

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

**THURSDAY, SEPTEMBER 6, 2018
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 Lisa Bartlett, Alternate	

CHIEF EXECUTIVE OFFICER
Michael Schrader

CHIEF COUNSEL
Gary Crockett

CLERK OF THE BOARD
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. National Committee for Quality Assurance Accreditation
 - b. Medi-Cal Audit
 - c. Whole-Child Model Family Advisory Committee
 - d. Medi-Cal Provider Enrollment
 - e. Annual Network Certification
 - f. PACE Anniversary Event
 - g. Key Meetings

PUBLIC COMMENTS

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

CONSENT CALENDAR

2. [Minutes](#)
 - a. Approve Minutes of the August 2, 2018 Regular Meeting of the CalOptima Board of Directors
 - b. Receive and File Minutes of the June 28, 2018 Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee, and the June 14, 2018 Meeting of the CalOptima Board of Directors' Provider Advisory Committee
3. [Consider Revisions to the Fiscal Year \(FY\) 2018-19 Board of Directors' Quality Assurance Committee and Board of Directors' Finance and Audit Committee Meeting Schedule](#)
4. [Acting as the CalOptima Foundation: Consider Appointments to the CalOptima Foundation Audit Committee](#)

REPORTS

5. [Consider Changes to the Member Auto-Assignment Limits for the CalOptima Community Network](#)
6. [Consider Authorizing Amendment to Medi-Cal Contract with Kaiser Foundation Health Plan, Inc., to Extend Member Enrollment Terms](#)
7. [Consider Ratification of Overpayments to Health Networks Related to the Medi-Cal Component of the OneCare Connect Rates](#)
8. [Consider Adoption of Resolution Approving and Adopting Updated Human Resources Policies](#)
9. [Consider Authorizing Employee and Retiree Group Health Insurance for Calendar Year 2019](#)

10. Consider Ratification of Amendment to Contract with the California Department of Health Care Services for the California Technical Assistance Program (CTAP) Grant and CTAP Policy; Consider Retirement of CalOptima Regional Extension Center Policies
11. Consider Modifications and Development of CalOptima Policies and Procedures Related to Whole-Child Model, Medicaid and CHIP Managed Care Final Rule, and Annual Policy Review
12. Consider Approval of Proposed Updated Behavioral Health Policy and Form to Support the Administration of Behavioral Health Treatment Services for Medi-Cal Members
13. Consider Authorization of Expenditure Plan for Intergovernmental Transfer (IGT) 6 and 7 Funds, Including the Release of Requests for Proposals for Community Grants to Address Children's Mental Health, Opioid and Other Substance Overuse, and Other Community Needs Identified by the CalOptima Member Health Needs Assessment
14. Consider Ratification of the Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9)
15. Consider Approval of Process for Considering 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
16. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Events
17. Consider Ratification of Contract for Legal Services
18. Consider Chief Executive Officer and Chief Counsel Performance Reviews and Compensation *(to follow Closed Session)*

ADVISORY COMMITTEE UPDATES

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

INFORMATION ITEMS

21. CalOptima Delivery System Overview
22. July 2018 Financial Summary
23. Compliance Report
24. Federal and State Legislative Advocates Report
25. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

- CS 1 Pursuant to Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer)
- CS 2 Pursuant to Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS
Agency Designated Representatives: (Paul Yost, M.D. and Lee Penrose)
Unrepresented Employee: (Chief Executive Officer)
- CS 3 Pursuant to Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Counsel)
- CS 4 Pursuant to Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS
Agency Designated Representatives: (Paul Yost, M.D. and Lee Penrose)
Unrepresented Employee: (Chief Counsel)

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, October 4, 2018 at 2:00 p.m.

MEMORANDUM

DATE: September 6, 2018
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

CalOptima Earns Accreditation at the Commendable Level

I am proud to announce great news about CalOptima's ongoing commitment to quality. As a result of our National Committee for Quality Assurance (NCQA) reaccreditation audit in July, CalOptima was awarded NCQA accreditation at the commendable level. According to the NCQA, commendable status is afforded to organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement. This outstanding agencywide achievement will be in effect for three years. I sincerely appreciate your Board's support for all the programs and policies that enable CalOptima to maintain our dedication to quality care.

Medi-Cal Audit Results Reflect Commitment to Compliance

CalOptima completed a successful annual Department of Health Care Services (DHCS) Medi-Cal audit, with the regulator's August 27 draft report showing just one finding. The audit evaluated CalOptima's compliance with our contract and regulations in several areas: utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, internal organization and administration, facility site reviews, and medical records review. The single finding was in case management and care coordination for behavioral health, and the finding is in the process of being corrected with new policies your Board will consider this month. The audit covered the period February 1, 2017, through January 31, 2018.

Whole-Child Model Family Advisory Committee (WCM FAC) Holds Inaugural Meeting

On August 9, CalOptima officially launched the WCM FAC, our newest advisory committee, which will be instrumental in helping us prepare for the upcoming transition of California Children's Services. Seven committee members attended, and the meeting included an update on our implementation efforts as well as an open discussion of topics for future meetings. Also, Pam Patterson was chosen by the group to serve as interim chair until the next meeting in October, when a chair and vice chair will be elected.

CalOptima Engages Providers to Ensure Their Enrollment in Medi-Cal

Driven by the federal Mega Reg and a state All Plan Letter, all Medi-Cal providers and provider groups must be officially enrolled in the Medi-Cal program by January 1, 2019. Among the goals is reducing fraud, waste and abuse by having more strict enrollment records. CalOptima has been outreaching to non-enrolled providers and groups in letters, calls and office visits, and many

have worked to get enrolled. However, at this time, approximately 100 of our 1,600 primary care providers have yet to complete the process, and these providers care for approximately 40,000 members. Because regulatory requirements require contracts with non-enrolled providers to be terminated as of January 1, it is possible that some members may need to be reassigned in 2019.

Annual Network Certification Confirms the Strength of CalOptima's Provider Network

Passed in October 2017 to implement a major provision of the federal Mega Reg, Assembly Bill 205 now requires DHCS to publish the outcome of Medi-Cal managed care plans' annual network certification, including noncompliance with time and distance standards. Upon DHCS review, CalOptima's robust provider network met all the requirements. This achievement is not universal among health plans, and a [report](#) released by the state in July detailed the corrective actions needed at nine commercial and public Medi-Cal managed care plans. Time and distance standards are important for quality care, reflecting how long members must wait for available appointments and how far they must travel to see their doctors.

Program of All-Inclusive Care for the Elderly (PACE) to Host Anniversary Event

CalOptima is strengthening our relationship with PACE participants in a special event celebrating our program's fifth anniversary. On Saturday, September 29, PACE staff will join with participants and their families to enjoy activities and entertainment.

KEY MEETINGS

- **America's Health Insurance Plans (AHIP) CEO Visits CalOptima**
As a new AHIP member, CalOptima welcomed CEO Matt Eyles in late August for an introductory visit. AHIP is the largest organization representing health insurers, and it is making a concerted effort to expand services for Medicaid plans. Matt and I discussed AHIP resources and advocacy efforts as well as the prospect of federal Medicaid reforms.
- **Community Health Center Visits Highlight Orange County Safety Net**
To honor our partnerships with community health centers, I participated in National Health Center Week in August. Along with Isabel Becerra, CEO of the Coalition of Orange County Community Health Centers, I toured Camino Health Center in Lake Forest and Serve the People in Santa Ana, two of our valued Federally Qualified Health Centers. These safety net facilities are responsible for delivering quality services to thousands of CalOptima members.
- **CalOptima Joins Hispanic Chamber of Commerce**
CalOptima recently became a member of the Hispanic Chamber of Commerce, and on August 3, I spoke briefly at a meeting with chamber members held at our offices. I highlighted our shared mission of enhancing the lives of Orange County's Hispanic population. The chamber represents 30,000 Hispanic-owned businesses, and CalOptima serves more than 358,000 members who identify as Hispanic.
- **Orange County Group Seeks Better Behavioral Health System**
On August 10, I attended the Be Well Summit at Saddleback Church in San Juan Capistrano. The meeting gathered approximately 70 local public and private-sector leaders to consider improvements to Orange County's system for behavioral health.

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

August 2, 2018

A Regular Meeting of the CalOptima Board of Directors was held on August 2, 2018, 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; Ron DiLuigi, Supervisor Andrew Do, Alexander Nguyen, M.D., Richard Sanchez ([at 2:04 p.m.] non-voting), Scott Schoeffel, Supervisor Michelle Steel

Members Absent: Ria Berger, Lee Penrose

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

Chair Yost announced the following changes to the agenda: Agenda Item 17, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds, and Agenda Item 23, Whole Child Model Update, will be presented after the Consent Calendar is considered; and Agenda Item 19, Consider Chief Executive Officer Performance Review and Compensation, to follow closed session.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader provided an overview of the meeting agenda and reported that surveyors from the National Committee for Quality Assurance (NCQA) were on site in early July to conduct their tri-annual audit of CalOptima related to the extension of our NCQA accreditation for another three years. The audit is important to our overall level of accreditation that includes Healthcare Effectiveness Data and Information Set (HEDIS) quality of care scores and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) satisfaction scores.

PUBLIC COMMENT

Mallory Vega, Vice President, Direct Care Services, Alzheimer's OC – Oral re: Update on the successful launch of Acacia Adult Day Services and South County Adult Day Services as CalOptima Program of All-Inclusive Care for the Elderly (PACE) Alternative Care Setting (ACS) sites in April and July 2018 respectively.

[Back to Agenda](#)

CONSENT CALENDAR

2. Minutes

- a. Approve Minutes of the June 7, 2018 Regular Meeting of the CalOptima Board of Directors
- b. Receive and File Minutes of the April 26, 2018 Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee, the May 10, 2018 Meeting of the CalOptima Board of Directors' Member Advisory Committee, and the May 10, 2018 Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Supervisor Do, seconded and carried, the Board approved the Consent Calendar as presented. (Motion carried 7-0-0; Directors Berger and Penrose absent)***

The agenda was reordered to hear Report Item 17, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds.

17. Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

Vice Chair Khatibi did not participate in this item due to his service on the Illumination Foundation Board and left the room during the discussion and vote. Due to his role with the Orange County Health Care Agency, Director Sanchez did not participate in this item and left the room during the discussion and vote. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors: 1) Approved an additional grant allocation of up to \$10 million to the Orange County Health Care Agency (OCHCA) from the Department of Health Care Services-approved and Board-approved Intergovernmental Transfer 6 and 7 Homeless Health priority area; 2) Replaced the current cap of \$150 on the daily rate and the 15-day stay maximum paid out of CalOptima funds with a 50/50 cost split arrangement with the County for stays of up to 90 days for homeless CalOptima members referred for medically justified recuperative care services under OCHCA's Whole Person Care Pilot program; and 3) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the grant agreement with the County of Orange to include indemnity language and allow for use of the above allocated funds for recuperative care services under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members. (Motion carried 5-0-0; Vice Chair Khatibi, and Directors Berger, Penrose, and Schoeffel absent)***

The agenda was reordered to hear Agenda Item 23, Whole-Child Model Update.

23. Whole-Child Model Update

Richard Helmer, M.D., Chief Medical Officer, provided an overview of the Whole-Child Model (WCM) program implemented by the Department of Health Care Services to integrate California Children's Services (CCS) into select Medi-Cal plans. It was reported that approximately 13,000

Orange County children are receiving CCS services; 90% are CalOptima members. CalOptima will implement the WCM program effective January 1, 2019. Candice Gomez, Executive Director, Program Implementation, presented a review of internal implementation efforts, network development, and stakeholder engagement related to the WCM implementation.

REPORTS

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

Action: On motion of Director Nguyen, seconded and carried, the Board of Directors approved the provider payment methodology for the CalOptima Medi-Cal Whole-Child Model program as presented. (Motion carried 6-0-0; Vice Chair Khatibi, and Directors Berger and Penrose absent)

4. Consider Authorizing Updates to Medi-Cal Provider Payment Rate Methodology

Action: On motion of Supervisor Do, seconded and carried, the Board of Directors approved rebasing of capitated health network payment methodology for Medi-Cal Classic members effective January 1, 2019. (Motion carried 6-0-0; Vice Chair Khatibi, and Directors Berger and Penrose absent)

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

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

Action: On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to: 1) Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action; 2) Modify capitation rates effective January 1, 2019, to include rates associated with the Whole-Child Model program to the extent authorized by the Board of Directors in a separate Board action; 3) Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model; and 4) Extend contracts through June 30, 2019. (Motion carried 5-0-0; Vice Chair Khatibi, and Directors Berger, Penrose, and Schoeffel absent)

6. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for CHOC Physicians Network and Children's Hospital of Orange County

Chair Yost did not participate in this item due to his affiliation with CHOC as a physician anesthesiologist, and he passed the gavel to Vice Chair Khatibi and left the room during the discussion

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

Action: *On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts for CHOC Physicians Network and Children’s Hospital of Orange County to: 1) Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action; 2) Modify capitation rates effective January 1, 2019, to include rates associated with the Whole-Child Model program to the extent authorized by the Board of Directors in a separate Board action; 3) Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model; and 4) Extend contracts through June 30, 2019. (Motion carried 5-0-0; Chair Yost, and Directors Berger, Penrose, and Schoeffel absent)*

7. Consider Actions Related to Orange County Advantage Medical Group and Fountain Valley Regional Hospital and Medical Center, Including Ratification of Health Network Contract Amendments

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

Action: *On motion of Supervisor Do, seconded and carried, the Board of Directors ratified the Medi-Cal contract amendments for the Physician Hospital Consortium (PHC) health network contracts for Orange County Advantage Medical Group (OCAMG) and Fountain Valley Regional Hospital and Medical Center, which: 1) Extend the contracts through December 31, 2018; 2) Extend the current capitation rates for assigned members effective July 1, 2018 through December 31, 2018; 3) Reflect changes in Child Health and Disability Prevention (CHDP) Program responsibilities and rates to the extent authorized by the Board of Directors in a separate Board action; 4) Reflect the responsibility of OCAMG to pay individual providers Proposition 56 appropriated funds and to compensate OCAMG an administrative fee for performance of these responsibilities to the extent authorized by the Board in a separate action; and 5) Amend the contract terms to reflect applicable regulatory changes and other requirements. (Motion carried 6-0-0; Directors Berger, Penrose, and Schoeffel absent)*

8. Consider Authorizing Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contract with Kaiser Permanente

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

Action: *On motion of Supervisor Do, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contract amendments of the CalOptima Medi-Cal Full-Risk*

Health Network Contract with Kaiser Permanente to: 1) Modify capitation rates effective January 1, 2019, to include rates associated with the Whole-Child Model program to the extent authorized by the Board of Directors in a separate Board action; and 2) Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model. (Motion carried 6-0-0; Directors Berger, Penrose, and Schoeffel absent)

9. Consider Authorizing Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contracts with Heritage Provider Network, Inc., Monarch Family Healthcare and Prospect Medical Group
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contract amendments of the CalOptima Medi-Cal Full-Risk Health Network Contract with Heritage Provider Network, Inc., Monarch Family Healthcare, and Prospect Medical Group to: 1) Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action; 2) Modify capitation rates effective January 1, 2019, to include rates associated with the Whole-Child Model program to the extent authorized by the Board of Directors in a separate Board action; 3) Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model; and 4) Extend contracts through June 30, 2019. (Motion carried 6-0-0; Directors Berger, Penrose, and Schoeffel absent)

10. Consider Authorizing Amendments to the CalOptima Medi-Cal Shared Risk Health Network Physician Contracts for AltaMed Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Group
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: On motion of Director Nguyen, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contract amendments of the CalOptima Medi-Cal Shared Risk Health Network Physician Contracts for AltaMed Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Group to: 1) Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action; 2) Modify capitation rates effective January 1, 2019, to include rates associated with the Whole-Child Model program to the extent authorized by the Board of Directors in a separate Board action; 3) Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model; and 4) Extend contracts through June 30, 2019. (Motion carried 6-0-0; Directors Berger, Penrose, and Schoeffel absent)

11. Consider Authorizing Contract with a Non-Medical Transportation Vendor Effective January 1, 2019

Action: *On motion of Supervisor Do, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into an 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-year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion. (Motion carried 7-0-0; Directors Berger and Penrose absent)*

12. Consider Adoption of Resolution Approving Updated Human Resources Policy; Authorize Purchase of Additional Timekeeping Equipment; and Authorize Contract with a Vendor to Support Chief Medical Officer Recruitment Efforts and Related Budget Allocation Changes

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

Action: *On motion of Supervisor Do, seconded and carried, the Board of Directors: 1) Adopted Resolution 18-0802-01, approving an update to Human Resources Policy GA.8022: Performance and Behavior Standards; 2) Authorized the purchase of additional Touch Clock timekeeping computers; 3) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to select and contract with a vendor for Chief Medical Officer (CMO) recruitment services consistent with CalOptima's Board-approved Purchasing Policy; and 4) Authorized reallocation of budgeted but unspent funds of up to \$150,000 from Salaries, Wages and Benefits to Purchased Services to fund the CMO recruitment contract. (Motion carried 6-0-0; Directors Berger, Penrose, and Schoeffel absent)*

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

Action: *On motion of Director DiLuigi, seconded and carried, the Board of Directors appointed Jacqueline Ruddy to serve as the Consumer Representative on the Member Advisory Committee for the term ending June 30, 2020. (Motion carried 7-0-0; Directors Berger and Penrose absent)*

14. Consider Recommended Appointments to the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee as Community Representatives

Sesha Mudunuri, Executive Director, Operations, presented the recommended action to appoint individuals as Community Representatives to the Whole-Child Model Family Advisory Committee for one or two-year terms as indicated or until a successor is appointed, beginning in Fiscal Year 2018-19. Mr. Mudunuri clarified that the Member Advisory Committee's recommendation included four candidates: Diane Key for a two-year term ending June 30, 2020; Sandra Cortez-Schultz for a one-year term ending June 30, 2019; Pamela Austin for a one-year term ending June 30, 2019; and Michael Arnot for a two-year term ending June 30, 2020.

Supervisor Do commented that the Board has emphasized the importance of having the Whole-Child Model Family Advisory Committee membership (i.e., seven to nine family members and two to four community-based organization representatives) serve as the voice of the families of children in the California Children's Services (CCS) program, and the Board prioritized the inclusion of as many family members as possible before considering representatives of community-based organizations. Supervisor Do recommended revising the recommended action to appoint two of the recommended community-based organization representatives: Diane Key, Director of Women's and Children's Services at UCI Medical Center; and Sandra Cortez-Schultz, Customer Service Manager at CHOC Children's Hospital. Supervisor Do further commented that the Whole-Child Model Family Advisory Committee (WCM-FAC) should recruit additional Family Representatives for Board consideration. Chair Yost added that the WCM-FAC should be a family-driven committee, and strongly suggested that a Family Representative serve as its Chair.

Action: *On motion of Supervisor Do, seconded and carried, the Board of Directors appointed the following individuals to the Whole-Child Model Family Advisory Committee (WCM-FAC) as Community Representatives for one or two-year terms as indicated or until a successor is appointed, beginning in Fiscal Year 2018-19: Diane Key for a two-year term ending June 30, 2019, and Sandra Cortez-Schultz for a one-year term ending June 30, 2019. The Board also recommended that a Family Representative serve as the Chair of the WCM-FAC. (Motion carried 7-0-0; Directors Berger and Penrose absent)*

15. Consider Adoption of Resolution Approving New and Revised Office of Compliance Policies and Procedures

Action: *On motion of Director Schoeffel, seconded and carried, the Board of Directors adopted Resolution No. 18-0802-02, approving new and revised Office of Compliance policies and procedures as presented. (Motion carried 7-0-0; Directors Berger and Penrose absent)*

16. Consider Authorizing Capital Improvements Related to the Build Out of the Tenth Floor at 505 City Parkway West, Orange, California, Authorizing Procurement of Professional Services and Public Works Contracts to Implement These Capital Improvements, and the Awarding of Related Contracts

Action: *On motion of Director DiLuigi, seconded and carried, the Board of Directors: 1) Authorized capital improvements related to the build out of the tenth floor at 505 City Parkway West, Orange, California (the 505 Building); 2) Authorized staff to procure related professional services and public works contracts consistent with the Board-approved Purchasing Policy to implement these capital improvements; and 3) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to contract with selected vendors to implement capital improvements in an amount not to exceed the Board-approved 505 Building Capital Budget for Fiscal Year (FY) 2018-2019. (Motion carried 7-0-0; Directors Berger and Penrose absent)*

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

Action: *On motion of Director DiLuigi, seconded and carried, the Board of Directors: 1) Authorized the expenditure of up to \$2,500 and CalOptima staff participation at the 9th Annual Alzheimer's Orange County Latino Conference on Saturday, November 3, 2018, at Templo Calvario Church in Santa Ana; 2) Made a finding that such expenditure is for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3) Authorized the Chief Executive Officer to execute agreements as necessary for the event and expenditure. (Motion carried 7-0-0; Directors Berger and Penrose absent)*

19. Consider Chief Executive Officer Performance Review and Compensation

This item followed closed session; no action taken.

ADVISORY COMMITTEE UPDATES

20. Member Advisory Committee (MAC) Update

Sally Molnar, MAC Chair, thanked the Board for approving the recommended appointment of Jacqueline Ruddy as the MAC Consumer Representative.

21. Provider Advisory Committee (PAC) Update

PAC Vice Chair Teri Miranti provided an overview of the topics discussed at their June 14, 2018 meeting, including the Request for Proposal process for Intergovernmental Transfer (IGT) 6 and 7 funding, proposed Senate Bill 1152 regarding the hospital patient discharge process for homeless members, and the implementation of the Whole-Child Model program.

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

Patty Mouton, OCC MAC Vice Chair, reported on the activities at their June 28, 2018 meeting, including updates on the Palliative Care program, an Access to Care overview, and the grievance and appeals process.

INFORMATION ITEMS

The following Information Items were accepted as presented:

24. June 2018 and May 2018 Financial Summaries
25. Compliance Report
26. Federal and State Legislative Advocates Reports
27. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Vice Chair Khatibi directed staff to present a recommendation at the September 6, 2018 Board meeting to consider completely lifting the cap on auto assignments to the CalOptima Community Network, including an analysis of staffing and budget proposals related to the potential adjustment. Supervisor Do also requested that staff provide an update on CalOptima's current delivery system in terms of health networks and contracted providers.

Chair Yost reported that the Legal Structure/HR Ad Hoc has been dissolved, and he asked for volunteers to serve on an ad hoc to review Request for Information responses and making recommendations to the Board of Directors related to the expenditure of Intergovernmental Transfer (IGT) 5 funds.

ADJOURN TO CLOSED SESSION

Chair Yost adjourned the meeting in memory of Kenneth Bell, M.D., an Orange County physician, health care advocate, and former CalOptima Chief Medical Officer. Dr. Bell was a passionate member advocate, teacher, and community leader who was nationally recognized for his work in promoting women's health issues. It was noted that Dr. Bell was instrumental in securing funding through Kaiser Permanente that enabled the development of CalOptima as a solution to Orange County's Medi-Cal crisis at the time. On behalf of the Board, Chair Yost extended condolences to Dr. Bell's family.

The Board of Directors adjourned to closed session at 4:02 p.m. pursuant to: 1) Government Code Section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. Two Cases: Orange Coast Memorial Medical Center v. CalOptima. Orange County Superior Court (OCSC) Case No. 30-2017-00926361-CU-BC-CJC; and Long Beach Memorial Medical Center, et al. v. CalOptima. OCSC Case No. 30-2018-00966383-CU-BC-CJC; 2) Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer); 3) Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS: Agency Designated Representatives: (Paul Yost, M.D. and Lee Penrose), Unrepresented Employee: (Chief Executive Officer).

