile, House and Senate appropriators on both sides of the aisle are negotiating a deal to raise discretionary spending caps for 2020. The Administration has come out against raising the spending limits, proposing to cut nondefense programs by 9 percent while boosting defense spending by 5 percent. Democrats on the House Budget Committee rejected these limits, approving draft legislation on April 3 that would raise the caps by $176 billion in FY 2020 and $180 billion in FY 2021. The full House could vote on the measure as soon as this week. In addition, while the Senate Budget Committee recently approved a budget resolution that accords with the Administration's strict spending caps, Chairman Michael Enzi (R-WY) has said that a "cap adjustment" may be necessary. The President's opposition notwithstanding, House and Senate appropriators are expected to proceed with levels above the President's strict spending limits, and an eventual caps deal is expected.

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The President's opposition to additional hurricane aid for Puerto Rico is also complicating efforts to pass a long-awaited disaster assistance bill in the Senate. The multibillion dollar package would provide funds for areas affected by hurricanes, flooding, and wildfires across the country. Republicans' $13 billion proposal failed to advance past a procedural vote last week, particularly after the President took to Twitter to claim that Puerto Rico's leaders are "grossly incompetent" and have spent aid money "foolishly or corruptly." Negotiations on the aid package continue, with both sides uncertain if the Senate will reach an agreement this week. House Democrats have stated that they will offer their own disaster package should the Senate legislation fail to move soon.

Medicaid Legislation

On March 25, the House voted to pass under suspension of the rules the Medicaid Services Investment and Accountability Act (H.R. 1839). The package, which includes extensions of several Medicaid programs, was approved by the Senate on April 2 and now awaits the President's signature.

Among other provisions, the bill:

- Provides $20 million in additional grant funds for the Money Follows the Person Program;
- Extends states' flexibility to disregard individuals' spousal income and assets when determining eligibility for home and community-based services and supports through September 30, 2019;
- Extends the Community Mental Health Services Demonstration Program through June 30, 2019, or two years, whichever is longer;
- Establishes civil monetary penalties for the misclassification of covered outpatient drugs under the Medicaid drug rebate program; and
- Creates a state option to establish health homes for children with medically complex conditions.

Drug Pricing and Health Care Costs

House committees are starting to move legislation to address prescription drug pricing issues, even as more sweeping proposals have been avoided. On April 4, the House Energy and Commerce Committee advanced six bills aimed at promoting generic and biosimilar competition. The bills passed with bipartisan support following the adoption of several amendments intended to address Republican concerns with the CREATES Act (H.R. 965) and the Protecting Consumer Access to Generic Drugs Act (H.R. 1499). The other bills reported to

the full House included: the Payment Commission Data Act (H.R. 1781); the Bringing Low-cost Options and Competition while Keeping Incentives for New Generics (BLOCKING) Act (H.R. 938); the Purple Book Continuity Act (H.R. 1520); and the Orange Book Transparency Act (H.R. 1503). Additionally, the Energy and Commerce Committee Oversight Subcommittee will hold its second hearing on rising insulin prices on April 10.

The House Ways and Means Committee Health Subcommittee plans to mark up a package of drug pricing transparency bills on April 9. The draft legislation, known as the Prescription Drug Sunshine, Transparency, Accountability and Reporting Act (STAR Act), contains several proposals related to price disclosures, rebate transparency, and inpatient hospital drug costs.

On the Senate side, five pharmacy benefit managers (PBMs) will testify before the Finance Committee on April 9. The five PBMs are Cigna Corporation, CVS Caremark and CVS Health Corporation, Humana Inc., OptumRx and Prime Therapeutics LLC. Finance Committee Chairman Chuck Grassley (R-IA) and Ranking Member Ron Wyden (D-OR) sent a letter to Cigna, CVS, and Optum on April 2, questioning whether PBMs "are appropriately leveraging their power for the benefit of taxpayers and patients, especially patients who take multiple or high-cost medications."