The Board reconvened to open session at 5:25 p.m. with no reportable actions taken.

ADJOURNMENT

Hearing no further business, the meeting was adjourned at 5:25 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: September 6, 2018

MINUTES

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

June 28, 2018

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC) was held on June 28, 2018 at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Acting Chair Christine Chow called the meeting to order at 3:07 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Christine Chow, Acting Chair; Ted Chigaros, Josefina Diaz, Sandy Finestone, Sara Lee, Adam Crits (non-voting), Kristin Trom

Members Absent: Gio Corzo, Chair; Patty Mouton, Vice Chair; John Dupies, Erin Ulibarri (non-voting), Jyothi Atluri (non-voting), Richard Santana

Others Present: Ladan Khamseh, Chief Medical Officer; Richard Bock, M.D., Chief Medical Officer; Phil Tsunoda, Executive Director, Public Affairs; Candice Gomez, Executive Director, Program Implementation; Sessa Mudunuri, Executive Director, Operations; Tracy Hitzeman, Executive Director, Clinical Operations; Dr. Emily Fonda, Medical Director, Medical Management; Albert Cardenas, Director, Customer Service (Medicare); Becki Melli, Customer Service; Eva Garcia, Customer Service

MINUTES

Approve the Minutes of the April 26, 2018 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

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

PUBLIC COMMENT

There were no requests for public comment.

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Medical Officer (CMO) Update

Richard Bock, M.D., Chief Medical Officer introduced Betsy Ha as the new Executive Director in the Quality Analytics Department. Dr. Bock reported that CalOptima received a 100% score on the recent data validation audit conducted by the Centers for Medicare & Medicaid Services (CMS), and noted

[Back to Agenda](#)

that the National Committee for Quality Assurance (NCQA) surveyors will be on site in July to review CalOptima's quality standards.

Federal and State Legislative Update

Philip Tsunoda, Executive Director, Public Affairs provided a Federal and State Legislative update. At their June 7, 2018 meeting, the Board authorized the release of Requests for Information (RFI) for Intergovernmental Transfer Funds (IGT) 5 categories identified in the recent CalOptima Member Health Needs Assessment, and the RFIs are due by July 9, 2018.

INFORMATION ITEMS

OCC MAC Member Updates

Acting chair Christine Chow reported that, on June 7, 2018, the Board of Directors reappointed the following individuals to the OCC MAC for FY 2018-19: Ted Chigaros, Long-Term Care Facility Representative; Gio Corzo, Community-Based Adult Services Representative; Patty Mouton, Seniors Representative; and Christine Chow, Member Advocate. The Board also approved the appointment of Keiko Gamez as the OneCare Connect Member/Family Member Representative, whose term will begin on July 1, 2018. Gio Corzo and Patty Mouton were reappointed to serve as Chair and Vice Chair, respectively, for FY 2018-19. It was reported that Orange County In Home Support Services (IHSS) Public Authority Representative Amber Nowak has resigned. Staff anticipates that IHSS will designate a representative to serve on the OCC MAC in the coming months.

In response to Acting Chair Chow's request for topics for the August 23, 2018 OCC MAC meeting agenda, Member Chigaros requested adding an item regarding transportation for dialysis members, and IHSS Union Provider Representative Santana will provide a presentation, and OCC MAC Member/Family Member Trom will provide a presentation at the October 25, 2018 meeting.

OCC MAC Member Presentation on Ombudsman Update

Sara Lee, Members from Ethnic or Cultural Community Representative, presented an Ombudsman update. Ms. Lee reported on inquiries received by the Office of the Ombudsman pertaining to Denti-Cal benefits. Discussion ensued regarding OCC member eligibility as it relates to Medi-Cal benefits and share of cost. Staff provided an overview of eligibility and enrollment including communication with affected members regarding the process.

Palliative Care Presentation Update

Tracy Hitzeman, Executive Director, Clinical Operations, reported that the Department of Health Care Services (DHCS) released an All-Plan letter to health plans in November 2017, which became effective January 1, 2019. DHCS identified eligibility criteria for this initiative that focused on four general categories: cancer, chronic obstructive pulmonary disease, congestive heart failure, and liver disease, as well as sub-criteria to meet eligibility. CalOptima's health networks are responsible for all palliative care services for their assigned members, and the DHCS provides guidance regarding reporting requirements used to evaluate the effectiveness of program implementation.

OCC MAC Member Presentation on Access to Care

Marsha Choo, Manager, Quality Analytics, provided an overview on Access to Care with the goal to: ensure the provision of medically necessary services in a timely manner; monitor accessibility and availability of appropriate clinical care and network providers; identify opportunities for improvement and improve overall access to care; and to meet all access regulatory requirements, regulations and reporting requirements to DHCS and CMS.

OCC MAC Member Presentation on Grievance and Appeals Process

Ana Aranda, Grievance and Appeals Director, presented an overview on the Grievance and Appeals process, including member submittal of a grievance, and the review process for member grievances received. Multiple departments work together to address access to care issues, and providers are educated to provide awareness and encourage action. Grievance tracking and trending reports are in place to address areas of improvement and information is shared with internal and external stakeholders for further action.

ADJOURNMENT

Acting Chair, Christine Chow announced that the next OCC MAC Meeting will be held on Thursday, August 23, 2018.

Hearing no further business, the meeting adjourned at 4:19 p.m.

/s/ Eva Garcia
Eva Garcia
Program Assistant

Approved: August 23, 2018

MINUTES

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

June 14, 2018

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, June 14, 2018, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Teri Miranti, PAC Chair, called the meeting to order at 8:06 a.m., and Member Batra led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Teri Miranti, Chair; Suzanne Richards, MBA, FACHE, Vice Chair; Anjan Batra, M.D.; Donald Bruhns; Steve Flood; Jena Jensen; Craig G. Myers; Pamela Pimentel, R.N.; Jacob Sweidan, M.D.

Members Absent: Theodore Caliendo, M.D.; Pamela Kahn, R.N.; John Nishimoto, O.D.; George Orras, Ph.D., FAAP; Mary Pham, Pharm.D., CHC

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Gary Crockett, Chief Counsel; Richard Bock, M.D., Deputy Chief Medical Officer; Candice Gomez, Executive Director, Program Implementation; Tracy Hitzeman, Executive Director, Clinical Operations; Michelle Laughlin, Executive Director, Network Operations; Phil Tsunoda, Executive Director, Public Policy and Public Affairs; Cheryl Simmons, Staff to the PAC

MINUTES

Approve the Minutes of the May 10, 2018 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: On motion of Vice Chair Richards, seconded and carried, the Committee approved the minutes of the May 10, 2018 meeting. (Motion carried 9-0-0; Members Caliendo, Kahn, Nishimoto, Orras and Pham absent)

PUBLIC COMMENTS

No requests for public comment were received.

CEO AND MANAGEMENT REPORTS

Federal and State Legislative Update

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, provided a brief update on the local political candidates who have advanced to the November general election. Mr. Tsunoda updated the PAC on the Request for Proposal (RFP) for Intergovernmental Transfer Funds (IGT) 6 and 7. After discussion among the PAC, he agreed to provide additional information to the PAC at their August meeting. PAC members also discussed California Senate Bill (SB) 1152 Hospital Patient Discharge Process: Homeless Patients and asked Mr. Tsunoda to present on this topic at a future PAC meeting.

Chief Medical Officer Update

Richard Bock M.D, Deputy Chief Medical Officer, provided updates on the HEDIS 2018 submission, NCQA and Stars preliminary reports. Dr. Bock shared that preliminary results suggested that the data trending is similar to what was seen in the prior year. It is anticipated that the threshold for scoring will be announced in a couple of months. It was also noted that CalOptima will have its tri-annual NCQA on-site accreditation audit in July.

INFORMATION ITEMS

Direct Payments to Hospitals

Greg Hamblin, Chief Financial Officer, provided the PAC with a presentation on Directed Payments to Hospitals. He noted that CalOptima planned to use the Proposition 56 (Tobacco Tax) funds received to supplement and assist hospitals in four different ways. Mr. Hamblin explained that the four programs included: Proposition 56's Physician Supplemental Payments, Public Hospital Enhanced Payment Program (EPP), Public Hospital Quality Incentive Pool (QIP) and Provide Hospital Directed Payment (PHDP) topics. Mr. Hamblin committed to continuing to update the PAC as more information becomes available.

Whole-Child Model Update

Candice Gomez, Executive Director, Program Implementation, discussed the Whole-Child Model (WCM) and noted that CalOptima had received the All Plan Letter (APL) that was released on June 7, 2018. She also reviewed the division of WCM responsibilities, including the demographics of children in Orange County who are currently receiving California Children Services (CCS) and confirmed that 90% of the children were already CalOptima members. Ms. Gomez also discussed the planned meetings that would be held during a June – December timeframe which included a Community Based Organization (CBO) meeting in June and a general stakeholder meeting in July. Additional general and family events are being planned through the end of 2018 and invitations to some of these events will be sent to the PAC once the event schedule has been finalized.

Palliative Care Update

Tracy Hitzeman, Executive Director, Clinical Operations updated the PAC on the first quarter statistics for the Palliative Care Program. She noted that one of the barriers identified in this

program is the members lack of knowledge about the program and unique cultural beliefs and norms. Plans are in process to hold ongoing community and provider education events. PAC will be informed when these events are scheduled.

PAC Member Updates

Chair Miranti notified the members that the Board had approved Brian S. Lee, L.Ac., Ph.D. as the new Allied Health Services Representative, Junie Lazo-Pearson, Ph.D., BCBA-D as the new Behavioral Health Representative, Pamela Pimentel as the new Nurse Representative and a second term for Teri Mirani as the Health Network Representative. The Board also approved Dr. Nishimoto as the new PAC Chair and Teri Miranti as the new Vice Chair. Chair Miranti introduced Dr. Lazo-Pearson who attended the meeting.

Chair Miranti reminded the members that the next PAC meeting is scheduled for August 9, 2018 at 8:00 a.m. and asked the members to forward any agenda items to the Staff to the PAC.

ADJOURNMENT

There being no further business before the Committee, Chair Miranti adjourned the meeting at 9:20 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: August 9, 2019

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

3. Consider Revisions to the Fiscal Year (FY) 2018-19 Board of Directors' Quality Assurance Committee and Board of Directors' Finance and Audit Committee Meeting Schedule

Contact

Michael Schrader, Chief Executive Officer, (714) 246-8400

Recommended Actions

Approve recommended revisions to the adopted FY 2018-19 CalOptima Board of Directors Meeting Schedule to:

1. Change the September 19, 2018 Board of Directors' Quality Assurance Committee (QAC) meeting to September 12, 2018 at 3:30 p.m.; and
2. Change the September 20, 2018 Board of Directors' Finance and Audit Committee (FAC) meeting to September 18, 2018 at 2:00 p.m.

Discussion

On June 7, 2018, the Board of Directors adopted the FY 2018-19 schedule of meetings for the Board of Directors, Board of Directors' Finance and Audit Committee, and Board of Directors' Quality Assurance Committee through June 30, 2019. As adopted, the Board of Directors' Quality Assurance Committee meeting schedule reflects quarterly meetings at 3:00 p.m. on the third Wednesday in the months of September, November, February and May, and the Board of Directors' Finance and Audit Committee meeting schedule reflects quarterly meetings at 2:00 p.m. on the third Thursday in the months of September, November, February and May.

Due to conflicting schedules, the following revisions to the QAC and FAC meeting schedule are requested:

- Revise the date of the QAC meeting scheduled on Wednesday, September 19, 2018 at 3:00 p.m. to Wednesday, September 12, 2018 at 3:30 p.m.; and
- Revise the date of the FAC meeting scheduled on Thursday, September 20, 2018 at 2:00 p.m. to Tuesday, September 18, 2018 at 2:00 p.m.

Unless otherwise noticed, all QAC and FAC meetings will be held at CalOptima's offices located at 505 City Parkway West in Orange, California.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

The recommended action will revise the Board of Directors' FY 2018-19 Meeting Schedule as required in Section 5.2 of the Bylaws.

CalOptima Board Action Agenda Referral
Consider Revisions to the FY 2018-19 Board of Directors' Quality
Assurance Committee and the Board of Directors' Finance and
Audit Committee Meeting Schedule
Page 2

Concurrence

Gary Crockett, Chief Counsel

Attachment

Proposed Revised FY 2018-19 Board of Directors' Meeting Schedule

/s/ Michael Schrader
Authorized Signature

8/29/2018
Date



Board of Directors Meeting Schedule July 1, 2018 – June 30, 2019

All meetings are held at the following location, unless notice of an alternate location is provided:

505 City Parkway West
Orange, California 92868

Board of Directors Monthly – First Thursday Meeting Time: 2:00 p.m.	Finance and Audit Committee Quarterly – Third Thursday Meeting Time: 2:00 p.m.	Quality Assurance Committee Quarterly – Third Wednesday Meeting Time: 3:00 p.m.
<i>July 2018[^]</i>		
August 2, 2018		
September 6, 2018	September 20 18, 2018*	September 19 12, 2018**
October 4, 2018		
November 1, 2018	November 15, 2018	November 21, 2018
December 6, 2018		
<i>January 2019[^]</i>		
February 7, 2019	February 21, 2019	February 20, 2019
March 7, 2019		
April 4, 2019		
May 2, 2019	May 16, 2019	May 15, 2019
June 6, 2019 [†]		

[^]No Regular meeting scheduled

[†]Organizational Meeting

*Proposed Revised Meeting at 2 p.m.

**Proposed Revised Meeting at 3:30 p.m.

Adopted June 7, 2018

CALOPTIMA FOUNDATION BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2017 **Meeting of the CalOptima Foundation Board of Directors**

Consent Calendar

4. Consider Appointments to the CalOptima Foundation Audit Committee

Contact

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

Recommended Action

Reappoint Lee Penrose and Victor K. Hausmaninger to the CalOptima Foundation Audit Committee for terms ending on September 30, 2020.

Background

In accordance with Article 9, Section 3 of the CalOptima Foundation's Bylaws, the Foundation Board of Directors shall appoint an Audit Committee. The primary role of the Audit Committee is to make recommendations to the Foundation Board of Directors regarding the hiring and termination of an independent auditor, and in conferring with the independent auditor to ensure the Foundation's financial affairs are in order. In addition, in the event that the auditor's firm provides non-audit services, the Audit Committee shall ensure that the auditor adheres to applicable standards for auditor independence. Audit Committee members may also provide advice and guidance on audit-related issues as the Foundation Board of Directors considers expansion of the organization's grant making role.

Members of the Committee may not include the Chairperson of the Board, the Chief Financial Officer (CFO) of the Foundation, any employee of the Foundation, or any person with a material financial interest in any entity doing business with the Foundation. The Committee may be composed of one or more persons, and may include persons other than directors of the corporation. The length of terms for Audit Committee membership is generally made for approximately two years.

Discussion

Staff recommends the reappointments of the following individuals to the CalOptima Foundation Audit Committee:

- Lee Penrose
A member of the CalOptima Board of Directors' Foundation Audit Committee since December 2012, Mr. Penrose serves as a Director on the CalOptima Board of Directors and the Chair of the Board of Directors' Finance and Audit Committee. He has held positions with insurance, physician practice management and hospital administration, and most recently, held positions as regional Chief Operating Officer and CFO for Providence St. Joseph Health within their Southern California Region. Mr. Penrose previously held leadership positions at St. Jude Medical Center in Fullerton, serving first as CFO from 2000 to 2008, and then as President and Chief Executive Officer from 2008 to 2016. Mr. Penrose was appointed a CalOptima Board Director in November 2011.

- Victor K. Hausmaninger, CPA
A member of the CalOptima Foundation Audit Committee since October 2014, Mr. Hausmaninger is the Founding Partner of HBLA Certified Public Accountants, Inc., and has spent his entire career as a certified public accountant, serving as Audit Partner with Deloitte & Touche. In 1985, he formed HBLA where he re-engineered his “Big 4” experience and standards and offered accounting services to privately owned businesses and their owners. His background includes extensive experience in providing business advisory, tax and audit services to non-profit organizations, and business entities in industries including, manufacturing, high technology, real estate, financial institutions, construction, and distribution. Mr. Hausmaninger’s professional affiliations include the American Institute of Certified Public Accountants, California Society of Certified Public Accountants, and he currently serves on the board of directors of the Biblica Foundation, the West Coast Lumber and Building Material Association, and the Center Club in Costa Mesa.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

Pursuant to the Bylaws of the CalOptima Foundation, members of the Audit Committee are to be appointed by the CalOptima Foundation Board of Directors.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

8/29/2018
Date

Continued a Future Board of Directors Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

5. Consider Changes to the Member Auto-Assignment Limits for the CalOptima Community Network

Contact

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

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

Recommended Action

Consider authorizing removal of the 10% auto-assignment limit for the CalOptima Community Network (CCN) and revise Policy EE.1106, Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment to reflect such changes.

Background/Discussion

On November 5, 2009, the CalOptima Board of Directors authorized staff to organize a contracted CalOptima Direct Network. This action authorized staff to establish contracts between CalOptima directly with community providers for the delivery of health care services to CalOptima members enrolled in CalOptima Direct.

At its February 6, 2014 meeting, the Board authorized expansion of the Direct Network to include CCN, which would allow participation of a broader range of providers and to supplement the existing delivery system and expand member choice through CCN. CCN expansion was based on the following attributes:

1. Accept any willing and qualified provider;
2. Allow enrollment of any members eligible for health network enrollment;
3. Stop auto-enrollment, excluding assign-back and family link, to CCN when total enrollment reached 10% of CalOptima's overall membership; and
4. Directly contract with independent and group physicians.

At the same meeting, staff reported that CalOptima had and would continue to actively seek stakeholder feedback on the development of CCN. Some of the feedback received from existing health networks was the concern that CCN would compete with the existing networks, that it could create an incentive for physicians to no longer participate with existing networks, and that it might provide an unfair financial advantage for CalOptima, including as it related to funding and provider reimbursements levels. Other providers, including individual physicians, the Member Advisory Committee, and the Orange County Medical Association were supportive of the proposal and provided positive feedback. CCN has now been in place for several years. The CCN provider network currently includes over 3,000 contracted primary care physicians and specialists in Orange County, with nearly 75,000 assigned members. The 10% auto-assignment was closed effective April 2017, and no new members have been auto-assigned to CCN since that time. However, enrollment in CCN has continued to grow due to member selection. In terms of quality scores, CCN ranks 9th in the group of 13 health networks. Kaiser Foundation Health Plan is not included in the auto-assignment process.

Continued a Future Board of Directors Meeting

CalOptima Board Action Agenda Referral
Consider Changes to the Member Auto-Assignment Limits for the
CalOptima Community Network
Page 2

At its August 2, 2018 meeting, the Board directed staff to provide additional information regarding CCN and include an agenda item that would allow the Board to consider revisions to/removal of the 10% CCN auto-assignment cap. In the event that the Board opts to remove the 10% auto-assignment limit, as proposed, there would be no limit on CCN auto-assignment and enrollment; based on Board policy, the other contracted health networks are individually limited to a maximum of one-third of all CalOptima Members eligible for enrollment.

Fiscal Impact

Should the Board change the member auto-assignment limits for CCN, Management expects the change to be budget neutral to CalOptima.

Medical Expenses

In the event the Board changes the CCN member auto-assignment limits, there is no anticipated change to total medical expenses due to variances in cost or utilization. Staff does not anticipate an increase in medical expenses due to cost as health network capitation rates are based on CalOptima's fee-for-service (FFS) provider rates and payment methodologies. The methodologies are equivalent regarding rates and assumptions. Likewise, staff does not anticipate an increase in medical expenses due to utilization as the actual historical utilization rates used in developing health network capitation rates and actual FFS utilization rates are not significantly different for similar populations. There is a large overlap (82%) between health network and CCN primary care providers, and staff assumes provider practice patterns will largely be the same whether the member is with CCN or a contracted health network provider. Also, the overall impact of the potential shift in members due to this potential policy change appears minimal and is not expected to have any measurable change in total medical expenses.

Administrative Expenses

In addition, the potential change to the CCN member auto-assignment limit will not materially impact overall budgeted expenses. The CalOptima Fiscal Year 2018-19 Operating Budget included a consolidated administrative loss ratio (ALR) of 4.4% and a Medi-Cal ALR of 4.1%. The current CCN enrollment is approximately 75,000 members. Based on current enrollment projections, the removal of the 10% CCN auto-assignment limit would direct approximately 3,600 more auto-assigned members to CCN over a one-year period. With member choice and attrition, this number is expected to result in a net increase in CCN enrollment of roughly 1,800 on an annual basis, or by an average of roughly 150 net new members per month. As such, staff anticipates the overall impact on administrative expenses is quite minimal and is not expected to have any measurable impact on the ALR.

Rationale for Recommendation

The removal of the auto-assignment membership limits for CCN would potentially shift 7.8% of the average auto-assigned members to CCN providers, while 92.2% of the auto-assigned members would continue to be assigned to the other health network providers.

Concurrence

Gary Crockett, Chief Counsel

Continued a Future Board of Directors Meeting

CalOptima Board Action Agenda Referral
Consider Changes to the Member Auto-Assignment Limits for the
CalOptima Community Network
Page 3

Attachments

1. Presentation: Auto-Assignment - Summary
2. Board Action dated November 5, 2009, Approve Modifications to CalOptima Direct.
3. Board Action dated March 6, 2014, Authorize the Chief Executive Officer (CEO) to Modify CalOptima Policies as Necessary to Establish a CalOptima Community Network within CalOptima Direct.
4. EE.1106, Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment.

/s/ Michael Schrader
Authorized Signature

8/29/2018
Date



CalOptima
Better. Together.

Auto-Assignment – Summary

**Board of Directors Meeting
September 6, 2018**

Greg Hamblin, Chief Financial Officer

Overview

- Auto-Assignment Policy
 - Overview of Policy
 - Performance Criteria
 - Performance Based Ranking
 - Auto-Assignment Retention Rates
- Other Quality Metrics
- Medi-Cal Enrollment by Network
- Financial Information/Considerations
- Current Policy Impact
- Policy Change Impact
- Recommended Action

Auto-Assignment Policy

- The CalOptima Auto-Assignment Policy was structured to ensure the following:
 1. Members have access to health care services in geographic proximity to his or her residence.
 2. Community Health Center Safety Net provider participation in the CalOptima program.
 - Community Clinics
 - FQHCs
 3. Member assignment to Health Network or CCN based on performance criteria.
 - Auto-Assignment Limitation
 - Health Network maximum enrollment not to exceed 33.33% of total health network eligible members
 - CCN maximum enrollment not to exceed 10.00% of total health network eligible members
 - Auto-assignment is turned off once the maximum enrollment is reached

Auto-Assignment Policy (cont.)

- On average ~7,000 new/returning members are auto-assigned each month
 - Assignment is based on geographic zip code locations and performance based criteria
 - Members can request to change their Health Network or CCN affiliation once per month
- Of the ~7,000 members being auto-assigned:
 - 45% or ~3,150 are auto-assigned to the Clinics/ FQHCs
 - Each Clinic/ FQHC can selected a Health Network affiliation or CCN affiliation in order to receive its allocation of auto-assigned members
 - Currently, all Clinics/ FQHCs are affiliated with the Health Networks for auto-assignment

Auto-Assignment Policy (cont.)

- 55% or ~3,850 are auto-assigned to a Health Network or CCN
 - Currently, the Health Networks receive all auto-assignment as CCN auto-assignment is turned off based on the maximum enrollment limitation set by policy
 - Auto-assignment is based on a Health Network's or CCN's, performance-based criteria and resulting ranking
 - Performance Criteria
 - Specific performance indicators have been established
 - Each performance indicator is assigned a weight % and points
 - Relative ranking is based on the sum of weighted scores for all indicators
 - The ranking, in numerical sequence, is used as the processing order for auto-assignment
 - Results take effect the following year for a one year period

Performance Criteria

Category	Indicator	Possible Points	Weight
Quality of Clinical Service	Well Child Visits: 3 rd , 4 th , 5 th , 6 th Years	0, 2, 5, 10	10%
	Adolescent Well-Care Visits	0, 2, 5, 10	10%
	HbA1c Testing/ Well Child Visit – 15 months	0, 2, 5, 10	10%
	Postpartum Care/ Childhood Immunization Combo 2	0, 2, 5, 10	10%
	Breast Cancer Screening/ Child Immunization MMR	0, 2, 5, 10	10%
	LDL Screening/ Appropriate Treatment Children URI	0, 2, 5, 10	10%
Administrative Excellence	Child Member Satisfaction Survey	0, 4, 10, 20	20%
	Encounters	0, 2, 5, 10	10%
	Auto-Assignment Retention Rate	0, 2, 5, 10	10%
Total			100%

Performance Based Ranking

Current Ranking	Medi-Cal	
	Weighting %	Relative Ranking
Health Network A	13.4%	1
Health Network B	11.1%	2
Health Network C	10.8%	3
Health Network D	9.6%	4
Health Network E	9.5%	5
Health Network F	9.1%	6
Health Network G	8.1%	7
Health Network H	7.5%	8
CCN	6.8%	9
Health Network I	5.4%	10
Health Network J	4.8%	11
Health Network K	2.9%	12
Health Network L	1.0%	13

As of January 1, 2018

Note: Kaiser is excluded from auto-assignment

Auto-Assignment Retention Rates

- Data Source: Auto-assignments from July 2016 – March 2017
 - CCN auto-assignment was closed effective April 2017
- Measures members initially auto-assigned and their retention rate on a quarterly basis; up to a maximum of 8 quarters (2 years)
 - Measured through June 2018
- Finding: On average, CCN retention rate was 8% to 9% higher than the Health Network rate for each period

Period	Health Network	CCN	Difference
One quarter	74%	82%	8%
Two quarters	60%	69%	9%
Three quarters	52%	61%	9%
Four quarters	42%	53%	11%
Five quarters	36%	45%	9%
Six quarters	33%	41%	8%
Seven quarters	31%	40%	9%
Eight quarters	25%	33%	8%

Medi-Cal Enrollment by Network (July 2018)

Health Network	Model	Enrollment	% Total
CHOC Health Alliance	PHC	146,549	22.5%
Monarch Family Healthcare	HMO	81,235	12.4%
CCN – CalOptima (Auto-assignment turned off)	FFS	75,618	11.6%
Arta Western	SRG	65,592	10.1%
Alta Med Health Services	SRG	46,335	7.1%
Family Choice Health Network	SRG	46,227	7.1%
Kaiser (No Auto-assignment by choice)	HMO	45,659	7.0%
Prospect Medical Group	HMO	33,989	5.2%
United Care Medical Network	SRG	32,334	5.0%
Noble	SRG	24,798	3.8%
Talbert Medical Group	SRG	23,889	3.7%
AMVI Care Health Network	PHC	22,386	3.4%
Heritage – Regal Medical Group	HMO	5,863	0.9%
OC Advantage	PHC	2,126	0.3%
Total Health Network Enrollment		652,600	100.0%
CalOptima Direct (No Auto-assignment)	FFS	104,533	
Total Medi-Cal Enrollment		757,133	

Financial Information/Considerations

- 2 different Payment Models

1. Capitation

- PMPM is paid to a Health Network for each enrolled member
 - Capitation PMPM rates are based on CalOptima's Fee-For-Service (FFS) payment policies, methodologies and fee schedules using actual, historical incurred utilization rates
 - HMO/PHC – Capitation paid for certain Professional & Hospital services (some carve outs and re-insurance paid on FFS basis)
 - SRG – Capitation paid for certain Professional services (some carve outs and re-insurance paid on FFS basis)

2. Fee-For-Service (FFS)

- Provider is paid a fee for each particular service performed
 - FFS payment rates are based on CalOptima's payment policies, methodologies and fee schedules
 - CCN – Payments made on FFS basis

➤ Capitation rates are based on the same payment policies, methodologies and rates experienced under FFS

Financial Information/Considerations

3. Administrative Expenses

- Capitation

- CalOptima includes an Administrative and Medical Management load as part of the capitation rate paid to the health networks
- The Administrative load rate is developed based on CalOptima FFS administrative and medical management costs
- Delegated health networks only perform some of the administrative functions that CalOptima performs
- The administrative and medical management costs that CalOptima includes as part of the capitated rates are equivalent to the incurred administrative and medical management costs experienced under FFS

Current Policy Impact

- Under the current policy, auto-assignment to CCN is turned off when the total number of CCN members exceeds 10% of Eligible Network Enrollment
 - CCN auto-assignment was closed effective April 2017
 - Limitation is currently still in place with 0% auto-assignment to CCN
 - CCN Current enrollment is 75,618
 - $652,600 \text{ Total members} \times 10\% = 65,260 \text{ limitation threshold}$
- Currently, all auto-assignment (~7,000 per month) is through the Health Networks
 - ~3,150 or 45% to Clinic/ FQHC: Selected Health Network affiliation
 - ~3,850 or 55% to Health Networks

Policy Change Impact

- Removing the 10% Auto-assignment limitation from CCN
 - Annualized impact based on current data:
 - CCN would receive ~3,600 or 7.8% of the available members through Auto-Assignment
 - Health Networks would receive ~42,600 or 92.2% of the available members through Auto-Assignment
 - Auto-assignment member loss will significantly mitigate these numbers
 - Retention rates:
 - At the end of 4 quarters: 42% Health Network and 51% CCN
 - At the end of 8 quarters: 25% Health Network and 33% CCN
 - Member loss from auto-assignment could be due to:
 - Member choice: selecting another Health Network or CCN
 - Loss of Medi-Cal coverage
 - There would be no significant financial impact to CalOptima due to this policy change at this level of membership and historical retention rates

Recommended Action

- Consider Changes to the Member Auto-Assignment Limits for the CalOptima Community Network

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2009 **Regular Meeting of the CalOptima Board of Directors**

Report Item

VI. C. Approve Modifications to CalOptima Direct

Contact

Javier Sanchez, Executive Director of State Programs, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer to organize a CalOptima Direct (COD) network to improve the quality and coordination of health care services delivered to Medi-Cal members enrolled in COD.

Background

CalOptima currently provides services to approximately 336,000 members in the Medi-Cal program. There are four components of the delivery system:

1. Health Plan services - Cost: \$404 million Members: 344,982
CalOptima pays directly for long term care room and board, pharmaceuticals, pediatric preventive services and vision care for all CalOptima Medi-Cal members
2. CalOptima Direct - Cost: \$208 million Members: 103,591
CalOptima pays fee for service expenses for medically and administratively complex members.
3. Shared Risk Groups - Cost: \$172 million Members: 105,007
CalOptima pays for hospital associated expenses and Medical Groups are capitated and subsequently pay for professional expenses.
4. Delegated Health Networks - Cost: \$142 million Members: 136,384
2 HMOs, 3 Medical Groups and 2 Hospitals are capitated and subsequently pay for professional and hospital expenses

(Note: Cost data is based on FY 2008-09 financial statements and enrollment figures are for the month of September 2009.)

CalOptima Direct is CalOptima's fee-for-service (FFS) program for certain Medi-Cal members. COD enrollment averages approximately 100,000 members at any given time. Approximately 68,000 COD members are dual eligibles for whom Medicare is the primary payer of most expenses. The remaining populations served through COD include members who are in the process of transitioning to contracted health networks, members with a share of cost, foster children, members with Medi-Cal only Long Term Care (LTC) aid codes and members with qualified medical conditions or who have complex needs. Members with qualified medical conditions include members diagnosed with hemophilia, end stage renal

disease (ESRD), members enrolled in the breast and cervical cancer treatment program (BCCTP), and members awaiting organ transplants. COD also serves members who were transitioned to COD under special circumstances approved by the CalOptima Board such as the Seniors and Persons with Disabilities Pilot (SPDP), and members with specific continuity of care needs who were transitioned to COD by Chief Medical Officer (CMO) approval according to CalOptima policy.

To receive reimbursement for services rendered to COD members, providers currently register with CalOptima. If a provider is contracted with COD, the provider must be credentialed by CalOptima, similar to providers who are currently contracted through CalOptima's health networks. However, in contrast to the CalOptima members assigned to the health networks and shared risk groups, COD members are free to use any willing provider registered with CalOptima. This model makes it difficult to coordinate care since members either do not have a primary care medical home or if they access primary care providers, CalOptima has no formal contractual relationship with primary care providers.

CalOptima Direct began the process of developing a contracted network in 2006, when it began contracting with hospitals. CalOptima staff received authority in June 2007 to directly contract with physicians and ancillary providers who provide services to COD members. To date, CalOptima has contracted with approximately 300 specialists and various ancillary providers and hospitals. Some of these specialists are hospitalist physicians who collaborate with CalOptima's Utilization Management staff to manage inpatient services. However, because the providers of primary care services do not hold contracts with CalOptima, they cannot be held to the same requirements that CalOptima is held to under its contract with the Department of Health Care Services (DHCS), and they are not bound to the policies and procedures approved by CalOptima. Accordingly, in order to assure compliance with approved policies and procedures and quality of care standards, and in order to assure a comprehensive model of care for COD members, CalOptima staff will contract with certain primary care physicians including those who already provide services to COD members as registered CalOptima providers.

Discussion

COD Membership

The current COD membership shall remain the same. At this point, the COD FFS program is not available for member choice, except in certain circumstances outlined in CalOptima policy.

CalOptima has determined that the following categories of members will best be served in the COD FFS program: members residing outside of Orange County; transitional members waiting to be assigned to a delegated health network; dual eligible members enrolled in One Care; members with Share of Cost (SOC); and dual eligible members not enrolled in One Care.

Members in the foster child category will continue to have the option of selecting one of CalOptima's contracted health networks or to remain in COD according to current policy. If

members in the Foster Child category choose COD, they will receive care in the COD managed network.

Members that formerly participated in the Seniors and Persons with Disabilities Pilot (SPDP) and members transitioned to COD by CMO Exception for continuity of care purposes following the termination of the St. Joseph Heritage Medical Group from Noble, will receive care in the COD Managed Network and will have the option of selecting a health network. However, unlike Foster Children, they will not have the option of choosing to return to COD (after selecting a health network) unless their status or condition changes to make them eligible in the future to be transitioned to COD based on qualifying conditions or benefits.

The following categories of COD members will receive care under the COD Managed Network: members with Medi-Cal only long term care (LTC) Aid Codes; members with continuous Medi-Cal share-of-cost (SOC) benefits; members with qualifying conditions such as those awaiting an organ transplant, diagnosed with ESRD, diagnosed with Hemophilia, those eligible for the breast and cervical cancer program (BCCTP), and institutionalized members who reside at the Fairview facility.

COD Providers

As stated above, the providers presently providing services to COD members must register with CalOptima. The process of registration simply allows CalOptima to process the provider's claim(s).

CalOptima staff believes that contracting with primary care physicians will lead to the following enhancements in the COD provider network:

- State and Federal Regulation and CalOptima Policies and Procedures – The process of contracting with a COD managed network will allow CalOptima to hold all contracted physicians to the same requirements and obligations required under its contract with DHCS. These requirements include credentialing standards, the right to access records, peer review, and corrective action plans. These requirements are similar to what CalOptima requires of its shared risk groups and health networks.
- Contracting and Coordination of Care by Primary Care Physicians (PCP) – CalOptima's 2009 contract with DHCS requires written contracts between CalOptima and each provider of health services which regularly furnishes services to members. CalOptima staff will identify physicians registered with COD as Pediatricians, Family Practitioners, General Practitioners, Obstetrician/Gynecologists and Internal Medicine (collectively defined as PCPs) that already serve COD members and offer them contracts. Contracts shall not be executed with any such provider until completion of CalOptima's credentialing standards.
- Recruitment of PCP Network – The COD provider network will include only contracted providers who meet contracting requirements as described above. CalOptima will only offer PCP contracts to physicians registered as Pediatricians, Family Practitioners, General Practitioners, Obstetrician/Gynecologists and Internal Medicine physicians who have provided outpatient services to five (5) or more unique CalOptima Medi-Cal Members from June 2007 to September 2009. In addition, CalOptima may offer

contracts to other primary care providers as necessary to ensure that COD members have adequate access to primary care services according CalOptima's contract with the DHCS.

- PCP Payment – Contracted PCPs in the COD managed network will be paid on a fee-for-service (FFS) basis at 123% of the COD fee schedule which is based on the Medi-Cal fee schedule. Registered non-contracted physicians will be reimbursed FFS at 100% of the COD fee schedule. For contracted PCPs, this reimbursement methodology will begin on the effective date of the contract. For non-contracted physicians, this methodology will be effective on April 1, 2010 in order to allow registered physicians an opportunity to contract with CalOptima. Consequently, those providers who meet the quality standards as determined by CalOptima and follow the policy and procedures of the COD managed network will be rewarded for their efforts in a manner which is similar to the way CalOptima provides incentives to health network providers. In the future, CalOptima staff may request authority to develop alternative PCP payment methodologies to compensate physicians for providing enhanced primary care services COD members.
- Coordination of Care in the COD Managed Network – The current COD FFS program as described in the background section will continue to exist in COD in order to maintain a vehicle for covering services provided to COD sub-populations that cannot be served in a coordinated model of care. The COD managed network will operate in the same manner as CalOptima's contracted health networks with respect to assignment of a primary care provider to members and function according to managed care principles. CalOptima has categorized COD members according to benefit structure and medical diagnosis, and has identified a model of care to best serve the health care needs of the members.
- PCP Assignment – Assignment of a primary care medical home, or PCP, is a fundamental aspect of a coordinated care model of care. COD members who receive care in the COD managed network will be assigned to a PCP. Members will select a PCP of their choice according to DHCS requirements and CalOptima policy. CalOptima will make several attempts during a six-month period to allow each member served in the COD managed network to select a PCP of their choice. Members who do not select a PCP during the six-month phase in period ending June 30, 2010 will be assigned to a PCP based on the following criteria:
 - The first attempt will be to identify and assign members to a contracted PCP that the member accessed during in the last year (based on claims data).
 - If a prior primary care provider cannot be identified, members will be assigned to a contracted PCP who is located near the member's address .
 - Members will be allowed to change PCPs once per month in the same manner as members assigned to CalOptima's health networks, and according to CalOptima's policy.

Members that remain in COD FFS, as described above, will not be assigned to a PCP.

Quality and Fiscal Impact

As the COD managed network development process moves forward, the impact on the quality of care should be significant. Additionally, the financial impact should reflect savings in total healthcare costs. A coordinated utilization management program and early intervention for hospitalized Medi-Cal patients should allow CalOptima to improve quality of care, while decreasing healthcare costs for COD members.

CalOptima staff will track the financial performance of the COD provider network through monthly financial statements which will track performance against a fiscal year budget. Revenue for the COD managed network budget will be based on CalOptima's capitation rates and will be risk adjusted in the same manner as health network capitation is adjusted. Retroactive expenses will be accounted for in COD FFS expenses and shall not be considered COD managed network expenses.

Rationale for Recommendation

Staff recommends that CalOptima complete the development of a contracted primary care network and a coordinated model of care within COD. The intent of this proposed change is to ensure that quality healthcare, provided cost effectively, will be delivered in the most appropriate manner to the COD membership.

Concurrence

Procopio, Cory, Hargreaves & Savitch LLP

Attachment

CalOptima Direct Model of Care Matrix

/s/ Richard Chambers
Authorized Signature

10/29/2009
Date

CalOptima Direct Model of Care Matrix

Membership Category	Average Monthly Enrollment	Source of Enrollment	COD FFS	COD Managed Network Optional – Choice of HN or COD	COD Managed Network Optional – One Way out of COD	COD Managed Network
Out of Area as defined by the State	140	Newly Eligible	✓			
HN Transitional	9,500	Newly Eligible	✓			
Medi-Medi <i>IN</i> OneCare	9,300	Newly Eligible	✓			
Share of Cost	450	Newly Eligible	✓			
Medi-Medi <i>NOT IN</i> OneCare	59,500	Newly Eligible	✓			
Foster Care	3,860	Newly Eligible		✓		
Members of the former Seniors and Persons with Disability Pilot (SPDP)	1,970	Monarch UCI PHC			✓	
CMO Exception: <ul style="list-style-type: none"> • Members living with HIV/AIDS • Continuity of Care: St. Joseph Heritage Termination 	500	Transitioned from Health Networks			✓	
Medi-Cal Only LTC Aid Codes	4,500	Newly Eligible				✓
Qualified Medical Conditions: <ul style="list-style-type: none"> • Organ Transplant list • End Stage Renal Disease (ESRD) • Hemophilia • Breast and Cervical Cancer Treatment BCCTP Program 	1,500	Newly Eligible Transitioned from Health Networks				✓
Fairview Residents	100	Newly Eligible				✓

All Members in the COD Managed Network will be assigned a primary care physician

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 6, 2014 **Regular Meeting of the CalOptima Board of Directors**

Report Item

VI. J. Authorize the Chief Executive Officer (CEO) to Modify CalOptima Policies as Necessary to Establish a CalOptima Community Network within CalOptima Direct

Contacts

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

Bill Jones, Chief Operating Officer, (714) 246-8400

Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the CEO to take the following actions necessary to establish a community network within CalOptima Direct for all lines of business:

1. Update Member enrollment and eligibility policies for Medi-Cal, OneCare and Cal MediConnect including CalOptima Direct Policy DD.2006; and
2. Allow budget flexibility among expense categories during Fiscal Year (FY) 2013-14 as appropriate based on new CalOptima Direct membership as a result of policy changes.

Background

On November 5, 2009, the CalOptima Board of Directors (Board) authorized staff to organize a contracted CalOptima Direct network to improve the quality and coordination of health care services delivered to Medi-Cal members enrolled in CalOptima Direct. This action authorized staff to establish contracts between CalOptima Direct and providers for the delivery of health care services to CalOptima members. Prior to this Board action, CalOptima Direct was a loosely managed fee-for-service delivery model with limited provider contracts.

In February 2013, the Board directed staff to explore options for expanding CalOptima's delivery system. Based on strong collaboration with community and provider stakeholders, CalOptima management subsequently issued a Request for Proposals (RFP) to add new networks and sought stakeholder input regarding possible options.

CalOptima completed a successful RFP process, identifying 118 potential new primary care providers and 975 new specialists to be added to the provider network. These providers would be included in the network after successfully passing a readiness review. In addition, CalOptima continued preparations for participation in the Cal MediConnect program. During this process, it was determined that CalOptima must place an even greater emphasis on the patient/provider relationship, and seek to further expand the provider network in order to minimize the opt-out rate for Cal MediConnect and maximize provider participation.

At its December 2013, the Board authorized the CEO to further explore and evaluate the possible expansion of the provider delivery system through the creation of a direct CalOptima Community Network. Specifically, CalOptima staff understood the direction of the Board to require that CalOptima:

- Seek input from existing health networks and other stakeholders;
- Solicit letters of interest from providers;
- Define network criteria and implementation requirements;
- Evaluate potential costs and areas of risk including:
 - Impact to existing networks and delivery system and provider participation requirements for individual lines of business;
 - Changes in member care resulting from the inclusion of providers not selected by current networks and any related quality or credentialing issues;
 - Financial ramifications of potential risk shifting (i.e., increases to risk resulting from adverse selection) based on provider participation in both the network and direct models with the same membership;
 - Additional staffing and other potential administrative costs associated with managing a new network; and
- Return to Board in February 2014 with findings and recommendations.

Discussion

Consistent with CalOptima's mission to focus on expanding member choice and ensuring continuity of care, staff proposes that the Board authorize the development of a new Community Network within CalOptima Direct that will allow providers to contract with CalOptima directly to provide services to members in all CalOptima programs, including those currently eligible for Health Network assignment. While the CalOptima Community Network will provide value to all CalOptima members, it is particularly important for expanded provider options for members in Cal MediConnect once participation in the program is approved by federal and state regulators.

While it will be part of CalOptima Direct, the proposed CalOptima Direct Community Network will be separate and distinct from the CalOptima Care Network which delivers services to specific CalOptima Medi-Cal populations. The CalOptima Direct Community Network would be built on four (4) primary constructs:

1. Accept any willing and qualified provider;
2. Allow enrollment of any members eligible for health network enrollment;
3. Stop auto enrollment, excluding assign-back and family link, to the Community Network when total enrollment reaches 10% of CalOptima's overall membership;
4. Directly contract with independent and group physicians (i.e., no delegation of services).

As currently envisioned, the Community Network would be part of CalOptima Direct and have responsibility for all administrative services, managed care operations, and delivery of services to members not delegated to contracted Health Networks. CalOptima's leadership team brings many years of experience in managing a direct network and implementing these operational functions.

To ensure a level playing field with existing contracted health networks, physicians contracting with CalOptima Direct's Community Network would be required to: (i) participate in all CalOptima programs, and (ii) be qualified to provide services to all membership categories as appropriate. Physicians and other providers would have the option of participating in multiple networks.

CalOptima originally expressed interest in developing a CalOptima Direct Community Network consisting of only those physicians who were not contracted with an existing network. However, consistent with current practice of permitting physicians to participate in multiple networks, the proposal has been amended to expand participation to all physicians.

Based on the direction provided by the Board in December 2013, staff has taken a number of exploratory steps, including soliciting input from a range of stakeholders and further defining the network criteria and implementation requirements.

Stakeholder Feedback

CalOptima has and will continue to actively seek stakeholder feedback on the development of the CalOptima Direct Community Network. The current request was developed and includes stakeholder feedback that was sought and received between the February 2013 and December 2013 BOD meetings. Since the December 2013 Board of Directors meeting, staff planned and conducted the following stakeholder events:

Meeting	Date
Health Network CEO Forum	12/12/13
CalOptima Member Advisory Committee (MAC)	1/16/14
CalOptima Provider Advisory Committee (PAC)	1/16/14
Health Network Forum	1/22/14
Financial Advisory Committee (FAC)	2/18/14
Monthly Cal MediConnect Stakeholder Forums	November, January and February

CalOptima received a range of feedback from stakeholders at these meetings. Individual physicians, the Member Advisory Committee, and the Orange County Medical Association were supportive of the proposal and provided positive feedback. The strongest concerns were expressed by existing health networks. Feedback included concerns that establishing the CalOptima Direct Community Network would:

- Create competition between the CalOptima Direct Community Network and existing Networks;
- Create an incentive for physicians to no longer participate with existing Networks; and
- Create an unfair financial advantage for CalOptima, including funding and provider reimbursements levels.

There were three (3) major risk categories identified during the stakeholder process. The categories and associated mitigation is outlined below:

1. Member Experience and Changes in Member Care

CalOptima's first priority is ensuring access to high quality care for members. The creation of a CalOptima Direct Community Network will improve member access to care in several key ways:

- Provide CalOptima the flexibility to create a broader provider network for members to choose from;
- Create an avenue for physicians who do not currently contract or fully participate with

- health networks to serve CalOptima members; and
- Enable CalOptima to preserve existing member-provider relationships for members transitioning to CalOptima and for existing Dual Eligible Medi-Cal members newly receiving their Medicare benefits from CalOptima.