Meanwhile, Sen. Lamar Alexander (R-TN), chairman of the Health, Education, Labor and Pensions (HELP) Committee, said he expects the panel will vote this summer on broad legislation to lower health care costs, with the goal of combining it with legislation passed by the Finance Committee and sending a bill to the Senate floor by June or July. Sen. Alexander noted that he has received more than 400 recommendations from stakeholders on lowering health care costs. A final package, he stated, could include proposals related to prescription drug pricing, surprise medical bills, direct primary care, and rebates. Sens. Bill Cassidy (R-LA) and Maggie Hassan (D-NH) continue to work on bipartisan surprise billing legislation.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

CALOPTIMA LEGISLATIVE REPORT

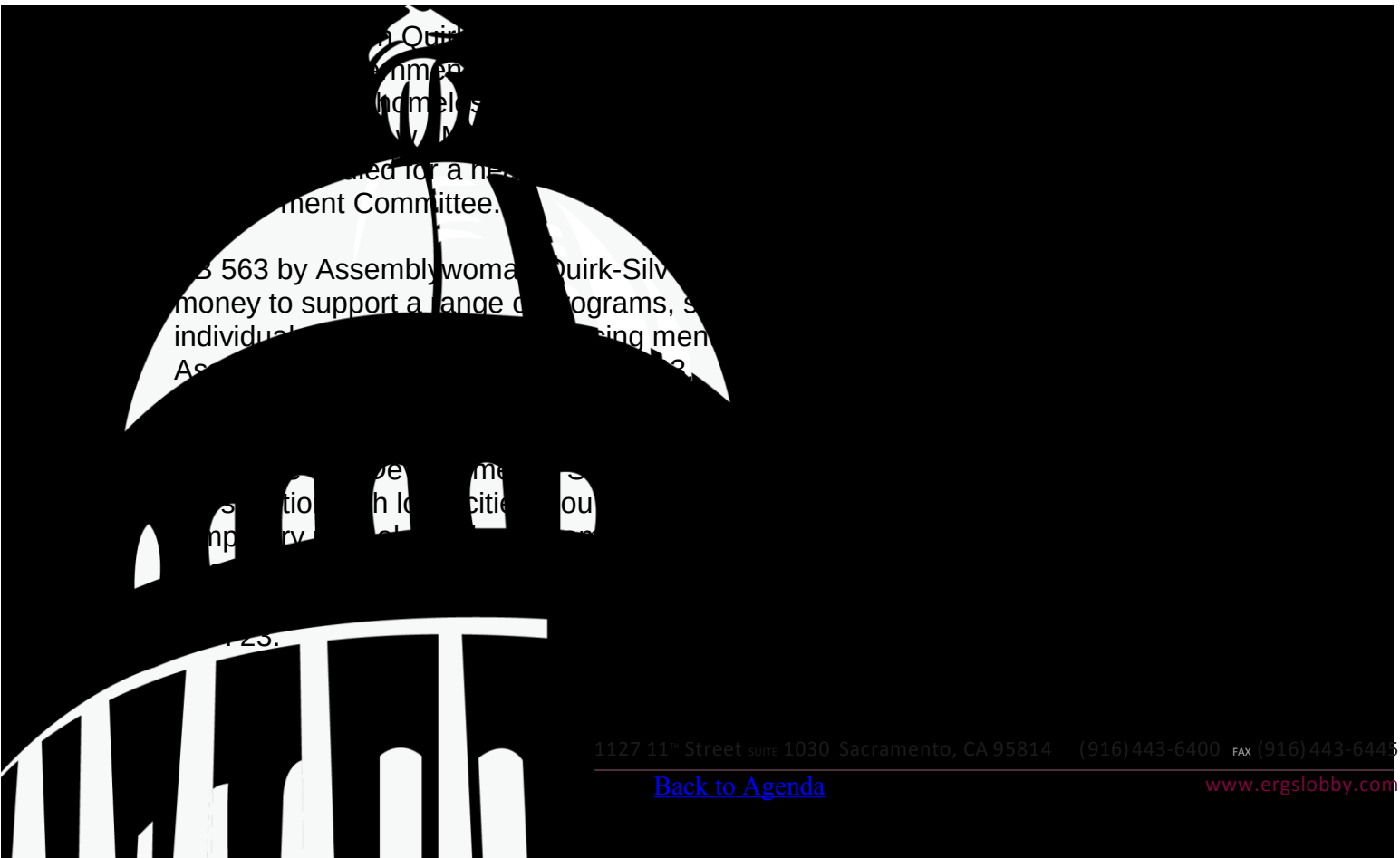
By Don Gilbert and Trent Smith

April 8, 2019

April is one of the busiest months of the year in the Legislature. Policy committees are meeting to hear many of the approximately 2,600 bills introduced this year. April 26 is the deadline for bills to pass out of policy committees. Bills that do not meet this deadline will have to wait until next year before they can be debated further.

We continue to support SB 714 by Senator Umberg, which was recently amended to add language intended to clarify how the Department of Managed Health Care (DMHC) defines "a risk-based payment" for purposes of requiring a Knox-Keene License. The Senate Rules Committee must still assign SB 714 to a policy committee before it can be debated and voted on.