CalOptima is projected to experience a rapid increase in enrollment. CalOptima's expected growth will primarily come from Medi-Cal Expansion and Cal MediConnect. Ensuring flexibility in contracting and service delivery is critical to meeting the needs of new populations.

2. Provider Participation and Impact to Existing Networks

One of the primary goals for the CalOptima Direct Community Network is to allow independent physicians and small provider groups to contract with CalOptima to provide services to members in all CalOptima programs. Physicians participating in the CalOptima Direct Community Network will be required to meet the same strict quality standards that are required of all Medi-Cal participating providers. CalOptima has solicited and received letters of intent (LOI) from over 400 primary care and specialty physicians and nine (9) Community Clinics to participate in the CalOptima Community Network. Of the total number of physicians, about 8% are new to the CalOptima delivery system.

The creation of the CalOptima Community Network will allow the participation of a broader range of providers. However, the impact of a new CalOptima administered network on existing health networks must carefully be evaluated. Staff has actively worked with the health networks to identify, understand, and determine ways to address their concerns. As a result, the CalOptima Direct Community Network will supplement the existing delivery system and the proposed design will include several safeguards to ensure that health networks continue to operate on a level playing field:

- The CalOptima Direct Community Network would be required to meet the same contractual requirements as existing networks;
- The CalOptima Direct Community Network would be treated like all other networks in the member assignment process;
- Physicians and other providers would have the option of participating in multiple networks; and
- CalOptima will track the financial performance of the Community Network separate from the CalOptima Care Network.

3. Financial Risk Shifting and Administrative Costs

In order for the CalOptima Direct Community Network to be successful, CalOptima must control for risk shifting, monitor member panel acuity between networks, and control for administrative efficiency. If approved, CalOptima staff will develop policies to strengthen continuity of care requirements and create dis-incentives to prevent risk shifting by delegated health networks such as requiring that delegated health networks be financially responsible for the cost of services provided to members that move from a health network to the CalOptima Direct Community Network for a period of time.

The current risk adjusted revenue per member per month (PMPM) will be applied to the CalOptima Direct Community Network, consistent with how current health networks are reimbursed. By monitoring this closely and adjusting for member acuity, CalOptima will have the appropriate controls in place to prevent risk shifting between networks.

Administrative costs will be comparable to or better than the current administrative ratio, including the health networks. This reflects that all functions will be performed by CalOptima and have little to no delegation, with credentialing being the exception. Functions performed by CalOptima will include, but are not limited to case management, claims processing, customer service, and utilization management.

As noted above, the CalOptima Direct Community Network would be required to meet the same contractual requirements as existing health networks. In order to serve CalOptima members, the CalOptima Direct Community Network would be required to pass a comprehensive readiness review. Staff will also regularly evaluate the efficiencies and effectiveness of the CalOptima Direct Community Network, and will provide regular communications to the Board and our member and provider communities. In addition, staff will return to the Board for consideration of further related policy considerations, as appropriate.

Fiscal Impact

The recommended action is expected to be budget neutral to CalOptima. Staff is not requesting a budget augmentation to the FY 2013-14 Operating Budget; however, staff requests budget flexibility among expense categories as appropriate based on membership in the CalOptima Direct Community Network.

Rationale for Recommendation

The establishment of a direct CalOptima Community Network provides a significant opportunity for CalOptima to increase member access to care, broaden the network of physicians in Orange County and, increase CalOptima's direct contact with members. The CalOptima Direct Community Network will enable CalOptima to expand capacity and expertise, and generate greater administrative efficiencies.

Concurrence

Gary Crockett, Chief Counsel

Attachment

None

/s/ Michael Schrader
Authorized Signature

2/28/2014
Date



Policy #: EE.1106
Title: **Health Network and CalOptima
Community Network Minimum and
Maximum Member Enrollment**
Department: Network Management
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 03/01/96
Last Review Date: 08/01/17
Last Revised Date: 08/01/17

I. PURPOSE

This policy establishes minimum and maximum Member enrollment for a Health Network, Primary Hospital, Primary Physician Group, and CalOptima Community Network (CCN).

II. POLICY

A. Minimum enrollment

1. The minimum enrollment requirement shall apply to a Health Network and CCN thirty-six (36) months after the initial Member enrollment date.
2. After the initial thirty-six (36) months of Member enrollment, a Health Network shall maintain a Member enrollment of at least five-thousand (5,000) Members for the remainder of the term of the Contract for Health Care Services.
3. If a Health Network fails to maintain an average Member enrollment over three (3) consecutive months of at least five-thousand (5,000) Members, CalOptima may terminate the Contract for Health Care Services in accordance with the terms of that contract.

B. Maximum enrollment

1. Except as otherwise provided in Section II.B.3. of this policy:
 - a. Combined Member enrollment in a Primary Hospital or Primary Physician Group shall not exceed one-third (1/3) of all Members eligible for Health Network enrollment.
 - b. Member enrollment in a Health Network shall not exceed one third (1/3) of all Members eligible for Health Network enrollment.
 - c. Combined Member enrollment in CCN shall not exceed ten percent (10%) of all Members eligible for Health Network enrollment.
2. If a Health Network, Primary Hospital, or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, such Health Network, Primary Hospital, or Primary Physician Group shall not be eligible to contract with CalOptima as part of an additional Health Network.
3. Subject to the provisions of this policy, CalOptima shall continue to enroll Members in a Health Network, or CCN, until the Health Network, CCN, Primary Hospital, or Primary Physician

Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months.

- a. If a Health Network reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, CalOptima shall cease all auto assignment of Members to the Health Network effective the first (1st) calendar day of the immediately following month.
- b. If a Primary Hospital or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, CalOptima shall cease all auto-assignment of Members to each Health Network comprised of such Primary Hospital or Primary Physician Group effective the first (1st) calendar day of the immediately following month.
- c. If CCN reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, CalOptima shall cease all auto assignment of Members to CCN effective the first (1st) calendar day of the immediately following month.
- d. Notwithstanding the provisions of this section, CalOptima shall continue to enroll a Member in a Health Network, or CCN, if:
 - i. The Member selects the Health Network or CCN in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process;
 - ii. The Member has Family Linked Members currently enrolled in the Health Network or CCN;
 - iii. The Member is re-enrolled in the Health Network, or CCN, after experiencing a lapse of Medi-Cal eligibility less than three-hundred-sixty-five (365) calendar days in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process;
 - iv. The Member otherwise meets criteria for enrollment into CCN, in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.
 - v. CalOptima auto assigns the Member to the Health Network or CCN based on auto assignment allocation to a Community Clinic as set forth in CalOptima Policy AA.1207a: CalOptima Auto Assignment; or
 - vi. CalOptima's Chief Medical Officer (CMO) or Designee determines that it is in the Member's best interest to enroll in the Health Network or CCN.

C. Health Network Enrollment Changes

1. CCN and a Health Network, and its Contracted Providers, shall not advise, urge, or otherwise encourage Members to change Health Networks as a direct result from the Member's medical history or health status.
2. CCN and a Health Network shall be responsible for all Members who either select or are otherwise auto-assigned to the Health Network and are strictly prohibited from discriminating against Members based on:

- a. Diagnosis;
 - b. Medical or claims history;
 - c. Age;
 - d. Mental or physical disability;
 - e. Genetic information;
 - f. Source of payment;
 - g. Sexual orientation;
 - h. Marital status;
 - i. Creed;
 - j. Religion;
 - k. Sex/Gender identity;
 - l. Race;
 - m. Color;
 - n. Ancestry; and
 - o. National origin.
3. CalOptima shall process alleged acts of discrimination in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.
- D. CalOptima's Board of Directors shall have the right to selectively waive a Health Network's or CCN's minimum and maximum enrollment or limit a Health Network's or CCN's enrollment if it determines that such action is in the best interest of Members.

III. PROCEDURE

A. Minimum and Maximum Enrollment

1. CalOptima's Health Network Relations Department shall monitor a Health Network, CCN Primary Hospital, and Primary Physician Group enrollment for compliance with the minimum and maximum enrollments set forth in this policy.
2. If a Health Network fails to maintain an average enrollment over three (3) consecutive months of at least five-thousand (5,000) Members after the initial thirty-six (36) months, of the initial Member enrollment:

- a. CalOptima's Health Network Relations Department shall notify the CalOptima's Compliance Committee; and
 - b. Upon approval from CalOptima's Compliance Committee, CalOptima's Regulatory Affairs & Compliance Department will review the Health Network's non-compliance and issue a notice in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.
3. If a Health Network, CCN, Primary Hospital, or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months:
- a. CalOptima's Health Network Relations Department shall notify CalOptima's Compliance Committee;
 - b. Upon approval from CalOptima's Compliance Committee, CalOptima's Network Management Department shall notify the Health Network, CCN, Primary Hospital, or Primary Physician Group that such Health Network, CCN, Primary Hospital, or Primary Physician Group is not eligible to contract with CalOptima for any other Health Network;
 - c. Upon approval from CalOptima's Compliance Committee, and except as provided in Section II.B.3.c. of this policy, CalOptima shall cease Member auto-assignment to the Health Network and shall make appropriate adjustments to the auto-assignment allocation as set forth in CalOptima Policy AA.1207a: CalOptima Auto Assignment; and
 - d. CalOptima's Health Network Relations Department shall notify the Health Network, Primary Hospital, Primary Physician Group, or CCN of the enrollment limit.
4. If Member enrollment in a Health Network, CCN, Primary Hospital, or Primary Physician Group falls below the maximum enrollment limit for three (3) consecutive months, CalOptima shall reinstate Member auto assignment to the Health Network.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

- A. CalOptima Contract for Health Care Services
- B. CalOptima Policy AA.1207a: CalOptima Auto Assignment
- C. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
- D. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
- E. CalOptima Policy HH.1104: Complaints of Discrimination
- F. CalOptima Policy HH.2002Δ: Sanctions
- G. CalOptima Policy HH.2005Δ: Corrective Action Plan

VI. REGULATORY AGENCY APPROVALS

- A. 03/29/16: Department of Health Care Services
- B. 01/23/15: Department of Health Care Services

VII. BOARD ACTIONS

- A. 08/04/16: Regular Meeting of the CalOptima Board of Directors
- B. 03/06/14: Regular Meeting of the CalOptima Board of Directors
- C. 08/30/06: Regular Meeting of the CalOptima Board of Directors
- D. 05/07/02: Regular Meeting of the CalOptima Board of Directors
- E. 01/05/99: Regular Meeting of the CalOptima Board of Directors
- F. 03/12/96: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	03/01/1996	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	03/07/1996	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	01/01/2007	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	12/01/2011	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	09/01/2014	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	02/01/2016	EE.1106	Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	08/04/2016	EE.1106	Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	08/01/2017	EE.1106	Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment	Medi-Cal

IX. GLOSSARY

Term	Definition
CalOptima Community Network	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.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: <ol style="list-style-type: none"> 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).
Contracted Provider	A Provider who is obligated by written contract to provide Covered Services to Members on behalf of CalOptima, its contracted Health Networks or Physician Medical Groups.
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.
Family Linked Member	A Member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another Member who is in his or her family and who resides in the same household.
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 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).

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

6. Consider Authorizing Amendment to Medi-Cal Contract with Kaiser Foundation Health Plan, Inc., to Extend Member Enrollment Terms

Contact

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

Recommended Action

Authorize the CEO, with the assistance of Legal Counsel, to amend the contract between Kaiser Foundation Health Plan, Inc. (Kaiser) and CalOptima to continue to provide that new CalOptima Members who are family linked with an existing CalOptima Kaiser Member will be automatically assigned to Kaiser, and new CalOptima Members who had a previous relationship with Kaiser within the last twelve (12) months will be able to choose Kaiser as their CalOptima Health Network.

Background

As part of the transition of the Healthy Families program into Medi-Cal, DHCS, CalOptima and Kaiser negotiated an agreement that provided for the assignment of former Kaiser Members who transition into CalOptima from Kaiser's Healthy Families program to be assigned to Kaiser. The agreement also provided for new members entering through the Affordable Care Act's Medi-Cal expansion that had a previous relationship with Kaiser within the last twelve months or have a family link to an existing CalOptima Kaiser Member to be assigned to Kaiser when they became CalOptima Members. The agreement also covered an arrangement where Kaiser's rates would be set by DHCS, rather than CalOptima, and that DHCS would provide certain oversight functions. In May 2017, DHCS provided notice that it would no longer participate in the arrangement, effectively ending the underpinnings of the special terms in the agreement between Kaiser and CalOptima. However, because the arrangements regarding the assignment of Members who have had a previous relationship with Kaiser has been working well for CalOptima, Kaiser and the Members, who can always choose another Health Network if they are dissatisfied with Kaiser, both Kaiser and staff believe that the arrangement should continue.

Discussion

The previous arrangement was memorialized by incorporating the two-way Continuity of Care Agreement into the CalOptima-Kaiser Contract for Health Care Services. Because significant portions of that attached contract are no longer valid, staff is recommending that the contract be amended to remove that attachment, along with the attached non-binding three-way agreement between DHCS, CalOptima and Kaiser, and to incorporate a version of the assignment system for former Kaiser members who become CalOptima members into the Contract for Health Care Services directly. This contract change is necessary to preserve the existing ability of new CalOptima Members who are former Kaiser members to be Kaiser members through CalOptima despite the fact that Kaiser's provider panel remains otherwise closed to new CalOptima Members and will preserve the practice of automatically assigning new Members who are family-linked to an existing CalOptima Kaiser Member to Kaiser.

Fiscal Impact

The recommended action to amend the contract between Kaiser and CalOptima to include the enrollment provisions for new CalOptima Members who were previously Kaiser Members, is anticipated to have no additional fiscal impact.

Rationale for Recommendation

The recommended Board action is intended to ensure that new CalOptima Medi-Cal members with a prior relationship with Kaiser will be able to continue to access these providers.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by this Recommended Board Action
2. Board Action dated March 7, 2013, Authorize and Direct the Chief Executive Officer to Execute Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan (Kaiser)
3. Letter dated May 2, 2017 from Jennifer Kent, Director DHCS, to Dr. Susan Fleischman, Vice President, Medicaid, CHIP and Charitable Care, Kaiser Foundation Health Plan, Inc.

/s/ Michael Schrader
Authorized Signature

8/29/2018
Date

*Attachment to September 6, 2018 Board of Directors Meeting –
Agenda Item 6*

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2013 **Regular Meeting of the CalOptima Board of Directors**

Report Item

VII. C. Authorize and Direct the Chief Executive Officer to Execute Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan (Kaiser)

Contact

Julie Bomgren, Director, Government Affairs, (714) 246-8400

Recommended Actions

1. Authorize and Direct the Chief Executive Officer (CEO) to execute a three-way agreement with the DHCS and Kaiser related to the transition of Healthy Families Program (HFP) children and Medi-Cal beneficiaries who are former Kaiser members or family-linked within the previous 12 months.
2. Authorize and Direct the CEO to execute an agreement with Kaiser related to transitioning certain defined categories of members to Kaiser as described in the two-way agreement.
3. Authorize and direct the CEO to enter into an amendment of the current Medi-Cal agreement with Kaiser consistent with these agreements.

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 1995, CalOptima entered into an agreement with Kaiser to provide health care services under CalOptima's Medi-Cal program. As a Health Network for Medi-Cal, Kaiser currently provides health care services, including pharmacy services to approximately 11,500 CalOptima Medi-Cal members. Along with CalOptima, Kaiser is a health plan in the HFP and serves approximately 13,500 HFP children in Orange County. With the elimination of HFP, and in accordance with the HFP transition implementation plan, children enrolled in Kaiser HFP will transition to CalOptima in Phase 2, anticipated to occur no sooner than April 1, 2013.

Discussion

In June 2012, the Legislature passed Assembly Bill (AB) 1494 which provides for the transition of all HFP subscribers to Medi-Cal.

In June 2012, Kaiser approached the State to consider the development of an agreement whereby Kaiser will retain its HFP members upon their transition into Medi-Cal through a direct contractual relationship with DHCS. As a direct contractual relationship in the existing managed care county delivery systems throughout California is not possible due to state and federal statutes, DHCS, Kaiser and the Medi-Cal managed care plans developed two agreements to address the HFP transition and future Medi-Cal enrollment.

DHCS/Kaiser/Plan Agreement

The first agreement is, by its own terms, a nonbinding agreement, between DHCS, Kaiser and the managed care plans. This template has already been signed by DHCS and Kaiser. It indicates that it sets forth a framework for a seamless transition of care for current Kaiser members in the HFP and Medi-Cal beneficiaries who were Kaiser members or family-linked within the previous twelve months.

The three-way agreement includes the following provisions:

1. DHCS, Kaiser and managed care plans will work to develop a contract template for the subcontract between plans and Kaiser.
2. A centralized oversight and compliance process to include a uniform policies and procedures audit program will be created to oversee Kaiser's obligations under the contract template (it may be necessary for two processes, one for Northern California and one for Southern California). The agreement indicates that this process will be conducted and funded by DHCS unless otherwise agreed to by the parties.
3. A process will be developed to improve the existing and future enrollment processes for Kaiser members including a validation process (of the applicant's eligibility to choose Kaiser).
4. In COHS counties including Orange County, the enrollment process for current/previous Kaiser members will mimic the existing process for all Medi-Cal members. The COHS plans such as CalOptima will assign to Kaiser new Medi-Cal members currently or previously enrolled with Kaiser in the previous twelve months or family-linked in the previous twelve months. This auto assignment to Kaiser is contingent upon COHS plans receiving required and accurate data from Kaiser and federal and state regulators. COHS members will be assigned to Kaiser only upon verification of previous coverage by Kaiser.
5. The agreement does not restrict the ability of Medi-Cal beneficiaries to choose a different provider than Kaiser during or after the beneficiary has been assigned to CalOptima.

Kaiser/Plan Agreement

The second agreement, between Kaiser and the managed care plan, is titled "Care Continuity Agreement" and defines the beneficiaries for whom the managed care plan will ensure transition to Kaiser as: 1) all members of CalOptima currently assigned to Kaiser; 2) individuals who are eligible for Medi-Cal on and after January 1, 2014 under Medi-Cal expansion and who enroll in CalOptima and are assigned to Kaiser; 3) HFP beneficiaries who are Kaiser members on the effective date of the transition; and 4) beneficiaries who are eligible for Medi-Cal or HFP after the effective date of the transition and who were Kaiser members or family-linked within the previous twelve months. This agreement has been signed by Kaiser but does not include aid codes on the attachments.

The two-way agreement includes the following provisions:

1. Kaiser will provide rate development template (RDT) data to managed care plans for inclusion in the plan RDT for the rate setting process.

2. Effective July 1, 2013, for aid codes not directly funded through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), an administrative withhold by the managed care plan will not exceed 2% of the net capitation Medi-Cal amount (the withhold may be based on the plan risk-adjusted equivalent of the net capitation amount). For aid codes directly funded through CHIPRA, there will be no administrative fee withhold.
3. Managed care plan contracts with Kaiser will be amended to include these provisions. However this Agreement indicates that it may be terminated only upon execution of an amendment to the parties, and that the terms of this Agreement will be re-evaluated in five years.
4. Kaiser may enter into a direct contract with DHCS if Kaiser is unable to reach a subcontracting agreement with Plan.

Upon approval by the Board of Directors, CalOptima modified its Medi-Cal auto assignment policy to accommodate the transition of HFP members and to the extent possible, preserve the provider/member and member/health network relationships. For children transitioning from other HFP health plans to Medi-Cal, CalOptima anticipates that DHCS will provide the Medi-Cal health plan a file that will include the incoming health plan code and name for transitioning HFP children. In order to ensure a seamless transition of care for Kaiser members, it will be necessary that CalOptima receive a timely, clean file for processing. Otherwise, CalOptima staff will follow our standard new member auto assignment process.

Fiscal Impact

With Kaiser's current membership, the 2% administrative withhold provision equates to approximately \$250,000 annually which is one-half of the amount regularly included in DHCS capitation rates for administration. However, as an HMO, Kaiser will perform some of the functions that CalOptima would normally be responsible for, which will reduce CalOptima's cost accordingly.

Rationale for Recommendation

These template agreements were negotiated with DHCS, Kaiser and managed care plans and the provisions for transitioning HFP members are consistent with the requirements included in the recent amendment to CalOptima's Primary Agreement with DHCS related to the transition of HFP subscribers into Medi-Cal.

Concurrence

Michael H. Ewing, Chief Financial Officer
Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

3/1/2013
Date



JENNIFER KENT
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

May 2, 2017

SENT VIA ELECTRONIC MAIL

Dr. Susan Fleischman
Vice President, Medicaid, CHIP, and Charitable Care
Kaiser Foundation Health Plan, Inc.
3100 Thornton Avenue
Burbank, CA 91504

Dear Dr. Fleischman,

In 2013, the Department of Health Care Services (DHCS) negotiated with Kaiser Foundation Health Plan, Incorporated (Kaiser) and other health plans to enter into 3-way Agreements to transition the Healthy Families Program (HFP) population into Medi-Cal managed care. The HFP transition was completed in 2014.

As of April 2015, DHCS fulfilled the terms of its obligations under the 3-way Agreements, including the:

- 1) Development of a model contract template.
 - DHCS developed and approved these contracts in January 2013.
- 2) Creation of a centralized oversight and compliance process utilized by DHCS.
 - In December 2014, DHCS established the Managed Care Quality and Monitoring Division as the centralized oversight process for Medi-Cal managed care.
- 3) Development of a process to improve enrollment for members and beneficiaries.
 - In January 2014, DHCS approved a continuity of care process, through DHCS' Health Care Options program to improve the enrollment process.
- 4) Development of an enrollment process in County Organized Health System (COHS) counties to match existing processes for all Medi-Cal members.
 - In April 2015, DHCS approved changes to this enrollment process by allowing eligible members to enroll with Kaiser who have family and/or prior enrollment linkage.

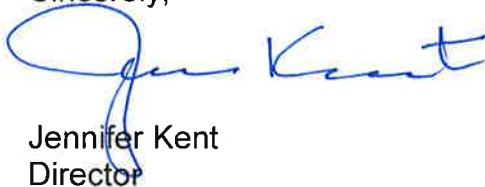
Based on the implementation activities above, DHCS has met its obligations under the original 3-way Agreements. With the HFP population now fully transitioned into the Medi-Cal program for several years, DHCS does not intend to continue to participate in these agreements. Health plans may, at their own discretion and subject to negotiations between the contracting parties, continue to contract with each other to provide services to the populations that were transitioned under the 3-way Agreements as well as any

Dr. Susan Fleischman
Page 2
May 2, 2017

new populations that are mutually agreed upon. Any current or future agreements between plans and its subcontracting plans must address appropriate clinical and data oversight activities.

Should you have any questions regarding this letter, please contact your Contract Manager.