We are very aware that addressing Orange County's homelessness crisis is very important to CalOptima. Therefore, we are closely monitoring several bills introduced by Assemblywoman Quirk-Silva intended to address the issue. The Assemblywoman introduced AB 139, which requires local governments to include in their General Plan reporting process, the number of emergency shelter beds currently available within the jurisdiction, and the number of shelter beds that the jurisdiction has contracted for that are located within another jurisdiction. AB 139 is scheduled for a hearing in the Assembly Housing and Community Development Committee on April 24.



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We will be closely following all of the Quirk-Silva bills to see if they are amended to directly impact CalOptima.

Also, we will continue to closely monitor SB 66 authored by Senator Atkins. This bill would authorize reimbursement for a maximum of two visits taking place at an FQHC or RHC on the same day at a single location, if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit. SB 66 passed the Senate Health Committee with an 8-0 vote on March 20. The bill now awaits a hearing in the Senate Appropriations Committee, where the bill's potential cost to the state will be considered.

SB 29 by Senator Durazo is another bill of great interest to CalOptima. This measure makes undocumented immigrants between the ages of 19-26 eligible for Medi-Cal benefits. SB 29 passed the Senate Health Committee on March 20 on a 7-1 vote. The bill now awaits a hearing in the Senate Appropriations Committee. Ultimately, we expect this policy will be adopted as part of the budget process, as Governor Newsom included it in his budget proposal.

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Board of Directors Meeting
May 2, 2019

CalOptima Community Outreach Summary — April 2019

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 several 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

CalOptima had the opportunity to attend the 6th Annual Nowruz Festival on Sunday, March 24, 2019, at the Colonel Bill Barber Marine Corps Memorial Park. Organized by the Iranian American Community Group, this was an educational event celebrating the Persian New Year that highlights the culture and traditions of the Persian community. The day was filled with live performances, cultural displays, children's activities, Persian food and a backgammon competition.

CalOptima staff had the opportunity to share information about CalOptima's programs and services with our members who speak Farsi, which is one of CalOptima's threshold languages. A special thank you to our volunteers who represented CalOptima at this event celebrating the Persian New Year. A special thank you to our Executive Director, Candice Gomez, and CalOptima staff Samira Zahedi, Dana Huerta, and Sayonara Dawoodtabar.

For additional information or questions, please contact Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

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Summary of Public Activities
During April 2019, CalOptima participated in 45 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
4/01/19	• Orange County Health Care Agency Mental Health Services Act Steering Committee
4/02/19	• Collaborative to Assist Motel Families Meeting
4/03/19	• Orange County Strategic Plan for Aging General Meeting • Orange County Healthy Aging Initiative Meeting • Anaheim Human Services Network Meeting
4/04/19	• Homeless Provider Forum
4/05/19	• Help Me Grow Advisory Meeting • Covered Orange County General Meeting
4/08/19	• Orange County Veterans and Military Families Collaborative Meeting • Fullerton Collaborative Meeting
4/09/19	• Orange County Strategic Plan for Aging — Social Engagement Committee Meeting
4/10/19	• Buena Park Collaborative Meeting • Anaheim Homeless Collaborative Meeting • Orange County Communications Workgroup
4/11/19	• Garden Grove Collaborative Meeting • Kid Healthy Community Advisory Committee Meeting • Orange County Women's Health Project Advisory Meeting
4/12/19	• Senior Citizens Advisory Council Board Meeting
4/16/19	• Orange County Children's Partnership Committee Meeting • Placentia Community Collaborative Meeting
4/17/19	• Covered Orange County Steering Committee Meeting • Minnie Street Family Resource Center Professional Roundtable • Orange County Promotoras Meeting • La Habra Move More, Eat Healthy Campaign Meeting
4/18/19	• Orange County Children's Partnership Committee Meeting • Surf City Senior Providers Network Meeting and Luncheon
4/22/19	• Community Health Research and Exchange

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4/23/19	• Orange County Senior Roundtable
4/24/19	• Disability Coalition of Orange County Meeting
4/25/19	• Orange County Care Coordination for Kids Meeting • Annual OC Leadership Forum on Aging hosted by Annual OC Leadership Forum on Aging (Sponsorship Fee: $1,000 included agency's name listed as supporter on event report, agency's logo placement on all marketing materials for event, agency recognition on event presentation slides, event program and during welcoming remarks and one resource table for outreach)

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff to Attend	Events/Meetings
4/05/19	2	• South Orange County Senior Day hosted by Office of Senator Patricia Bates and Assemblyman William P. Brough (Sponsorship Fee: $1,000 included a quarter page ad space in program and one resource table at the event for outreach)
4/06/19	2	• Third Annual Cambodia/Khmer New Year hosted by The Cambodian Family Community Center (Sponsorship Fee: $500 included an exhibitor table at the event and agency's logo on event flyers)
4/13/19	8	• Annual Dia del Nino Festival hosted by Arts Orange County (Sponsorship Fee: $1,000 included one resource table during the two-day event)
	4	• Spring Festival hosted by City of Westminster
4/14/19	3	• Peace of Mind: A Family Wellness Event hosted by Access California Services (Sponsorship Fee: $2,000 included agency's logo on all marketing materials for event, acknowledgment of sponsorship on the day of the event, and one resource table for outreach)
4/20/19	2	• Spring Family Eggstravaganza and Family Health Fair
	2	• Easter Egg Hunt and Resource Fair hosted by City of Stanton
4/25/19	2	• Cooking Up Change Greater Orange County hosted by Kid Healthy (Sponsorship Fee: $2,500 included agency recognition on event signage and in social media and video, complimentary event tickets for six, invitation to VIP Reception for two and one resource table at the event for outreach)
4/26/19	1	• Annual Celebration of Day of the Child hosted by 4GIRLS (Sponsorship Fee: $1,000 included one resource table for outreach)
4/27/19	1	• Clinic in the Park hosted by CSUF Center for Healthy Neighborhoods
	3	• Annual Community Resource Fair hosted by Families Forward

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2	• Annual Family Fun Day & Resource Fair hosted by TASK (Sponsorship Fee: $1,500 included agency's logo on event marketing materials, two event banners displayed at event, agency's name and logo included in two email newsletters sent to 7,000 households in Ventura, Los Angeles, Orange, Riverside, San Diego and Imperial counties, in two event-specific email blasts sent to 2,000 Orange and Los Angeles County households each, in six Facebook posts and six Tweets, in press release, public and verbal recognition at event, agency's logo on event host website for one year, and a vendor space location at the event)
2	• Annual Month of the Military Child Celebration hosted by Orange County Veterans and Military Families Collaborative (Sponsorship Fee: $1,000 included receipt of "Appreciation Award" at event, opportunity to provide giveaways or opportunity gifts, special sponsorship recognition during event and in all social media and press outreach, agency's logo placement and name mention in event program, placement of agency's information in participant packets, and one outreach table at the event)
1	• Independent City Timeline hosted by Orangewood Foundation

CalOptima organized or convened the following five community stakeholder events, meetings and presentations:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings/Presentations
4/10/19	• Community-based Organization Presentation for Santa Ana Unified School District Nurses — Topic: CalOptima: Medi-Cal in Orange County

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
4/03/19	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (English and Spanish)
4/10/19	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (English and Spanish)
4/17/19	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (English and Spanish)
4/24/19	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (English and Spanish)

CalOptima provided five (5) endorsements during this reporting period (e.g., letters of support, program/public activity events with support or use of name/logo).

1. Provide a Letter of Support for Korean Community Services' application for New Access Points Fund Application with Health Resources and Services Administration. Korean Community Services looks to expand services at current clinic in Buena Park and create new clinic in Irvine.

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2. Provide CalOptima's Logo to Orange County Health Care Agency to promote the Orange County Comprehensive Perinatal Services (CPSP) Provider Orientation Training.

3. Provide a Letter of Support for Serve the People Community Health Center's application for New Access Points Fund Application with Health Resources and Services Administration. Serve the People Community Health Center look to establish new access points of care for the homeless population in Santa Ana and mobilize their mobile clinic fleet at five homeless shelters and other service agencies.

4. Provide a Letter of Support for Families Together of Orange County's application for New Access Points Fund Application with Health Resources and Services Administration. Families Together of Orange County is seeking to get their facility in Tustin to be a Federally Qualified Health Center.

5. Provide CalOptima's OneCare Connect Logo to Harbage Consulting to update their program information flier.

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CalOptima Board of Directors
Community Activities

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 participation in public activities, which 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 partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors 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 several community meetings, including coalitions, 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.

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.