Sincerely,



Jennifer Kent
Director

cc: Sarah Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Care Services, MS 4050

Javier Portela, Division Chief
Managed Care Operations Division
Department of Health Care Services, MS 4409

Nathan Nau, Division Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services, MS 4400

Michelle Retke, Chief
Managed Care Systems & Support Branch
Managed Care Operations Division,
Department of Health Care Services, MS 4409

Sergio Lopez, Chief
Operations Section
Managed Care Operations Division
Department of Health Care Services, MS 4409

cc: Continued on next page

Gwendolyn Leake-Isaacs
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Alameda, CA 94502

Michael Schrader, CEO
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Orange, CA 92868

Gregory Hund, CEO
Cal Viva
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Fresno, CA 93711

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Contra Costa Health Plan
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Martinez, CA 94553

Dale Villani, CEO
Gold Coast Health Plan
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Douglas Hayward, CEO
Kern Health Systems
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Bakersfield, CA 93311

John Baackes, CEO
L.A. Care Health Plan
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017

John Grgurina Jr., CEO
San Francisco Health Plan
50 Beale Street, 12th Floor
San Francisco, CA 94105

Christine Tomcala, CEO
Santa Clara Family Health Plan
210 East Hacienda Avenue
Campbell, CA 95008

Nathaniel Oubre, Vice President
KP Cal, LLC (NorCal)
1800 Harrison Street
Oakland, CA 94612

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

7. Consider Ratification of Overpayments to Health Networks Related to the Medi-Cal Component of the OneCare Connect Rates

Contact

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

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

Recommended Actions

1. Ratify overpayments to health networks related to the Medi-Cal component of the OneCare Connect rates for the period of July 1, 2015 through January 31, 2018, in an amount not to exceed \$385,000; and
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose.

Background

As a County Organized Health System (COHS), CalOptima contracts with the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) to provide health care services to Cal MediConnect (i.e., OneCare Connect) beneficiaries in Orange County. The Board authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) launched on July 1, 2015, in Orange County. In support of this program, CalOptima contracted with delegated health networks to manage and deliver services assigned members. CalOptima's monthly capitation payments to health networks includes both Medicare and Medi-Cal components. The Medicare component of capitation to health networks is based on a percentage of premium (POP) from CMS. The Medi-Cal component of capitation is based on contracted per member per month (PMPM) rates for different cohorts.

Discussion

Prior to the start of the OCC program, DHCS provided CalOptima with high level information on how to assign members to appropriate cohorts or groups. The cohort logic uses aid codes, clinical conditions and intensity of service utilization in order to group like populations into cohorts. This would then inform CalOptima management on how to calculate health network capitation for the Medi-Cal rate component to ensure that capitation rates are sufficient for the health networks to reimburse providers for expenses incurred in providing care to members. As with all new program implementation, there was a level of uncertainty as to the accuracy of the initial cohort logic and the reliability of data sources.

In May 2018, DHCS performed the first full reconciliation for dates of services in 2016. During this reconciliation with DHCS, CalOptima was given additional information on certain data fields included in the cohort logic. This additional information necessitated that staff update the cohort logic to improve the assignment of members to specific groups.

[Back to Agenda](#)

Based on this information, CalOptima updated the logic in FACETS, CalOptima's core claims system, in July 2018, and identified that certain overpayments had been made. Pursuant to CalOptima Policy CMC.3001: Payment Arrangements to Health Networks – Capitation Payments, CalOptima made retroactive recoupments for the period of February 2018 through June 2018 in the July capitation payment to health networks and recovered approximately \$62,000.

In addition to these recoupments for the February 2018 through June 2018 period, Staff estimates the total remaining unrecouped overpayment to health networks based on the logic updates and related to the Medi-Cal component for OCC from the program's July 1, 2015 start date through January 31, 2018, is approximately \$385,000.

For Fiscal Year (FY) 2015-16 through FY 2017-18, CalOptima paid \$292.5 million in total capitation expenses for the OCC program. \$385,000 represents 0.13% of the total capitation paid during this time period. As such, Management recommends ratification of overpayments to health networks, in an amount not to exceed \$385,000.

Fiscal Impact

The recommended action to ratify overpayments to health networks related to the Medi-Cal component of the OCC rates for the period of July 1, 2015 through January 31, 2018, will not change CalOptima's net assets from prior years. However, if the overpayments were recouped, the recoupment would be reflected in the current year's operating results. The ratification is not projected to impact CalOptima's FY 2018-19 Operating Budget, approved by the Board on June 7, 2018, as the budget assumed capitation expenses based on the updated member cohort logic.

Rationale for Recommendation

Management recommends approval of the recommended actions in order to maintain and continue strong relationships with health networks.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

8/29/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Adoption of Resolution Approving and Adopting Updated Human Resources Policies

Contact

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

Recommended Action

Adopt Resolution approving and adopting new Human Resource Policy GA.8059: Attendance and Timekeeping, and updates to Human Resources Policies: GA.8027: Unlawful Harassment; GA.8051: Hiring of Relatives; and GA.8058: Salary Schedule.

Background/Discussion

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

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

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

	Policy No./Name	Summary of Changes	Reason for Change
1.	GA.8027: Unlawful Harassment	<ul style="list-style-type: none">Revised verbiage and definitions to include additional terms and clarification consistent with updates to California regulations.Changed disciplinary action reference to corrective action due to CalOptima's recent policy change.	<ul style="list-style-type: none">- Revised to align with updates to DFEH regulations.- Aligned to reflect changes to Policy GA.8022 Performance and Behavior Standards.
2.	GA.8051: Hiring of Relatives	<ul style="list-style-type: none">Clarification processes related to relationships established after employees' employment with CalOptima.	<ul style="list-style-type: none">- Verified Government Code section 12920 as referenced since last policy update (12/1/16).

			- Ensure policy aligns with current operations.
3.	GA.8058: Salary Schedule	<ul style="list-style-type: none"> This policy focuses solely on CalOptima’s Salary Schedule and requirements under CalPERS regulations. Attachment 1 – Salary Schedule has been revised in order to reflect recent changes, including the addition of new positions. A summary of the changes to the Salary Schedule is included for reference. 	<ul style="list-style-type: none"> Pursuant to CalPERS requirement, 2 CCR §570.5 CalOptima periodically updates the salary schedule to reflect current job titles and pay rates for each job position. New Position: Creation of a new Job Title typically due to a change in the scope of a current position or the addition of a new level in a job family. (2 positions) Remove Position: Elimination of a Job Title typically due to a change in the scope of a current position or the elimination of a position in a job family. (1 position)

The following table lists the proposed new Human Resources Policy that has been developed and is being presented for review and approval:

	Policy No./Name	Summary of Policy	Purpose of Policy
1.	GA.8059: Attendance and Timekeeping	<ul style="list-style-type: none"> The Policy establishes standards for attendance and timekeeping for both non-exempt and exempt employees. Clarifies expectations for work schedules, and meal and rest breaks. Timekeeping requirements and procedures are outlined for non-exempt (hourly) staff as well as expectations of exempt staff time and attendance. Scheduled, unscheduled, authorized and unauthorized absences are described along with definitions of excessive absences, tardiness, leave early and missed clocking. 	- To establish guidelines and procedures for attendance and timekeeping to reflect current requirements and align to new processes.

		<ul style="list-style-type: none"> • Establishes types of occurrences that may lead to corrective action. • Guidelines for corrective action are included and align with Policy GA.8022: Performance and Behavior Standards. • Requirements generally reflect current requirements established in CalOptima’s Employee Handbook, along with applicable Human Resources Policies. • New requirements, not otherwise addressed in other policies, include: <ul style="list-style-type: none"> • Processes and procedures applicable to recent enhancements to CalOptima’s electronic timekeeping system. • Establishing guidelines with respect to commute time for non-exempt teleworkers who are required to come to the central worksite from time to time. • Guidelines for employees to reflect principles of public accountability in work hours and timekeeping practices. 	
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Fiscal Impact

The recommended action to add a two (2) new job titles, Supervisor Nursing Services (PACE) and Executive Administrative Services Manager, and eliminate the job title, Executive Assistant to CEO, are budgeted items under the Fiscal Year 2018-19 Operating Budget and has no additional fiscal impact. The new policy and updates to existing policies are not anticipated to have an additional fiscal impact.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 18-0906, Approve Revised CalOptima Human Resources Policies
2. Revised CalOptima Policies:
 - a. GA.8027: Unlawful Harassment (redlined and clean copies)
 - b. GA.8051: Hiring of Relatives (redlined and clean copies)
 - c. GA.8058: Salary Schedule (redlined and clean copies) with revised Attachment A

3. Summary of Changes to Salary Schedule
4. New CalOptima Policy:
 - a. GA.8059: Attendance and Timekeeping

/s/ Michael Schrader
Authorized Signature

8/29/2018
Date

RESOLUTION NO. 18-0906

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

APPROVE NEW AND UPDATED HUMAN RESOURCES POLICIES

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached new Human Resources Policy GA.8059: Attendance and Timekeeping and updated Human Resources Policies: GA.8027: Unlawful Harassment; GA.8051: Hiring of Relatives; and GA.8058: Salary Schedule.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 6th day of September 2018.

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

Policy #: GA.8027
 Title: **Unlawful Harassment**
 Department: Human Resources
 Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/05/12

Last Review Date: ~~11/03/16~~

09/06/18

Last Revised Date: ~~11/03/16~~

09/06/18

Board Approved Policy

1 **I. PURPOSE**

2
 3 This policy outlines CalOptima’s zero tolerance for harassment, discrimination, and retaliation
 4 (collectively referred herein as “unlawful harassment”).
 5

6 **II. POLICY**

7
 8 A. CalOptima is committed to providing a work environment that is free of harassment, discrimination,
 9 and retaliation. Harassment and/or discrimination based on race, ~~sex~~Sex, Sex Stereotype, gender,
 10 Gender Identity, Gender Expression, Transitioning status, age, color, ~~national origin~~National Origin,
 11 immigration status, ancestry, mental or physical disability, sexual orientation, religion, religious
 12 creed, exercise of rights under Family and Medical Leave Act (FMLA), marital status, military and
 13 veteran status, medical condition, genetic information, or any other protected characteristic is a
 14 violation of state and federal law and is strictly prohibited by CalOptima. Any person who commits
 15 such a violation may be subject to personal liability as well as ~~disciplinary~~corrective action up to
 16 and including termination of employment.
 17

18 B. This policy applies to all of CalOptima’s agents, persons providing services pursuant to a contract,
 19 volunteers, unpaid interns, temporary employees, and employees, including supervisors and non-
 20 supervisory employees, and to non-employees who engage in unlawful harassment in the
 21 workplace.
 22

23 C. Prohibited harassment includes verbal, physical, and/or visually perceived conduct in any form that
 24 is based on a protected characteristic and which creates an intimidating, offensive, or hostile work
 25 environment (must be severe or pervasive) or that interferes with work performance. Such conduct
 26 constitutes harassment when:
 27

- 28 1. Submission to the conduct is made either an explicit, or implicit, condition of employment;
- 29 2. Submission to or rejection of the conduct is used as the basis for an employment decision; or
- 30 3. The harassment unreasonably interferes with an employee's work performance or creates an
- 31 intimidating, hostile, or offensive work environment.
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35 D. Prohibited unlawful harassment includes, but is not limited to, the following behaviors:
 36

1. Verbal conduct such as epithets, stereotypes based on protected ~~class~~characteristic-, derogatory or sexual jokes or comments, slurs or unwanted sexual advances, invitations, or comments;
 2. Visual displays, such as derogatory and/or sexually-oriented posters, photography, cartoons, drawings, or gestures;
 3. Physical conduct including assault, unwanted touching, intentionally blocking normal movement, or interfering with work because of sex, race, or any other protected ~~basis~~characteristic-; and/or
 4. Threats and demands to submit to sexual requests as a condition of continued employment, or to avoid some other loss and offers of employment benefits in return for sexual favors.
- E. CalOptima encourages reporting of all perceived or actual incidents of discrimination or harassment. An employee, temporary employee, volunteer, or unpaid intern who believes he or she is being, or has been, harassed or discriminated against based on a protected characteristic in any way, should report the facts of the incident or incidents immediately to his or her supervisor, manager, or, if he or she prefers, to the Human Resources (HR) Department. Supervisors and managers must report the incidents, or claims, immediately to the HR Department. A HR representative, or its designee, shall investigate any and all complaints of unlawful harassment based on a protected classcharacteristic and take appropriate preventive and/or corrective action, ~~including disciplinary action~~, when it is warranted. Reported complaints of unlawful harassment based on protected classcharacteristic will be investigated fairly, thoroughly, promptly, and in a confidential manner to the extent possible, involving only the parties who have a need to know. If a complaint is not resolved to the employee's or complainant's satisfaction, the employee or complainant may submit a request for review of the complaint via email to CalOptima's Executive Director of Human Resources.
- F. CalOptima will not tolerate retaliation against an employee, temporary employee, volunteer, unpaid intern, or persons providing services pursuant to a contract for reporting harassment and/or discrimination, for cooperating in an investigation, for making compliance complaints, or for engaging in similar protected activity-. Employees, temporary employees, volunteers, unpaid interns, or persons providing services pursuant to a contract engaging in any actions which are retaliatory against another employee, temporary employee, volunteer, unpaid intern, or persons providing services pursuant to a contract will be subjected to disciplinary action, up to and including termination of employment or contract.
- G. CalOptima encourages all employees, temporary employees, volunteers, and unpaid interns to report any incidents of harassment prohibited by this policy immediately so that complaints can be quickly and fairly resolved. Employees, temporary employees, volunteers, and unpaid interns should be aware that the Federal Equal Employment Opportunity Commission and the California Department of Fair Employment and Housing investigate and prosecute complaints of prohibited harassment in employment. If an individual believes that CalOptima has failed to adequately address a complaint of harassment, that person may file a complaint with one of these agencies.

III. PROCEDURE

Responsible Party	Action
Employee	Report the facts of any incident(s) of harassment or discrimination based on a protected class characteristic -or retaliation based on a protected activity immediately to your supervisor, manager, or, if you prefer, the HR Department.
Supervisor	<ul style="list-style-type: none"> ▪ <u> </u> Gather all relevant facts from reporting employee and report it immediately to the HR Department.
Human Resources	<ul style="list-style-type: none"> ▪ Disseminate the Unlawful Harassment Policy to all employees, temporary employees, volunteers and unpaid interns and require all employees, temporary employees, volunteers, and unpaid interns to acknowledge electronically that each individual has received and understood the Policy. ▪ Upon receipt of a complaint, gather sufficient facts to evaluate and determine what level of investigation is needed and appropriate for the circumstances. ▪ If a determination is made that no further investigation is required, document the decision and the reasoning and inform the complainant of the decision. ▪ Complete an impartial and timely investigation of the complaint, document and track the investigation, take appropriate preventive and/or corrective action, including disciplinary action, when it is warranted, and inform the complainant and/or offender of the decision. Every reported complaint of unlawful harassment based on a protected classcharacteristic will be investigated thoroughly, promptly, and in a confidential manner to the extent possible. HR will strive to maintain confidentiality during the investigation, but there is no guarantee of complete confidentiality. Only the parties who need to know will be involved.

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IV. ATTACHMENTS

Not Applicable

V. REFERENCES

- A. California Government Code, §§12926, 12935 and 12940 *et seq.*
- B. CalOptima Employee Handbook
- C. Title 2, California Code of Regulations (C.C.R.), ~~§§§~~11008 *et seq.*, 11027.1(a) and (b), and 11030(a)-(f)
- D. Title VII of the Civil Rights Act of 1964 (42, U.S.C., 2000e *et seq.*)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

- A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
- ~~A.~~B. 11/03/16: Regular Meeting of the CalOptima Board of Directors

- 1 ~~B.C.~~ 05/01/14: Regular Meeting of the CalOptima Board of Directors
- 2 ~~C.D.~~ 01/05/12: Regular Meeting of the CalOptima Board of Directors
- 3

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Policy #: GA.8027
Title: Unlawful Harassment

Revised Date: ~~11/03/16~~09/06
/18

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VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8027	Unlawful Harassment	Administrative
Revised	04/01/2014	GA.8027	Unlawful Harassment	Administrative
Revised	11/03/2016	GA.8027	Unlawful Harassment	Administrative
<u>Revised</u>	<u>09/06/2018</u>	<u>GA.8027</u>	<u>Unlawful Harassment</u>	<u>Administrative</u>

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IX. GLOSSARY

Term	Definition
Discrimination	Adverse employment action against an employee, volunteer, intern, or individual performing services pursuant to a contract on the basis of a protected class-characteristic- .
Harassment	Unwelcome conduct or comments, based on a protected classcharacteristic- , that are so severe or pervasive as to create an abusive working environment.
Retaliation	Adverse employment action against an employee because he or she filed a complaint or engaged in a protected activity.
Gender Expression	A person's gender-related appearance or behavior, <u>or the perception of such appearance or behavior</u> , whether or not stereotypically associated with the person's sex <u>assigned</u> at birth.
Gender Identity	A <u>Each</u> -person's identification <u>internal understanding of their gender, or the perceptions of a person's gender identity, which may include</u> as male, female, a <u>combination of male and female, neither male nor female</u> , a gender different from the person's sex <u>assigned</u> at birth, or transgender.
<u>National Origin</u>	<u>Includes, but is not limited to, the individual's or ancestors' actual or perceived: (1) physical, cultural, or linguistic characteristics associated with a national origin group; (2) marriage to or association with persons of a national origin group; (3) tribal affiliation; (4) membership in or association with an organization identified with or seeking to promote the interests of a national origin group; (5) attendance or participation in schools, churches, temples, mosques, or other religious institutions generally used by persons of a national origin group; (6) name that is associated with a national origin group; and (7) the basis of possessing a driver's license granted under Section 12801.9 of the Vehicle code.</u>
<u>National Origin Group</u>	<u>Includes, but is not limited to, ethnic groups, geographic places of origin, and countries that are not presently in existence.</u>
Sex	Includes the same definition as provided in Government Code section 12926 and Title 42 of the United States Code section 2000 e(k), which includes, but is not limited to, pregnancy, childbirth; breastfeeding, medical conditions related to pregnancy, childbirth, or breastfeeding, gender, <u>gender</u> identity, and gender expression, <u>or a perception by a third party of any of the aforementioned.</u>
Sex Stereotype	A <u>Includes, but is not limited to, an</u> assumption about a person's appearance or behavior, <u>gender roles, gender expression, or gender identity</u> , or about an individual's ability or inability to perform certain kinds of work based on a myth, social expectation, or generalization about the individual's sex.
Transgender	A general term that refers to a person whose gender identity differs from the person's sex <u>assigned</u> at birth. A transgender person may or may not have a gender expression that is different from the social expectations of the sex assigned at birth. A transgender person may or may not identify as "transsexual."

Term	Definition
<u>Transitioning</u>	<u>A process some transgender people go through to begin living as the gender with which they identify, rather than the sex assigned to them at birth. This process may include, but is not limited to, changes in name and pronoun usage, facility usage, participation in employer-sponsored activities (e.g., sports teams, team-building projects, or volunteering), or undergoing hormone therapy, surgeries, or other medical procedures.</u>

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DRAFT

Policy #: GA.8027
Title: **Unlawful Harassment**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/05/12
Last Review Date: 09/06/18
Last Revised Date: 09/06/18

1 **I. PURPOSE**

2
3 This policy outlines CalOptima’s zero tolerance for harassment, discrimination, and retaliation
4 (collectively referred herein as “unlawful harassment”).
5

6 **II. POLICY**

7
8 A. CalOptima is committed to providing a work environment that is free of harassment, discrimination,
9 and retaliation. Harassment and/or discrimination based on race, Sex, Sex Stereotype, gender,
10 Gender Identity, Gender Expression, Transitioning status, age, color, National Origin, immigration
11 status, ancestry, mental or physical disability, sexual orientation, religion, religious creed, exercise
12 of rights under Family and Medical Leave Act (FMLA), marital status, military and veteran status,
13 medical condition, genetic information, or any other protected characteristic is a violation of state
14 and federal law and is strictly prohibited by CalOptima. Any person who commits such a violation
15 may be subject to personal liability as well as corrective action up to and including termination of
16 employment.
17

18 B. This policy applies to all of CalOptima’s agents, persons providing services pursuant to a contract,
19 volunteers, unpaid interns, temporary employees, and employees, including supervisors and non-
20 supervisory employees, and to non-employees who engage in unlawful harassment in the
21 workplace.
22

23 C. Prohibited harassment includes verbal, physical, and/or visually perceived conduct in any form that
24 is based on a protected characteristic and which creates an intimidating, offensive, or hostile work
25 environment (must be severe or pervasive) or that interferes with work performance. Such conduct
26 constitutes harassment when:
27

- 28 1. Submission to the conduct is made either an explicit, or implicit, condition of employment;
- 29 2. Submission to or rejection of the conduct is used as the basis for an employment decision; or
- 30 3. The harassment unreasonably interferes with an employee's work performance or creates an
31 intimidating, hostile, or offensive work environment.

32 D. Prohibited unlawful harassment includes, but is not limited to, the following behaviors:

- 33 1. Verbal conduct such as epithets, stereotypes based on protected characteristic, derogatory or
34 sexual jokes or comments, slurs or unwanted sexual advances, invitations, or comments;
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- 1 2. Visual displays, such as derogatory and/or sexually-oriented posters, photography, cartoons,
2 drawings, or gestures;
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4 3. Physical conduct including assault, unwanted touching, intentionally blocking normal
5 movement, or interfering with work because of sex, race, or any other protected characteristic;
6 and/or
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8 4. Threats and demands to submit to sexual requests as a condition of continued employment, or to
9 avoid some other loss and offers of employment benefits in return for sexual favors.
10
11 E. CalOptima encourages reporting of all perceived or actual incidents of discrimination or
12 harassment. An employee, temporary employee, volunteer, or unpaid intern who believes he or she
13 is being, or has been, harassed or discriminated against based on a protected characteristic in any
14 way, should report the facts of the incident or incidents immediately to his or her supervisor,
15 manager, or, if he or she prefers, to the Human Resources (HR) Department. Supervisors and
16 managers must report the incidents, or claims, immediately to the HR Department. A HR
17 representative, or its designee, shall investigate any and all complaints of unlawful harassment
18 based on a protected characteristic and take appropriate preventive and/or corrective action, when it
19 is warranted. Reported complaints of unlawful harassment based on protected characteristic will be
20 investigated fairly, thoroughly, promptly, and in a confidential manner to the extent possible,
21 involving only the parties who have a need to know. If a complaint is not resolved to the
22 employee's or complainant's satisfaction, the employee or complainant may submit a request for
23 review of the complaint via email to CalOptima's Executive Director of Human Resources.
24
25 F. CalOptima will not tolerate retaliation against an employee, temporary employee, volunteer, unpaid
26 intern, or persons providing services pursuant to a contract for reporting harassment and/or
27 discrimination, for cooperating in an investigation, for making compliance complaints, or for
28 engaging in similar protected activity. Employees, temporary employees, volunteers, unpaid
29 interns, or persons providing services pursuant to a contract engaging in any actions which are
30 retaliatory against another employee, temporary employee, volunteer, unpaid intern, or persons
31 providing services pursuant to a contract will be subjected to disciplinary action, up to and including
32 termination of employment or contract.
33
34 G. CalOptima encourages all employees, temporary employees, volunteers, and unpaid interns to
35 report any incidents of harassment prohibited by this policy immediately so that complaints can be
36 quickly and fairly resolved. Employees, temporary employees, volunteers, and unpaid interns
37 should be aware that the Federal Equal Employment Opportunity Commission and the California
38 Department of Fair Employment and Housing investigate and prosecute complaints of prohibited
39 harassment in employment. If an individual believes that CalOptima has failed to adequately
40 address a complaint of harassment, that person may file a complaint with one of these agencies.

41
42 **III. PROCEDURE**
43

Responsible Party	Action
Employee	Report the facts of any incident(s) of harassment or discrimination based on a protected characteristic or retaliation based on a protected activity immediately to your supervisor, manager, or, if you prefer, the HR Department.