May

Date and Time	Event Title	Event Type/Audience	Staff/Financial Participation	Location
Wednesday, 5/1 3-5:30pm	*Health Education Workshop Healthy Weight, Healthy You	Open to the Public *Registration required.*	N/A	Boys and Girls Club of Garden Grove 10861 Acacia Pkwy Garden Grove

Thursday, 5/2 9-11am	++Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 5/2 9-10:30am	++Refugee Forum of OC	Steering Committee Meeting: Open to Collaborative Members	N/A	Access California Services 631 S. Brookhurst St. Anaheim
Saturday, 5/4 10am-1pm	City of Anaheim Annual Spring Healthy Living Fair	Health/Resource Fair Open to the Public	Registration fee $100 2 Staff	Downtown Anaheim Community Center 250 E. Center St. Anaheim
Monday, 5/6 1-4pm	++OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 5/7 9:30-11am	++Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Wednesday, 5/8 10-11am	++Buena Park Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Library 7150 La Palma Ave. Buena Park
Wednesday, 5/8 12-1:30pm	++Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Wednesday, 5/8 3-5:30pm	*Health Education Workshop Healthy Weight, Healthy You	Open to the Public *Registration required.*	N/A	Boys and Girls Club of Garden Grove 10861 Acacia Pkwy Garden Grove
Wednesday, 5/8 5-7pm	*Harbage Consulting and CalOptima Town Hall-OneCare Connect: What's Next?	Community Presentation Open to the Public	N./A	Alzheimer's Orange County 2515 McCabe Way Irvine

Thursday, 5/9 11:30am-12:30pm	++FOCUS Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Magnolia Park Family Resource Center 11402 Magnolia St. Garden Grove
Thursday, 5/9 12:30-1:30pm	++Kid Health Advisory Committee Mtg	Steering Committee Meeting: Open to Collaborative Members	N/A	OneOC 1901 E. Fourth St. Santa Ana
Thursday, 5/9 2:30-4:30pm	++OC Women's Health Project Advisory Board Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Thursday, 5/9 3:30-5:30pm	++State Council on Developmental Disabilities Regional Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	State Council on Developmental Disabilities 2000 E. Fourth St. Santa Ana
Friday, 5/10 9-10am	++OC Diabetes Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Health Care Agency 1725 W. 17th St. Santa Ana
Saturday, 5/11 9:30am-12:30pm	+Alzheimer's Family Center Healthy Brain Fair	Health/Resource Fair Open to the Public	Sponsorship $1,000 2 Staff	Alzheimer's Family Center 9451 Indianapolis Ave. Huntington Beach
Monday, 5/13 1-2:30pm	+OC Veterans and Military Families Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 5/13 2:30-3:30pm	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 5/14 9am-12pm	++City of Stanton Senior Resource Expo	Health/Resource Fair Open to the Public	1 Staff	Stanton Family Resource Center 11822 Santa Paula St. Stanton
Tuesday, 5/14 9-10:30am	++OC Strategic Plan for Aging	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine

	Social Engagement Committee			
Wednesday, 5/15 8am-5pm	+Mental Health Assoc. of OC Meeting of the Minds	Conference Open to the Public *Registration Required*	Sponsorship $1,000 5 Staff	Anaheim Marriott Hotel 700 Convention Way Anaheim
Wednesday, 5/15 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Minnie Street Family Resource Center 1300 McFadden Ave. Santa Ana
Wednesday, 5/15 1-4pm	++Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies
Wednesday, 5/15 1:30-3pm	++La Habra Move More, Eat Health Campaign	Steering Committee Meeting: Open to Collaborative Members	N/A	Friends of Family Community Clinic 501 S. Idaho St. La Habra
Thursday, 5/16 8:30-10am	++OC Children's Partnership Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana
Friday, 5/17 8am-12pm	++Age Well Senior Services Annual South County Senior Summit	Community Presentation Health/Resource Fair Open to the Public	$10,0000 Sponsorship 3 Staff	Soka University 1 University Dr. Aliso Viejo
Tuesday, 5/21 8:30-10am	++North OC Senior Collaborative All Members Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	St. Jude Community Services 130 W. Bastanchury Rd. Fullerton
Tuesday, 5/21 10-11:30am	++Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Trinity Center Placentia Presbyterian Church 849 Bradford Ave. Placentia
Tuesday, 5/21 10-11:30am	++OC Cancer Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	OC Cancer Society 1940 E. Deere Ave. Santa Ana

+ *Exhibitor/Attendee*
++ *Meeting Attendee*

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Thursday, 5/23 1-3pm	++Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Red Hill Ave. Santa Ana
Tuesday, 5/28 7:30-9am	++OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Tuesday, 5/28 2-4pm	++Susan G. Komen OC Unidos Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Susan G. Komen 2817 McGraw Ave. Irvine