Responsible Party	Action
Supervisor	<ul style="list-style-type: none"> ▪ Gather all relevant facts from reporting employee and report it immediately to the HR Department.
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IV. ATTACHMENTS

Not Applicable

V. REFERENCES

- A. California Government Code, §§12926, 12935 and 12940 *et seq.*
- B. CalOptima Employee Handbook
- C. Title 2, California Code of Regulations (C.C.R.), §§11008 *et seq.*, 11027.1(a) and (b), and 11030(a)-(f)
- D. Title VII of the Civil Rights Act of 1964 (42, U.S.C., 2000e *et seq.*)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

- A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
- B. 11/03/16: Regular Meeting of the CalOptima Board of Directors
- C. 05/01/14: Regular Meeting of the CalOptima Board of Directors
- D. 01/05/12: Regular Meeting of the CalOptima Board of Directors

1 **VIII. REVIEW/REVISION HISTORY**
2

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8027	Unlawful Harassment	Administrative
Revised	04/01/2014	GA.8027	Unlawful Harassment	Administrative
Revised	11/03/2016	GA.8027	Unlawful Harassment	Administrative
Revised	09/06/2018	GA.8027	Unlawful Harassment	Administrative

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IX. GLOSSARY

Term	Definition
Discrimination	Adverse employment action against an employee, volunteer, intern, or individual performing services pursuant to a contract on the basis of a protected characteristic.
Harassment	Unwelcome conduct or comments, based on a protected characteristic, that are so severe or pervasive as to create an abusive working environment. .
Retaliation	Adverse employment action against an employee because he or she filed a complaint or engaged in a protected activity.
Gender Expression	A person's gender-related appearance or behavior, or the perception of such appearance or behavior, whether or not stereotypically associated with the person's sex assigned at birth.
Gender Identity	Each person's internal understanding of their gender, or the perceptions of a person's gender identity, which may include as male, female, a combination of male and female, neither male nor female, a gender different from the person's sex assigned at birth, or transgender.
National Origin	Includes, but is not limited to, the individual's or ancestors' actual or perceived: (1) physical, cultural, or linguistic characteristics associated with a national origin group; (2) marriage to or association with persons of a national origin group; (3) tribal affiliation; (4) membership in or association with an organization identified with or seeking to promote the interests of a national origin group; (5) attendance or participation in schools, churches, temples, mosques, or other religious institutions generally used by persons of a national origin group; (6) name that is associated with a national origin group; and (7) the basis of possessing a driver's license granted under Section 12801.9 of the Vehicle code.
National Origin Group	Includes, but is not limited to, ethnic groups, geographic places of origin, and countries that are not presently in existence.
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Sex Stereotype	Includes, but is not limited to, an assumption about a person's appearance or behavior, gender roles, gender expression, or gender identity, or about an individual's ability or inability to perform certain kinds of work based on a myth, social expectation, or generalization about the individual's sex.
Transgender	A general term that refers to a person whose gender identity differs from the person's sex assigned at birth. A transgender person may or may not have a gender expression that is different from the social expectations of the sex assigned at birth. A transgender person may or may not identify as "transsexual."

Term	Definition
Transitioning	A process some transgender people go through to begin living as the gender with which they identify, rather than the sex assigned to them at birth. This process may include, but is not limited to, changes in name and pronoun usage, facility usage, participation in employer-sponsored activities (<i>e.g.</i> , sports teams, team-building projects, or volunteering), or undergoing hormone therapy, surgeries, or other medical procedures.

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Policy #: GA.8051
Title: **Hiring of Relatives**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 02/01/14
Last Revised Date: ~~09/06/18+~~
~~2/01/16~~
Last Review Date: ~~09/06/18+~~
~~2/01/16~~

Board Approved Policy

1 **I. PURPOSE**

2
3 This policy outlines CalOptima’s guidelines for hiring of relatives.

4
5 **II. POLICY**

6
7 A. CalOptima shall not discriminate in its employment and personnel actions with respect to its
8 employees and applicants on the basis of marital, or family, status. Notwithstanding this policy,
9 CalOptima retains the right to refuse to appoint a person to a position in the same department or
10 division, wherein his or her relationship to another employee has the potential for creating serious
11 conflicts, or an adverse impact on supervision, safety, security, or employee morale.

12
13 **III. PROCEDURE**

14
15 A. CalOptima shall consider the hiring of relatives, or non-relatives of the same residence (housemate),
16 only if (1) the applicant will not be working directly for, or directly supervising, an existing
17 employee, or (2) a determination can be made by the department head, with concurrence by the
18 Human Resources Director, that a potential for adverse impact on supervision, safety, security, or
19 employee morale does not exist. Supervising means having authority in the interest of CalOptima
20 to hire, transfer, suspend, layoff, recall, promote, discharge, assign, reward, or discipline other
21 employees, or responsibility to direct them.

22
23 B. If the relationship is established after the ~~employee’s~~employees’ employment with CalOptima, ~~it~~
24 has commenced (e.g., two (2) existing employees marry, or become housemates, ~~or relatives~~), and a
25 determination has been made that the potential for adverse impact does exist, the department head in
26 conjunction with the Human Resources Director, shall make reasonable efforts to minimize
27 problems of supervision, ~~or~~ safety, security, or morale, through reassignment of duties, relocation,
28 or transfer to another position for which ~~he or she~~one (1) of the employees is qualified, if such
29 position is available. ~~If no reassignment or transfer is practical, CalOptima is unable will~~
30 terminate one (1) of the employees from employment. The decision as to make an acceptable
31 accommodation, then the which employee will be reassigned, transferred, or terminated will be at
32 the discretion of CalOptima with consideration of CalOptima’s business needs. In certain
33 situations, and his or her relative and/or housemate shall be given at CalOptima’s sole discretion,
34 CalOptima may provide the employees with an opportunity to decide which ~~person~~employee shall
35 be reassigned, transferred, ~~if possible,~~ or terminated from employment. If the employees do not
36 make a decision within thirty (30) business days, CalOptima shall automatically reassign or transfer
37 one (1) of the employees, if ~~possible~~practical, or terminate one (1) of the employees from

1 employment. ~~The decision as to which employee will leave will be at the discretion of CalOptima~~
2 ~~with consideration of CalOptima's business needs.~~

- 3
4 C. This policy applies to individuals who are related by birth, marriage, domestic partner status, or
5 legal guardianship including, but not limited to, the following relationships: spouse, child, step-
6 children, parent, step-parent, grandparent, grandchild, brother, sister, half-brother, half-sister, aunt,
7 uncle, niece, nephew, parent-in-law, daughter-in-law, son-in-law, brother-in-law, and sister-in-law
8 (collectively, "relatives"). In implementing this policy, an applicant may be asked to state whether
9 he or she has a relative, or housemate, presently employed by CalOptima, but such information may
10 not be used as a basis for an employment decision except as stated herein.

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12 **IV. ATTACHMENTS**

13 Not Applicable

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16 **V. REFERENCES**

- 17
18 A. CalOptima Employee Handbook
19 B. CalOptima Policy GA.8000: Glossary of Terms
20 C. Government Code, §12920 *et seq.*

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22 **VI. REGULATORY AGENCY APPROVALS**

23 None to Date

24
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26 **VII. BOARD ACTIONS**

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28 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors

29 ~~A.B.~~ 12/01/16: Regular Meeting of the CalOptima Board of Directors

30 ~~B.C.~~ 05/01/14: Regular Meeting of the CalOptima Board of Directors

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32 **VIII. REVIEW/REVISION HISTORY**

33

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/2014	GA.8051	Hiring of Relatives	Administrative
Revised	12/01/2016	GA.8051	Hiring of Relatives	Administrative
<u>Revised</u>	<u>09/06/2018</u>	<u>GA.8051</u>	<u>Hiring of Relatives</u>	<u>Administrative</u>

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IX. GLOSSARY

Not Applicable

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Policy #: GA.8051
Title: **Hiring of Relatives**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 02/01/14
Last Revised Date: 09/06/18
Last Review Date: 09/06/18

1 **I. PURPOSE**

2
3 This policy outlines CalOptima’s guidelines for hiring of relatives.

4
5 **II. POLICY**

6
7 A. CalOptima shall not discriminate in its employment and personnel actions with respect to its
8 employees and applicants on the basis of marital, or family, status. Notwithstanding this policy,
9 CalOptima retains the right to refuse to appoint a person to a position in the same department or
10 division, wherein his or her relationship to another employee has the potential for creating serious
11 conflicts, or an adverse impact on supervision, safety, security, or employee morale.

12
13 **III. PROCEDURE**

14
15 A. CalOptima shall consider the hiring of relatives, or non-relatives of the same residence (housemate),
16 only if (1) the applicant will not be working directly for, or directly supervising, an existing
17 employee, or (2) a determination can be made by the department head, with concurrence by the
18 Human Resources Director, that a potential for adverse impact on supervision, safety, security, or
19 employee morale does not exist. Supervising means having authority in the interest of CalOptima
20 to hire, transfer, suspend, layoff, recall, promote, discharge, assign, reward, or discipline other
21 employees, or responsibility to direct them.

22
23 B. If the relationship is established after the employees’ employment with CalOptima has commenced
24 (*e.g.*, two (2) existing employees marry, or become housemates or relatives), and a determination
25 has been made that the potential for adverse impact does exist, the department head in conjunction
26 with the Human Resources Director, shall make reasonable efforts to minimize problems of
27 supervision, safety, security, or morale, through reassignment of duties, relocation, or transfer to
28 another position for which one (1) of the employees is qualified, if such position is available. If no
29 reassignment or transfer is practical, CalOptima will terminate one (1) of the employees from
30 employment. The decision as to which employee will be reassigned, transferred, or terminated will
31 be at the discretion of CalOptima with consideration of CalOptima’s business needs. In certain
32 situations, and at CalOptima’s sole discretion, CalOptima may provide the employees with an
33 opportunity to decide which employee shall be reassigned, transferred, or terminated from
34 employment. If the employees do not make a decision within thirty (30) business days, CalOptima
35 shall automatically reassign or transfer one (1) of the employees, if practical, or terminate one (1) of
36 the employees from employment.

37
38 C. This policy applies to individuals who are related by birth, marriage, domestic partner status, or
39 legal guardianship including, but not limited to, the following relationships: spouse, child, step-

1 children, parent, step-parent, grandparent, grandchild, brother, sister, half-brother, half-sister, aunt,
2 uncle, niece, nephew, parent-in-law, daughter-in-law, son-in-law, brother-in-law, and sister-in-law
3 (collectively, “relatives”). In implementing this policy, an applicant may be asked to state whether
4 he or she has a relative, or housemate, presently employed by CalOptima, but such information may
5 not be used as a basis for an employment decision except as stated herein.
6

7 **IV. ATTACHMENTS**

8
9 Not Applicable

10
11 **V. REFERENCES**

- 12
13 A. CalOptima Employee Handbook
14 B. CalOptima Policy GA.8000: Glossary of Terms
15 C. Government Code, §12920 *et seq.*
16

17 **VI. REGULATORY AGENCY APPROVALS**

18
19 None to Date
20

21 **VII. BOARD ACTIONS**

- 22
23 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
24 B. 12/01/16: Regular Meeting of the CalOptima Board of Directors
25 C. 05/01/14: Regular Meeting of the CalOptima Board of Directors
26

27 **VIII. REVIEW/REVISION HISTORY**

28

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/2014	GA.8051	Hiring of Relatives	Administrative
Revised	12/01/2016	GA.8051	Hiring of Relatives	Administrative
Revised	09/06/2018	GA.8051	Hiring of Relatives	Administrative

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IX. GLOSSARY

Not Applicable

DRAFT

Policy #: GA.8058
 Title: **Salary Schedule**
 Department: Human Resources
 Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 05/01/14
 Last Review Date: ~~02/01/18~~
 Last Revised Date: 09/06/18
~~02/01/18~~
09/06/18

Board Approved Policy

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I. PURPOSE

- A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).
- B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

- A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:
 - 1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;
 - 2. Identification of position titles for every employee position;
 - 3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;
 - 4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;
 - 5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;
 - 6. Indicates the effective date and date of any revisions;
 - 7. Retained by the employer and available for public inspection for not less than five (5) years; and

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

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

III. PROCEDURE

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

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

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

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

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of 02/01/1809/06/18)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors

~~A.~~B. 02/01/18: Regular Meeting of the CalOptima Board of Directors

~~B.~~C. 11/02/17: Regular Meeting of the CalOptima Board of Directors

~~C.~~D. 09/07/17: Regular Meeting of the CalOptima Board of Directors

~~D.~~E. 08/03/17: Regular Meeting of the CalOptima Board of Directors

~~E.~~F. 06/01/17: Regular Meeting of the CalOptima Board of Directors

~~F.~~G. 05/04/17: Regular Meeting of the CalOptima Board of Directors

~~G.~~H. 03/02/17: Regular Meeting of the CalOptima Board of Directors

~~H.~~I. 12/01/16: Regular Meeting of the CalOptima Board of Directors

~~I.~~J. 11/03/16: Regular Meeting of the CalOptima Board of Directors

~~J.~~K. 10/06/16: Regular Meeting of the CalOptima Board of Directors

~~K.~~L. 09/01/16: Regular Meeting of the CalOptima Board of Directors

~~L.~~M. 08/04/16: Regular Meeting of the CalOptima Board of Directors

Policy #: GA.8058
 Title: Salary Schedule

Revised Date:

02/01/1809/06/18

- M.N. 06/02/16: Regular Meeting of the CalOptima Board of Directors
- N.O. 03/03/16: Regular Meeting of the CalOptima Board of Directors
- O.P. 12/03/15: Regular Meeting of the CalOptima Board of Directors
- P.Q. 10/01/15: Regular Meeting of the CalOptima Board of Directors
- Q.R. 06/04/15: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative

Policy #: GA.8058
Title: Salary Schedule

Revised Date:

~~02/01/18~~09/06/18

- 1 **IX. GLOSSARY**
- 2
- 3 Not Applicable
- 4

Policy #: GA.8058
Title: **Salary Schedule**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 05/01/14
Last Review Date: 09/06/18
Last Revised Date: 09/06/18

1 **I. PURPOSE**

- 2
- 3 A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications
- 4 including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay
- 5 rate amounts).
- 6
- 7 B. This policy ensures the salary schedule is publicly available pursuant to the requirements of
- 8 Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of
- 9 the California Public Employees Retirement System (CalPERS) have their compensation
- 10 considered qualified for pension calculation under CalPERS regulations.

11

12 **II. POLICY**

- 13
- 14 A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5,
- 15 CalOptima has established the attached salary schedule for each CalOptima job position. In order
- 16 for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department
- 17 (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:
- 18
- 19 1. Approval and adoption by the governing body in accordance with requirements
- 20 applicable to public meetings laws;
- 21
- 22 2. Identification of position titles for every employee position;
- 23
- 24 3. Listing of pay rate for each identified position, which may be stated as a single amount
- 25 or as multiple amounts with a range;
- 26
- 27 4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily,
- 28 bi-weekly, monthly, bi-monthly, or annually;
- 29
- 30 5. Posted at the employer's office or immediately accessible and available for public review
- 31 from the employer during normal business hours or posted on the employer's internet
- 32 website;
- 33
- 34 6. Indicates the effective date and date of any revisions;
- 35
- 36 7. Retained by the employer and available for public inspection for not less than five (5) years;
- 37 and
- 38
- 39 8. Does not reference another document in lieu of disclosing the pay rate.

- 1
2 B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper
3 to implement the salary schedule for all other employees not inconsistent therewith.
4

5 **III. PROCEDURE**
6

- 7 A. The Human Resources Department (HR) will ensure that the salary schedule, meeting the
8 requirements above, are available at CalOptima's offices and immediately accessible for public
9 review during normal business hours or posted on CalOptima's internet website.
10
11 B. HR shall retain the salary schedule for not less than five (5) years.
12
13 C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness
14 of the salary schedule to market pay levels.
15
16 D. Any adjustments to the salary schedule requires that the Executive Director of HR make a
17 recommendation to the CEO for approval, with the CEO taking the recommendation to the
18 CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO
19 compensation, shall be effective unless and until approved by the CalOptima Board of Directors.
20

21 **IV. ATTACHMENTS**
22

- 23 A. CalOptima - Salary Schedule (Revised as of 09/06/18)
24

25 **V. REFERENCES**
26

- 27 A. Title 2, California Code of Regulations, §570.5
28

29 **VI. REGULATORY AGENCY APPROVALS**
30

31 None to Date
32

33 **VII. BOARD ACTIONS**
34

- 35 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
36 B. 02/01/18: Regular Meeting of the CalOptima Board of Directors
37 C. 11/02/17: Regular Meeting of the CalOptima Board of Directors
38 D. 09/07/17: Regular Meeting of the CalOptima Board of Directors
39 E. 08/03/17: Regular Meeting of the CalOptima Board of Directors
40 F. 06/01/17: Regular Meeting of the CalOptima Board of Directors
41 G. 05/04/17: Regular Meeting of the CalOptima Board of Directors
42 H. 03/02/17: Regular Meeting of the CalOptima Board of Directors
43 I. 12/01/16: Regular Meeting of the CalOptima Board of Directors
44 J. 11/03/16: Regular Meeting of the CalOptima Board of Directors
45 K. 10/06/16: Regular Meeting of the CalOptima Board of Directors
46 L. 09/01/16: Regular Meeting of the CalOptima Board of Directors
47 M. 08/04/16: Regular Meeting of the CalOptima Board of Directors
48 N. 06/02/16: Regular Meeting of the CalOptima Board of Directors
49 O. 03/03/16: Regular Meeting of the CalOptima Board of Directors
50 P. 12/03/15: Regular Meeting of the CalOptima Board of Directors

- Q. 10/01/15: Regular Meeting of the CalOptima Board of Directors
- R. 06/04/15: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
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Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative

- 1 **IX. GLOSSARY**
- 2
- 3 Not Applicable
- 4

CalOptima - Annual Base Salary Schedule - Revised September 6, 2018

Effective as of May 1, 2014

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

[Back to Agenda](#)

CalOptima - Annual Base Salary Schedule - Revised September 6, 2018

Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Community Partner Sr	L	612	\$54,288	\$70,512	\$86,736	
Community Relations Specialist	J	288	\$40,976	\$53,352	\$65,624	
Community Relations Specialist Sr	K	646	\$47,112	\$61,360	\$75,504	
Compliance Claims Auditor	K	222	\$47,112	\$61,360	\$75,504	
Compliance Claims Auditor Sr	L	279	\$54,288	\$70,512	\$86,736	
Contract Administrator	M	385	\$62,400	\$81,120	\$99,840	
Contracts Manager	N	207	\$71,760	\$93,184	\$114,712	
Contracts Specialist	K	257	\$47,112	\$61,360	\$75,504	
Contracts Specialist Int	L	469	\$54,288	\$70,512	\$86,736	
Contracts Specialist Sr	M	331	\$62,400	\$81,120	\$99,840	
* Controller	Q	464	\$114,400	\$154,440	\$194,480	
Credentialing Coordinator	J	41	\$40,976	\$53,352	\$65,624	
Credentialing Coordinator - Lead	J	510	\$40,976	\$53,352	\$65,624	
Customer Service Coordinator	J	182	\$40,976	\$53,352	\$65,624	
Customer Service Rep	H	5	\$33,696	\$42,224	\$50,648	
Customer Service Rep - Lead	J	482	\$40,976	\$53,352	\$65,624	
Customer Service Rep Sr	I	481	\$37,128	\$46,384	\$55,640	
Data Analyst	K	337	\$47,112	\$61,360	\$75,504	
Data Analyst Int	L	341	\$54,288	\$70,512	\$86,736	
Data Analyst Sr	M	342	\$62,400	\$81,120	\$99,840	
Data and Reporting Analyst - Lead	O	654	\$82,576	\$107,328	\$131,976	
Data Entry Tech	F	3	\$27,872	\$34,840	\$41,808	
Data Warehouse Architect	O	363	\$82,576	\$107,328	\$131,976	
Data Warehouse Programmer/Analyst	O	364	\$82,576	\$107,328	\$131,976	
Data Warehouse Project Manager	O	362	\$82,576	\$107,328	\$131,976	
Data Warehouse Reporting Analyst	N	412	\$71,760	\$93,184	\$114,712	
Data Warehouse Reporting Analyst Sr	O	522	\$82,576	\$107,328	\$131,976	
Database Administrator	M	90	\$62,400	\$81,120	\$99,840	
Database Administrator Sr	O	179	\$82,576	\$107,328	\$131,976	
** Deputy Chief Counsel	S	160	\$164,736	\$222,352	\$280,072	
** Deputy Chief Medical Officer	T	561	\$197,704	\$266,968	\$336,024	
* Director Accounting	P	122	\$95,264	\$128,752	\$162,032	
* Director Applications Management	R	170	\$137,280	\$185,328	\$233,376	
* Director Audit & Oversight	Q	546	\$114,400	\$154,440	\$194,480	
* Director Behavioral Health Services	P	392	\$95,264	\$128,752	\$162,032	
* Director Budget and Procurement	Q	527	\$114,400	\$154,440	\$194,480	
* Director Business Development	P	351	\$95,264	\$128,752	\$162,032	
* Director Business Integration	Q	543	\$114,400	\$154,440	\$194,480	
* Director Case Management	Q	318	\$114,400	\$154,440	\$194,480	
* Director Claims Administration	P	112	\$95,264	\$128,752	\$162,032	
* Director Clinical Outcomes	Q	602	\$114,400	\$154,440	\$194,480	
* Director Clinical Pharmacy	R	129	\$137,280	\$185,328	\$233,376	
* Director Coding Initiatives	P	375	\$95,264	\$128,752	\$162,032	
* Director Communications	P	361	\$95,264	\$128,752	\$162,032	
* Director Community Relations	P	292	\$95,264	\$128,752	\$162,032	
* Director Configuration & Coding	Q	596	\$114,400	\$154,440	\$194,480	
* Director Contracting	P	184	\$95,264	\$128,752	\$162,032	
* Director COREC	Q	369	\$114,400	\$154,440	\$194,480	
* Director Customer Service	P	118	\$95,264	\$128,752	\$162,032	
* Director Electronic Business	P	358	\$95,264	\$128,752	\$162,032	
* Director Enterprise Analytics	Q	520	\$114,400	\$154,440	\$194,480	
* Director Facilities	P	428	\$95,264	\$128,752	\$162,032	
* Director Finance & Procurement	P	157	\$95,264	\$128,752	\$162,032	
* Director Financial Analysis	R	374	\$137,280	\$185,328	\$233,376	
* Director Financial Compliance	P	460	\$95,264	\$128,752	\$162,032	
* Director Fraud Waste & Abuse and Privacy	Q	581	\$114,400	\$154,440	\$194,480	
* Director Government Affairs	P	277	\$95,264	\$128,752	\$162,032	
* Director Grievance & Appeals	P	528	\$95,264	\$128,752	\$162,032	
* Director Health Education & Disease Management	Q	150	\$114,400	\$154,440	\$194,480	

[Back to Agenda](#)

CalOptima - Annual Base Salary Schedule - Revised September 6, 2018

Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
* Director Health Services	Q	328	\$114,400	\$154,440	\$194,480	
* Director Human Resources	Q	322	\$114,400	\$154,440	\$194,480	
* Director Information Services	R	547	\$137,280	\$185,328	\$233,376	
* Director Long Term Support Services	Q	128	\$114,400	\$154,440	\$194,480	
* Director Medi-Cal Plan Operations	P	370	\$95,264	\$128,752	\$162,032	
* Director Network Management	P	125	\$95,264	\$128,752	\$162,032	
* Director OneCare Operations	P	425	\$95,264	\$128,752	\$162,032	
* Director Organizational Training & Education	P	579	\$95,264	\$128,752	\$162,032	
* Director PACE Program	Q	449	\$114,400	\$154,440	\$194,480	
* Director Process Excellence	Q	447	\$114,400	\$154,440	\$194,480	
* Director Program Implementation	Q	489	\$114,400	\$154,440	\$194,480	
* Director Project Management	Q	447	\$114,400	\$154,440	\$194,480	
* Director Provider Data Quality	Q	655	\$114,400	\$154,440	\$194,480	
* Director Provider Services	P	597	\$95,264	\$128,752	\$162,032	
* Director Public Policy	P	459	\$95,264	\$128,752	\$162,032	
* Director Quality (LTSS)	Q	613	\$114,400	\$154,440	\$194,480	
* Director Quality Analytics	Q	591	\$114,400	\$154,440	\$194,480	
* Director Quality Improvement	Q	172	\$114,400	\$154,440	\$194,480	
* Director Regulatory Affairs and Compliance	Q	625	\$114,400	\$154,440	\$194,480	
* Director Strategic Development	P	121	\$95,264	\$128,752	\$162,032	
* Director Systems Development	R	169	\$137,280	\$185,328	\$233,376	
* Director Utilization Management	Q	265	\$114,400	\$154,440	\$194,480	
Disease Management Coordinator	M	70	\$62,400	\$81,120	\$99,840	
Disease Management Coordinator - Lead	M	472	\$62,400	\$81,120	\$99,840	
EDI Project Manager	O	403	\$82,576	\$107,328	\$131,976	
Enrollment Coordinator (PACE)	K	441	\$47,112	\$61,360	\$75,504	
Enterprise Analytics Manager	P	582	\$95,264	\$128,752	\$162,032	
Executive Assistant	K	339	\$47,112	\$61,360	\$75,504	
Executive Assistant to CEO	L	264	\$54,288	\$70,512	\$86,736	Remove Position
Executive Administrative Services Manager	M	TBD	\$62,400	\$81,120	\$99,840	New Position
** Executive Director Clinical Operations	S	501	\$164,736	\$222,352	\$280,072	
** Executive Director Compliance	S	493	\$164,736	\$222,352	\$280,072	
** Executive Director Human Resources	S	494	\$164,736	\$222,352	\$280,072	
** Executive Director Network Operations	S	632	\$164,736	\$222,352	\$280,072	
** Executive Director Operations	S	276	\$164,736	\$222,352	\$280,072	
** Executive Director Program Implementation	S	490	\$164,736	\$222,352	\$280,072	
** Executive Director Public Affairs	S	290	\$164,736	\$222,352	\$280,072	
** Executive Director Quality Analytics	S	601	\$164,736	\$222,352	\$280,072	
** Executive Director, Behavioral Health Integration	S	614	\$164,736	\$222,352	\$280,072	
Facilities & Support Services Coord - Lead	J	631	\$40,976	\$53,352	\$65,624	
Facilities & Support Services Coordinator	J	10	\$40,976	\$53,352	\$65,624	
Facilities Coordinator	J	438	\$40,976	\$53,352	\$65,624	
Financial Analyst	L	51	\$54,288	\$70,512	\$86,736	
Financial Analyst Sr	M	84	\$62,400	\$81,120	\$99,840	
Financial Reporting Analyst	L	475	\$54,288	\$70,512	\$86,736	
Gerontology Resource Coordinator	M	204	\$62,400	\$81,120	\$99,840	
Graphic Designer	M	387	\$62,400	\$81,120	\$99,840	
Grievance & Appeals Nurse Specialist	N	226	\$71,760	\$93,184	\$114,712	
Grievance Resolution Specialist	J	42	\$40,976	\$53,352	\$65,624	
Grievance Resolution Specialist - Lead	L	590	\$54,288	\$70,512	\$86,736	
Grievance Resolution Specialist Sr	K	589	\$47,112	\$61,360	\$75,504	
Health Coach	M	556	\$62,400	\$81,120	\$99,840	
Health Educator	K	47	\$47,112	\$61,360	\$75,504	
Health Educator Sr	L	355	\$54,288	\$70,512	\$86,736	
Health Network Liaison Specialist (RN)	N	524	\$71,760	\$93,184	\$114,712	
Health Network Oversight Specialist	M	323	\$62,400	\$81,120	\$99,840	
HEDIS Case Manager	N	443	\$71,760	\$93,184	\$114,712	
HEDIS Case Manager (LVN)	M	552	\$62,400	\$81,120	\$99,840	
Help Desk Technician	J	571	\$40,976	\$53,352	\$65,624	

[Back to Agenda](#)

CalOptima - Annual Base Salary Schedule - Revised September 6, 2018

Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Help Desk Technician Sr	K	573	\$47,112	\$61,360	\$75,504	
HR Assistant	I	181	\$37,128	\$46,384	\$55,640	
HR Business Partner	M	584	\$62,400	\$81,120	\$99,840	
HR Compensation Specialist Sr	N	661	\$71,760	\$93,184	\$114,712	
HR Coordinator	J	316	\$40,976	\$53,352	\$65,624	
HR Representative	L	278	\$54,288	\$70,512	\$86,736	
HR Representative Sr	M	350	\$62,400	\$81,120	\$99,840	
HR Specialist	K	505	\$47,112	\$61,360	\$75,504	
HR Specialist Sr	L	608	\$54,288	\$70,512	\$86,736	
HRIS Analyst Sr	M	468	\$62,400	\$81,120	\$99,840	
ICD-10 Project Manager	O	411	\$82,576	\$107,328	\$131,976	
Infrastructure Systems Administrator	J	541	\$40,976	\$53,352	\$65,624	
Infrastructure Systems Administrator Int	K	542	\$47,112	\$61,360	\$75,504	
Inpatient Quality Coding Auditor	L	642	\$54,288	\$70,512	\$86,736	
Intern	E	237	\$25,272	\$31,720	\$37,960	
Investigator Sr	L	553	\$54,288	\$70,512	\$86,736	
IS Coordinator	J	365	\$40,976	\$53,352	\$65,624	
IS Project Manager	O	424	\$82,576	\$107,328	\$131,976	
IS Project Manager Sr	P	509	\$95,264	\$128,752	\$162,032	
IS Project Specialist	M	549	\$62,400	\$81,120	\$99,840	
IS Project Specialist Sr	N	550	\$71,760	\$93,184	\$114,712	
Kitchen Assistant	E	585	\$25,272	\$31,720	\$37,960	
Legislative Program Manager	N	330	\$71,760	\$93,184	\$114,712	
Licensed Clinical Social Worker	L	598	\$54,288	\$70,512	\$86,736	
Litigation Support Specialist	M	588	\$62,400	\$81,120	\$99,840	
LVN (PACE)	M	533	\$62,400	\$81,120	\$99,840	
Mailroom Clerk	E	1	\$25,272	\$31,720	\$37,960	
Manager Accounting	N	98	\$71,760	\$93,184	\$114,712	
Manager Actuary	P	453	\$95,264	\$128,752	\$162,032	
Manager Applications Management	P	271	\$95,264	\$128,752	\$162,032	
Manager Audit & Oversight	O	539	\$82,576	\$107,328	\$131,976	
Manager Behavioral Health	O	633	\$82,576	\$107,328	\$131,976	
Manager Business Integration	O	544	\$82,576	\$107,328	\$131,976	
Manager Case Management	O	270	\$82,576	\$107,328	\$131,976	
Manager Claims	N	92	\$71,760	\$93,184	\$114,712	
Manager Clinic Operations	O	551	\$82,576	\$107,328	\$131,976	
Manager Clinical Pharmacist	Q	296	\$114,400	\$154,440	\$194,480	
Manager Coding Quality	N	382	\$71,760	\$93,184	\$114,712	
Manager Communications	N	398	\$71,760	\$93,184	\$114,712	
Manager Community Relations	M	384	\$62,400	\$81,120	\$99,840	
Manager Contracting	O	329	\$82,576	\$107,328	\$131,976	
Manager Creative Branding	N	430	\$71,760	\$93,184	\$114,712	
Manager Cultural & Linguistic	N	349	\$71,760	\$93,184	\$114,712	
Manager Customer Service	N	94	\$71,760	\$93,184	\$114,712	
Manager Decision Support	O	454	\$82,576	\$107,328	\$131,976	
Manager Disease Management	O	372	\$82,576	\$107,328	\$131,976	
Manager Electronic Business	O	422	\$82,576	\$107,328	\$131,976	
Manager Employment Services	N	420	\$71,760	\$93,184	\$114,712	
Manager Encounters	N	516	\$71,760	\$93,184	\$114,712	
Manager Environmental Health & Safety	N	495	\$71,760	\$93,184	\$114,712	
Manager Facilities	N	209	\$71,760	\$93,184	\$114,712	
Manager Finance	N	148	\$71,760	\$93,184	\$114,712	
Manager Financial Analysis	O	356	\$82,576	\$107,328	\$131,976	
Manager Government Affairs	N	437	\$71,760	\$93,184	\$114,712	
Manager Grievance & Appeals	N	426	\$71,760	\$93,184	\$114,712	
Manager Health Education	N	173	\$71,760	\$93,184	\$114,712	
Manager HEDIS	O	427	\$82,576	\$107,328	\$131,976	
Manager Human Resources	O	526	\$82,576	\$107,328	\$131,976	
Manager Information Services	P	560	\$95,264	\$128,752	\$162,032	

[Back to Agenda](#)

CalOptima - Annual Base Salary Schedule - Revised September 6, 2018

Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Manager Information Technology	P	110	\$95,264	\$128,752	\$162,032	
Manager Integration Government Liaison	N	455	\$71,760	\$93,184	\$114,712	
Manager Long Term Support Services	O	200	\$82,576	\$107,328	\$131,976	
Manager Marketing & Enrollment (PACE)	O	414	\$82,576	\$107,328	\$131,976	
Manager Medical Data Management	O	519	\$82,576	\$107,328	\$131,976	
Manager Medi-Cal Program Operations	N	483	\$71,760	\$93,184	\$114,712	
Manager Member Liaison Program	N	354	\$71,760	\$93,184	\$114,712	
Manager Member Outreach & Education	N	616	\$71,760	\$93,184	\$114,712	
Manager Member Outreach Education & Provider Relations	O	576	\$82,576	\$107,328	\$131,976	
Manager MSSP	O	393	\$82,576	\$107,328	\$131,976	
Manager OneCare Clinical	O	359	\$82,576	\$107,328	\$131,976	
Manager OneCare Customer Service	N	429	\$71,760	\$93,184	\$114,712	
Manager OneCare Regulatory	N	197	\$71,760	\$93,184	\$114,712	
Manager OneCare Sales	O	248	\$82,576	\$107,328	\$131,976	
Manager Outreach & Enrollment	N	477	\$71,760	\$93,184	\$114,712	
Manager PACE Center	O	432	\$82,576	\$107,328	\$131,976	
Manager Process Excellence	O	622	\$82,576	\$107,328	\$131,976	
Manager Program Implementation	O	488	\$82,576	\$107,328	\$131,976	
Manager Project Management	O	532	\$82,576	\$107,328	\$131,976	
Manager Provider Data Management Services	N	653	\$71,760	\$93,184	\$114,712	
Manager Provider Network	O	191	\$82,576	\$107,328	\$131,976	
Manager Provider Relations	N	171	\$71,760	\$93,184	\$114,712	
Manager Provider Services	O	656	\$82,576	\$107,328	\$131,976	
Manager Purchasing	N	275	\$71,760	\$93,184	\$114,712	
Manager QI Initiatives	N	433	\$71,760	\$93,184	\$114,712	
Manager Quality Analytics	O	617	\$82,576	\$107,328	\$131,976	
Manager Quality Improvement	O	104	\$82,576	\$107,328	\$131,976	
Manager Regulatory Affairs and Compliance	O	626	\$82,576	\$107,328	\$131,976	
Manager Reporting & Financial Compliance	O	572	\$82,576	\$107,328	\$131,976	
Manager Strategic Development	O	603	\$82,576	\$107,328	\$131,976	
Manager Strategic Operations	N	446	\$71,760	\$93,184	\$114,712	
Manager Systems Development	P	515	\$95,264	\$128,752	\$162,032	
Manager Utilization Management	O	250	\$82,576	\$107,328	\$131,976	
Marketing and Outreach Specialist	J	496	\$40,976	\$53,352	\$65,624	
Medical Assistant	H	535	\$33,696	\$42,224	\$50,648	
Medical Authorization Asst	H	11	\$33,696	\$42,224	\$50,648	
Medical Case Manager	N	72	\$71,760	\$93,184	\$114,712	
Medical Case Manager (LVN)	L	444	\$54,288	\$70,512	\$86,736	
* Medical Director	S	306	\$164,736	\$222,352	\$280,072	
Medical Records & Health Plan Assistant	G	548	\$30,576	\$38,272	\$45,968	
Medical Records Clerk	E	523	\$25,272	\$31,720	\$37,960	
Medical Services Case Manager	K	54	\$47,112	\$61,360	\$75,504	
Member Liaison Specialist	I	353	\$37,128	\$46,384	\$55,640	
MMS Program Coordinator	K	360	\$47,112	\$61,360	\$75,504	
Nurse Practitioner (PACE)	P	635	\$95,264	\$128,752	\$162,032	
Occupational Therapist	N	531	\$71,760	\$93,184	\$114,712	
Occupational Therapist Assistant	M	623	\$62,400	\$81,120	\$99,840	
Office Clerk	C	335	\$21,008	\$26,208	\$31,408	
OneCare Operations Manager	O	461	\$82,576	\$107,328	\$131,976	
OneCare Partner - Sales	K	230	\$47,112	\$61,360	\$75,504	
OneCare Partner - Sales (Lead)	K	537	\$47,112	\$61,360	\$75,504	
OneCare Partner - Service	I	231	\$37,128	\$46,384	\$55,640	
OneCare Partner (Inside Sales)	J	371	\$40,976	\$53,352	\$65,624	
Outreach Specialist	I	218	\$37,128	\$46,384	\$55,640	
Paralegal/Legal Secretary	K	376	\$47,112	\$61,360	\$75,504	
Payroll Specialist	J	554	\$40,976	\$53,352	\$65,624	
Performance Analyst	L	538	\$54,288	\$70,512	\$86,736	
Personal Care Attendant	E	485	\$25,272	\$31,720	\$37,960	
Personal Care Attendant - Lead	E	498	\$25,272	\$31,720	\$37,960	

[Back to Agenda](#)

CalOptima - Annual Base Salary Schedule - Revised September 6, 2018

Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Personal Care Coordinator	I	525	\$37,128	\$46,384	\$55,640	
Pharmacy Resident	K	379	\$47,112	\$61,360	\$75,504	
Pharmacy Services Specialist	I	23	\$37,128	\$46,384	\$55,640	
Pharmacy Services Specialist Int	J	35	\$40,976	\$53,352	\$65,624	
Pharmacy Services Specialist Sr	K	507	\$47,112	\$61,360	\$75,504	
Physical Therapist	N	530	\$71,760	\$93,184	\$114,712	
Physical Therapist Assistant	M	624	\$62,400	\$81,120	\$99,840	
Policy Advisor Sr	O	580	\$82,576	\$107,328	\$131,976	
Privacy Manager	N	536	\$71,760	\$93,184	\$114,712	
Privacy Officer	P	648	\$95,264	\$128,752	\$162,032	
Process Excellence Manager	O	529	\$82,576	\$107,328	\$131,976	
Program Assistant	I	24	\$37,128	\$46,384	\$55,640	
Program Coordinator	I	284	\$37,128	\$46,384	\$55,640	
Program Development Analyst Sr	M	492	\$62,400	\$81,120	\$99,840	
Program Manager	M	421	\$62,400	\$81,120	\$99,840	
Program Manager Sr	O	594	\$82,576	\$107,328	\$131,976	
Program Specialist	J	36	\$40,976	\$53,352	\$65,624	
Program Specialist Int	K	61	\$47,112	\$61,360	\$75,504	
Program Specialist Sr	L	508	\$54,288	\$70,512	\$86,736	
Program/Policy Analyst	K	56	\$47,112	\$61,360	\$75,504	
Program/Policy Analyst Sr	M	85	\$62,400	\$81,120	\$99,840	
Programmer	L	43	\$54,288	\$70,512	\$86,736	
Programmer Int	N	74	\$71,760	\$93,184	\$114,712	
Programmer Sr	O	80	\$82,576	\$107,328	\$131,976	
Project Manager	M	81	\$62,400	\$81,120	\$99,840	
Project Manager - Lead	M	467	\$62,400	\$81,120	\$99,840	
Project Manager Sr	O	105	\$82,576	\$107,328	\$131,976	
Project Specialist	K	291	\$47,112	\$61,360	\$75,504	
Project Specialist Sr	L	503	\$54,288	\$70,512	\$86,736	
Projects Analyst	K	254	\$47,112	\$61,360	\$75,504	
Provider Enrollment Data Coordinator	I	12	\$37,128	\$46,384	\$55,640	
Provider Enrollment Data Coordinator Sr	J	586	\$40,976	\$53,352	\$65,624	
Provider Enrollment Manager	K	190	\$47,112	\$61,360	\$75,504	
Provider Network Rep Sr	L	391	\$54,288	\$70,512	\$86,736	
Provider Network Specialist	K	44	\$47,112	\$61,360	\$75,504	
Provider Network Specialist Sr	L	595	\$54,288	\$70,512	\$86,736	
Provider Office Education Manager	L	300	\$54,288	\$70,512	\$86,736	
Provider Relations Rep	K	205	\$47,112	\$61,360	\$75,504	
Provider Relations Rep Sr	L	285	\$54,288	\$70,512	\$86,736	
Publications Coordinator	J	293	\$40,976	\$53,352	\$65,624	
QA Analyst	L	486	\$54,288	\$70,512	\$86,736	
QA Analyst Sr	N	380	\$71,760	\$93,184	\$114,712	
QI Nurse Specialist	N	82	\$71,760	\$93,184	\$114,712	
QI Nurse Specialist (LVN)	M	445	\$62,400	\$81,120	\$99,840	
Receptionist	F	140	\$27,872	\$34,840	\$41,808	
Recreational Therapist	L	487	\$54,288	\$70,512	\$86,736	
Recruiter	L	406	\$54,288	\$70,512	\$86,736	
Recruiter Sr	M	497	\$62,400	\$81,120	\$99,840	
Registered Dietitian	L	57	\$54,288	\$70,512	\$86,736	
Regulatory Affairs and Compliance Analyst	K	628	\$47,112	\$61,360	\$75,504	
Regulatory Affairs and Compliance Analyst Sr	L	629	\$54,288	\$70,512	\$86,736	
Regulatory Affairs and Compliance Lead	M	630	\$62,400	\$81,120	\$99,840	
RN (PACE)	N	480	\$71,760	\$93,184	\$114,712	
Security Analyst Int	N	534	\$71,760	\$93,184	\$114,712	
Security Analyst Sr	O	474	\$82,576	\$107,328	\$131,976	
Security Officer	F	311	\$27,872	\$34,840	\$41,808	
SharePoint Developer/Administrator Sr	O	397	\$82,576	\$107,328	\$131,976	
Social Worker	K	463	\$47,112	\$61,360	\$75,504	
* Special Counsel	R	317	\$137,280	\$185,328	\$233,376	

[Back to Agenda](#)

CalOptima - Annual Base Salary Schedule - Revised September 6, 2018

Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
* Sr Director Regulatory Affairs and Compliance	R	658	\$137,280	\$185,328	\$233,376	
Sr Manager Financial Analysis	P	660	\$95,264	\$128,752	\$162,032	
Sr Manager Human Resources	P	649	\$95,264	\$128,752	\$162,032	
Sr Manager Information Services	Q	650	\$114,400	\$154,440	\$194,480	
Sr Manager Government Affairs	O	451	\$82,576	\$107,328	\$131,976	
Sr Manager Provider Network	O	651	\$82,576	\$107,328	\$131,976	
Staff Attorney	P	195	\$95,264	\$128,752	\$162,032	
Supervisor Accounting	M	434	\$62,400	\$81,120	\$99,840	
Supervisor Audit and Oversight	N	618	\$71,760	\$93,184	\$114,712	
Supervisor Behavioral Health	N	659	\$71,760	\$93,184	\$114,712	
Supervisor Budgeting	M	466	\$62,400	\$81,120	\$99,840	
Supervisor Case Management	N	86	\$71,760	\$93,184	\$114,712	
Supervisor Claims	K	219	\$47,112	\$61,360	\$75,504	
Supervisor Coding Initiatives	M	502	\$62,400	\$81,120	\$99,840	
Supervisor Customer Service	K	34	\$47,112	\$61,360	\$75,504	
Supervisor Data Entry	K	192	\$47,112	\$61,360	\$75,504	
Supervisor Day Center (PACE)	K	619	\$47,112	\$61,360	\$75,504	
Supervisor Dietary Services (PACE)	M	643	\$62,400	\$81,120	\$99,840	
Supervisor Disease Management	N	644	\$71,760	\$93,184	\$114,712	
Supervisor Encounters	L	253	\$54,288	\$70,512	\$86,736	
Supervisor Facilities	L	162	\$54,288	\$70,512	\$86,736	
Supervisor Finance	N	419	\$71,760	\$93,184	\$114,712	
Supervisor Grievance and Appeals	M	620	\$62,400	\$81,120	\$99,840	
Supervisor Health Education	M	381	\$62,400	\$81,120	\$99,840	
Supervisor Information Services	N	457	\$71,760	\$93,184	\$114,712	
Supervisor Long Term Support Services	N	587	\$71,760	\$93,184	\$114,712	
Supervisor MSSP	N	348	\$71,760	\$93,184	\$114,712	
Supervisor Nursing Services (PACE)	N	TBD	\$71,760	\$93,184	\$114,712	New Position
Supervisor OneCare Customer Service	K	408	\$47,112	\$61,360	\$75,504	
Supervisor Payroll	M	517	\$62,400	\$81,120	\$99,840	
Supervisor Pharmacist	P	610	\$95,264	\$128,752	\$162,032	
Supervisor Provider Enrollment	K	439	\$47,112	\$61,360	\$75,504	
Supervisor Provider Relations	M	652	\$62,400	\$81,120	\$99,840	
Supervisor Quality Analytics	M	609	\$62,400	\$81,120	\$99,840	
Supervisor Quality Improvement	N	600	\$71,760	\$93,184	\$114,712	
Supervisor Regulatory Affairs and Compliance	N	627	\$71,760	\$93,184	\$114,712	
Supervisor Social Work (PACE)	L	636	\$54,288	\$70,512	\$86,736	
Supervisor Systems Development	O	456	\$82,576	\$107,328	\$131,976	
Supervisor Therapy Services (PACE)	N	645	\$71,760	\$93,184	\$114,712	
Supervisor Utilization Management	N	637	\$71,760	\$93,184	\$114,712	
Systems Manager	N	512	\$71,760	\$93,184	\$114,712	
Systems Network Administrator Int	M	63	\$62,400	\$81,120	\$99,840	
Systems Network Administrator Sr	N	89	\$71,760	\$93,184	\$114,712	
Systems Operations Analyst	J	32	\$40,976	\$53,352	\$65,624	
Systems Operations Analyst Int	K	45	\$47,112	\$61,360	\$75,504	
Technical Analyst Int	L	64	\$54,288	\$70,512	\$86,736	
Technical Analyst Sr	M	75	\$62,400	\$81,120	\$99,840	
Technical Writer	L	247	\$54,288	\$70,512	\$86,736	
Technical Writer Sr	M	470	\$62,400	\$81,120	\$99,840	
Therapy Aide	J	521	\$40,976	\$53,352	\$65,624	
Training Administrator	L	621	\$54,288	\$70,512	\$86,736	
Training Program Coordinator	K	471	\$47,112	\$61,360	\$75,504	
Translation Specialist	G	241	\$30,576	\$38,272	\$45,968	
Web Architect	O	366	\$82,576	\$107,328	\$131,976	

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

[Back to Agenda](#)

CalOptima - Annual Base Salary Schedule - Revised September 6, 2018
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
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** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

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

Summary of Changes to Salary Schedule

For September 2018 Board Meeting:

Title	Old Wage Grade	New Job Code/ Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/ Changed
Supervisor Nursing Services	N/A	N	This new position will be responsible for the daily operations of the PACE nursing services. This position will have direct supervision of CalOptima's registered nurses and licensed vocational nurses at the PACE clinic. This position will be responsible for the nursing team's delivery of patient care including but not limited to nurse assessments, diagnosing and evaluation. (Department has approved budget line for position).	N/A	September 2018
Executive Administrative Services Manager	N/A	M	This new position will be responsible for providing executive level support to the CEO. The position will also be responsible for leading, training and coordinating the work of the Executive Administrative staff. He/she will be responsible for establishing and streamlining the executive administrative services.	N/A	September 2018
Executive Assistant to CEO	L	N/A	Remove title from salary schedule. Position is being eliminated.	N/A	September 2018

Policy #: GA.8059PP
Title: **Attendance and Timekeeping**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 09/06/18
Last Review Date: Not Applicable
Last Revised Date: Not Applicable

1 **I. PURPOSE**

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3 This policy provides employees and leaders with timekeeping guidelines to manage attendance
4 requirements.
5

6 **II. POLICY**

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8 A. CalOptima is a public agency and health plan that provides valuable services to eligible members in
9 Orange County. To accomplish this mission, it is imperative that every employee be present and
10 ready to work when scheduled in order to maintain excellent service to our members throughout the
11 business day during CalOptima’s core business hours. CalOptima provides eligible employees with
12 paid time off (PTO), holidays, and one (1) flexible holiday throughout the year to enable them to
13 take time off for rest and recreation and to recover from illness.
14

15 B. Regular, predictable, and reliable attendance is an essential function of all job positions at
16 CalOptima, and the responsibility of each employee at CalOptima. CalOptima’s policies and
17 practices are established pursuant to principles of public accountability. Employees are expected to
18 be punctual and report to work at the start of their scheduled shift, observe the time limits for break
19 and meal periods, and not leave work earlier than scheduled without prior approval from their
20 immediate supervisor. Efficient business operations depend on the reliability of all employees.
21

22 C. Directors, managers, and supervisors are accountable to ensure that attendance and timekeeping
23 policies and procedures are adhered to and to monitor their employees’ attendance on a daily basis
24 and address unsatisfactory attendance issues in a timely and consistent manner.
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26 **D. Work Schedule**

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- 28 1. An employee’s schedule is determined by the employee’s immediate supervisor or the
29 department supervisor based on CalOptima’s core business hours to ensure coverage, where
30 applicable.
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 - 32 2. An employee is given their work schedule by their immediate supervisor prior to or within their
33 first week of employment.
34
 - 35 3. An employee’s immediate supervisor shall notify an employee of a change to the employee’s
36 work schedule in a timely manner. At least one (1) weeks’ notice is a recommended best
37 practice, unless the change involves a 9/80 schedule, which requires at least two (2) weeks’
38 notice for non-exempt (hourly) employees. All changes must have an effective date on the first
39 day of a future pay period.
40

- 1 4. Non-exempt (hourly) employees on a 9/80 schedule must follow their exact scheduled hours on
2 their eight (8)-hour day. If there is a need to switch the scheduled 9/80 day to another day for a
3 non-exempt (hourly) employee, it must be done in the same work week.
4
- 5 5. As a public agency, CalOptima is not subject to California labor laws regarding meal and rest
6 period requirements. The federal Fair Labor Standards Act (FLSA), which CalOptima is subject
7 to, does not mandate meal and rest periods. However, CalOptima recognizes how important it
8 is to have a break during the day. Employees and their immediate supervisors will work out
9 individual meal and rest periods consistent with applicable CalOptima policies.
10
- 11 6. Non-exempt (hourly) employees are prohibited from off-the-clock work, including prior to
12 clocking-in for the day, following clocking-out for the day, and during meal breaks. Non-
13 exempt (hourly) employees who need to obtain remote access into CalOptima's system shall not
14 perform any work prior to clocking-in for the day, and are encouraged to discuss computer
15 system issues and access issues with their immediate supervisors to ensure any compensable
16 work time is addressed, but should refrain from performing CalOptima-related work until they
17 have clocked-in. Between logging into CalOptima's system and clocking-in, employees shall
18 not perform CalOptima-related work and are free to attend to personal matters if waiting to
19 clock-in. If an employee experiences a delay in logging into CalOptima's system of over ten
20 (10) minutes, the employee should promptly contact Information Services to resolve such
21 delays.
22
- 23 7. For non-exempt (hourly) employees who work from a Remote Work Location (other than the
24 Central Worksite), commute time may be compensated and included as part of the work day
25 only if all of the following apply:
26
 - 27 a. The employee is required to be onsite at the Central Worksite for meetings, training or other
28 events as determined by the employee's leadership in the middle of the work day; **and**
 - 29 b. The commute to or from the employee's Remote Work Location and CalOptima occurs in
30 the middle of the non-exempt employee's work day; **and**
 - 31 c. The employee cannot work from the Central Worksite for the entire work day.
32

33 E. Timekeeping Requirements

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- 37 1. Non-exempt (hourly) employees shall accurately record their time in and time away from work,
38 including unpaid meal breaks, in CalOptima's timekeeping system on a daily basis. Daily time
39 entry is required to ensure employees are paid based on the actual time worked. CalOptima's
40 timekeeping system will not round up or down an employee's time and will capture the time
41 worked based on clock-in/clock-out timestamps.
42
- 43 2. The immediate supervisor shall approve and/or correct the non-exempt (hourly) employee's
44 time record on a daily basis.
45
- 46 3. The time record for the non-exempt (hourly) employee will include the total hours worked each
47 day, including all regular and overtime hours worked, any Absence, Tardiness or time Leaving
48 Early, and unpaid time taken for meal breaks.
49

- 1 4. Exempt (salaried) employees' agreed upon work schedule and requested time off is recorded
2 and tracked in the timekeeping system. Exempt employees are responsible for timely notifying
3 their immediate supervisors of any deviations from their scheduled shift consistent with
4 applicable CalOptima policies and department requirements.
5

6 F. Overtime

- 7
8 1. When business requirements or other needs cannot be met during regular working hours,
9 employees may be scheduled to work overtime hours. A non-exempt employee will be expected
10 to work overtime when necessary to meet business needs, and non-exempt employees will be
11 paid time-and-a-half overtime accordingly for any overtime worked. Exempt employees are not
12 eligible for overtime payment, but exempt employees are expected to work beyond the forty
13 (40)-hour workweek when business needs require. CalOptima does not provide "comp time" to
14 non-exempt or exempt employees for hours worked beyond the forty (40)-hour workweek.
15
16 2. When possible, an employee's immediate supervisor will provide advance notice of mandatory
17 overtime.
18
19 3. A non-exempt employee may NOT work overtime without prior written authorization from
20 their immediate supervisor.
21
22 4. A non-exempt employee may receive corrective action for incurring overtime by working
23 before their scheduled work time or working after their scheduled work time without prior
24 authorization from his/her immediate supervisor.
25
26 5. A non-exempt employee is not permitted to start work early, finish work late, work during meal
27 periods, take work home, work on weekends, or perform any other unauthorized extra and/or
28 overtime work without prior authorization from their immediate supervisor.
29

30 **III. PROCEDURE**

31
32 A. Scheduled Absence

- 33
34 1. A Scheduled Absence occurs when an employee's time-off is arranged and approved in advance
35 with notice to the employee's immediate or department supervisor consistent with applicable
36 CalOptima Policies or within the specific time frame defined by the department.
37
38 2. Employees may use PTO for Scheduled Absences as described in CalOptima Policy GA.8018:
39 Paid Time Off (PTO).
40
41 3. Employees may also take time off for Scheduled Absences consistent with other applicable
42 CalOptima Policies, including, but not limited to CalOptima Policies: GA.8037: Leave of
43 Absence; GA.8038: Personal Leave of Absence; GA.8039: Pregnancy Disability Leave of
44 Absence; GA.8040: FMLA and CFRA Leave of Absence; and GA.8041: Workers'
45 Compensation Leave of Absence.
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47 B. Unscheduled Absence

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49 1. Employees may occasionally incur an Unscheduled Absence. Regardless of the reason for the
50 Unscheduled Absence:

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 - a. The employee must personally notify his/her immediate supervisor as far in advance as possible, but no later than one (1) hour prior to the start of the employee's scheduled shift or within the specific time frame defined by the department.
 - i. If the supervisor cannot be reached, the employee is expected to notify the department head or other designated department contact.
 - ii. If the employee is unable to call, he/she must have someone make the call on his/her behalf as soon as possible or no later than end of scheduled shift, unless the situation makes this impossible, then as soon as reasonably practical under the circumstances.
 - b. The employee must provide a reason for the Unscheduled Absence and the expected date of return or time of arrival.
 - c. The employee who is late for work may not stay on duty beyond his/her regular scheduled shift to make up for the lost time unless specifically authorized to do so by his/her immediate supervisor.
 - d. Employees must call in each day they will be absent or tardy unless they are on an approved Leave of Absence (LOA).
2. An immediate supervisor may grant an Authorized Absence for an Unscheduled Absence if the employee meets the four (4) criteria for an Authorized Absence as described in Section III.C.1.
 3. Failure to contact the Employee's immediate supervisor or designated department contact in a timely manner may be counted as an Occurrence as described in Section III.J.

C. Authorized Absence

1. An Authorized Absence or excused absence occurs when all four (4) of the following conditions are met:
 - a. The employee provides sufficient notice (a minimum of one (1) hour prior to the start of the scheduled work time or within the specific time frame defined by the department) to his/her immediate supervisor prior the commencement of his/her shift;
 - b. The employee provides a valid reason acceptable to his/her immediate supervisor;
 - c. Such Absence request is approved by his/her immediate supervisor; and
 - d. The employee has:
 - i. Sufficient accrued PTO to cover such absence unless otherwise allowed by company policy (i.e., LOA, bereavement, jury duty); or
 - ii. The immediate supervisor or manager waives this requirement and allows the absence to be an unpaid absence because the employee has not accrued sufficient PTO; or
 - iii. Exceptions as defined by the department.

2. The employee’s immediate supervisor may waive the notice requirement when it is warranted by the circumstance involved (example, when an employee has an emergent situation and cannot call).
3. An employee’s immediate supervisor may approve up to five (5) consecutive scheduled work days of Authorized Absences.
4. Absences of more than five (5) consecutive scheduled work days for an illness or pre-planned surgery must be submitted to and approved by HR for Leave of Absence consideration in accordance with CalOptima Policy GA.8037: Leave of Absence.
5. Use of PTO for pre-planned scheduled time off (non-LOA) with permission (e.g., vacation) does not require HR approval.
6. An approved LOA that is covered by CalOptima policies, State or Federal laws, including, but not limited to, Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), Paid Sick Leave, and Kin Care is considered to be an Authorized Absence.
7. Exempt employees are expected to work a minimum of eighty (80) hours per pay period, excluding holiday weeks, and as a result, are eligible to work a flexible schedule, where appropriate, based on CalOptima’s core business hours as determined by their immediate supervisor. Exempt employees requesting an occasional, short-term Scheduled Absence for a partial day may elect to make up time away from work within the same pay period or use accrued PTO if the employee does not otherwise make up the time off within the same pay period. An exempt employee who has exhausted all of his/her accrued PTO must enter in unpaid time off for full day and partial day absences if the employee does not otherwise make up the time off within the same pay period. Based on principles of public accountability, CalOptima will reduce the pay of an exempt employee for absences for personal reasons or because of illness or injury of one (1) full work day or less than one (1) work-day when accrued PTO is not used by an employee because:
 - a. Permission for its use has not been sought or has been sought and denied; or
 - b. Accrued PTO has been exhausted; or
 - c. The employee chooses to use leave without pay.
8. Failure to meet the above requirements may result in corrective action, up to and including termination, depending on the circumstances.

D. Unauthorized Absence

1. An Unauthorized Absence occurs when an employee misses one (1) hour or more of his/her scheduled shift without prior approval and when one (1), or more, of the four (4) conditions listed under Authorized Absence are not met.

- 1 2. If an employee fails to provide a doctor's note after four (4) consecutive days, or more, on
2 personal and unprotected sick time, then the days are considered Unauthorized Absences and an
3 Occurrence will be imposed.
4
- 5 3. If a non-exempt (hourly) employee is scheduled to work approved overtime and either fails to
6 report or reports after the scheduled start time, it will be considered as an Unauthorized Absence
7 and an Occurrence will be imposed.
8
- 9 4. Unauthorized Absences may result in corrective action, up to and including termination,
10 depending on the surrounding circumstances.
11

12 E. Department Specific Attendance Guidelines

- 13 1. Departments may establish guidelines for scheduling and reporting Absences or time away from
14 work that meets their specific business needs.
15 a. The guidelines must meet the basic requirements of CalOptima policies.
16 b. A department must submit their guidelines in writing to HR for approval.
17 c. If department specific guidelines have been established, employees are to follow the
18 procedures of their respective department to the extent such procedures do not conflict with
19 applicable laws.
20
- 21 2. In the absence of a department-specific guideline or directive on attendance, a department shall
22 adhere to the guidelines included in this Policy.
23
24

25 F. Timekeeping Guidelines

- 26 1. Employees are required to follow established guidelines for recording their hours worked.
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- 28 2. A non-exempt employee is required to record time in the Timekeeping system and to clock in at
29 the start of the scheduled shift and clock out at the end of their scheduled shift, as well as clock
30 out at the beginning of their scheduled meal break and clock in at the end of their scheduled
31 meal break.
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- 33 3. If there is a problem recording a clock in/out, a non-exempt employee must notify his/her
34 immediate supervisor in writing, no later than the conclusion of the shift.
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- 36 4. Non-exempt employees who consistently fail to accurately and timely clock in/out may receive
37 corrective action, up to and including termination of employment.
38
- 39 5. Excessive missed clock in/out will constitute an Occurrence as prescribed below in Section
40 III.J.2 of this Policy.
41 a. Failure to clock in/out at the beginning and/or end of their scheduled shift;
42 b. Failure to clock in/out for their meal break period;
43 c. Failure to accurately and timely report time worked; and/or
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- d. Clocking in/out and/or early/late for a scheduled shift without prior approval from the non-exempt employee's immediate supervisor.
- 6. Clocking in/out for another employee or having another employee clock in/out for the employee constitutes falsification of timekeeping records and is grounds for immediate termination for one (1) or both employees, depending on the circumstances.
- 7. Misrepresentations of work hours violate this Policy and the CalOptima Code of Conduct. Any employee who knowingly misrepresents or falsifies documentation about their time worked will be subject to corrective action, up to and including termination from employment.
- 8. Warnings received under this Policy will affect an employee's ability to internally apply and be considered for open positions.
- 9. Exempt employees are not required to complete timecards; however, exempt employees are expected to work a regular work schedule based on CalOptima's core business hours and should notify their supervisors in advance of any deviations from their normal work schedule and accurately record any exceptions to their regular work schedule, including, but not limited to:
 - a. Use of PTO when an employee does not otherwise make up time away from work during the same pay period; and
 - b. Unpaid time off when an exempt employee has exhausted his/her PTO, does not work a full day or works less than a full day, and does not otherwise make up the full day or partial day away from work during the same pay period.

G. Supervisor Guidelines:

- 1. Supervisors or managers of non-exempt employees shall:
 - a. Review and approve time records submitted by employees in the timekeeping system on a daily basis.
 - b. Review and approve all time records submitted by these employees no later than 12 p.m. PST/PDT on the Monday following the week in which the time was worked, unless otherwise notified by payroll or HR.
 - c. Monitor and address attendance issues timely and consistently.
 - d. Schedule required on-site meetings, trainings or other events in a manner that effectively minimizes commute time in the middle of a work day for non-exempt employees.
- 2. Supervisors or managers of exempt employees shall:
 - a. Review and approve time worked in the Timekeeping system on a weekly basis;
 - b. Review and approve time away from work requests; and

- c. Review and approve all worked time by these employees no later than 12 p.m. PST/PDT on the Monday following the week in which the time was worked.
3. There may be situations where it is not possible for a supervisor or manager to review time on a timely basis. These circumstances include, but are not limited to:
 - a. When the employee failed to record or submit his/her time in a timely manner;
 - b. When the supervisor or manager is out of the office due to an unforeseen event and does not have access to the Timekeeping system; and/or
 - c. When further investigation is needed regarding the time recorded and/or submitted to determine whether it is appropriate for approval.
4. When the immediate supervisor is not available to review their employees' time worked, the immediate supervisor's manager/director shall review and approve the employees' time worked in the Timekeeping system.
5. Supervisors or managers who fail to review and approve submitted time before the applicable deadline or fail to review/approve time at all may be subject to corrective action.
6. CalOptima retains the right to apply the appropriate level of corrective action, as circumstances require.
7. Warnings received under this Policy will affect a supervisor's or manager's ability to internally apply and be considered for open positions and from bonus consideration as per the guidelines and eligibility of those programs.
8. An employee is not permitted to approve his/her own time under any circumstance.

H. Noncompliance

1. Unscheduled Absences and Unauthorized Absences are to be handled expeditiously and fairly by leaders, including consistent policy application within each department.
2. Noncompliance includes:
 - a. Failure to give timely notice of an Unscheduled Absence (no call, no show).
 - b. Excessive Absenteeism, including, but not limited to:
 - i. Multiple occurrences of Unscheduled/Unauthorized Absences, full day or partial day, is to be noted and documented by the immediate supervisor in a timely and consistent manner.
 - ii. An Absence may be counted as an Occurrence as described in Section III.J.
 - iii. Unscheduled/Unauthorized Absence is considered excessive when the employee has three (3) or more Unauthorized/Unscheduled Occurrences within a rolling twelve (12)-month period.

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c. Excessive Tardiness

- i. A late arrival of fifteen (15) minutes or more, or the specific timeframe as defined by the department, past the scheduled shift start time is considered tardy.
- ii. A pattern of unexcused late arrivals and/or returning late from break/meal breaks is also considered tardy and is to be noted and documented by the immediate supervisor in a timely and consistent manner.
- iii. Tardiness may be counted as an Occurrence as described in Section III.J.
- iv. Tardiness is considered excessive when the employee has eight (8) Occurrences in a rolling twelve (12)-month period. When consecutive multiple occurrences (i.e., five (5) occurrences in one (1) week) take place, these may also be considered excessive.

d. Excessive Leave Early

- i. Leaving fifteen (15) minutes or more, or the specific time frame as defined by the department, before the end of scheduled work shift is considered to be Leave Early.
- ii. A pattern of Leaving Early before the end of the scheduled work shift, or prior to a scheduled break/meal break is to be noted and documented by the immediate supervisor in a timely and consistent manner.
- iii. A Leave Early may be counted as an Occurrence as described in Section III.J.
- iv. Leaving Early is considered excessive when the employee has three (3) or more Occurrences of Leaving Early from their scheduled shift and/or scheduled break/meal break without prior approval within a rolling twelve (12)-month period.

e. Excessive Missed Clocking In or Out

- i. Three (3) incidents of failing to clock-in or clock-out of a scheduled shift and/or scheduled meal break within a thirty (30) business day period is considered excessive.

3. Frequent or excessive incidents of not following CalOptima’s and/or the departmental attendance and punctuality requirements, notification procedures and/or the guidelines in this policy, including no-call/no-show, will be addressed by HR in accordance with the CalOptima Policy GA.8022: Performance and Behavior Standards.

I. Patterns of Absence, Leave Early, or Tardiness

- 1. The following may be considered patterns of excessive or unacceptable attendance issues:
 - a. Pattern of Unscheduled Absences, Leave Early, or Tardiness on Fridays, Mondays or other specific days.
 - b. Pattern of Unscheduled Absences, Leave Early, or Tardiness on days previously requested off but could not approved due to business needs.

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- c. Pattern of Unscheduled Absences, Leave Early, or Tardiness around the holidays, i.e., preceding or following a holiday or scheduled day off.
- 2. If a pattern of unscheduled usage of accrued PTO and/or unpaid time off is noticed, the immediate supervisor should work with HR on managing the corrective action process and addressing the issues with the employee.
 - a. When an employee has been previously counseled under CalOptima Policy GA.8022: Performance and Behavior Standards, the totality of the circumstances will be assessed when determining further action.
 - b. For situations involving corrective actions or termination of employment, the immediate supervisor or manager should consult with HR prior to taking action.
- 3. As timely and regular attendance is a performance expectation and condition of employment at CalOptima, employees who have exhibited unsatisfactory attendance during the year will have the behavior documented in their annual performance evaluation.
- 4. When the employee fails to report to work without giving notice to and/or receiving authorization from his/her immediate supervisor for three (3) consecutive scheduled work days, the employee is considered to have resigned, unless the situation makes this impossible.

J. Occurrence

- 1. Incidents of an employee’s Unscheduled or Unauthorized Absence, Tardiness, or Leaving Early should be documented by the immediate supervisor.
- 2. In the case of frequent or excessive incidents, each Occurrence may be calculated as follows:

OCCURRENCE	POINTS
Unauthorized Absence - one (1) or more consecutive day(s) of Absence(s) for the same reason	1 point for each Absence
Unscheduled Absence - one (1) or more day(s) of Absence for different reasons	1 point for each day
Unscheduled Absence (partial day) - over one (1) hour of Absence.	0.5 point for each incident
Tardiness or Leaving Early (15 or more minutes*)	0.5 point for each incident
Excessive Missed Clocking In or Out three (3) incidents within a thirty (30) business day period	0.5 point for each incident

* Or the specific time frame as defined by the department

- 3. Absences due to injuries or illness that qualify under applicable laws and CalOptima Policies will not be counted against an employee.
 - a. Documentation within the guidelines of the applicable laws may be required in these instances.

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- b. CalOptima will comply with the requirements of applicable federal, state or local laws that are relevant to this Policy.
- 4. Unscheduled/Unauthorized Absence, Tardiness, or Leaving Early occurring because of the following will not be included when considering the employee’s attendance record:
 - a. An approved LOA;
 - b. ”Kin Care” or “Protected Sick Leave” time using PTO in accordance with CalOptima Policy GA.8018 Paid Time Off (PTO);
 - c. Child-Related activities defined under Labor Code Section 230.8;
 - d. Work related injuries; or
 - e. As a reasonable accommodation under the Americans with Disabilities Act.
- 5. The immediate supervisor should properly document each occurrence of Unauthorized Absence, Tardiness, and/or Leave Early.
- 6. Patterns or issues with attendance should first be discussed with the employee. The immediate supervisor may partner with HR to discuss the attendance issue(s).

K. Performance Management Guidelines

- 1. When notified of an attendance issue by the employee’s immediate supervisor, manager, or director, HR shall review an employee’s attendance record and may institute corrective action for excessive Unscheduled Absences, Tardiness, or Leaving Early dating from the most recent occurrence to the prior twelve (12) months. All corrective actions and job performance issues will be taken into consideration when determining level of corrective action, up to and including termination.
- 2. CalOptima may apply the following guidelines, with management discretion, based on circumstances. These guidelines do not account for other job performance or behavioral issues and shall not be the exclusive guide if management is addressing multiple issues in addition to attendance and timekeeping. The guidelines are based on attendance and timekeeping issues on a rolling twelve (12)-month calendar:

Verbal Coaching	Documented Counseling Memo	Written Warning	Final Warning	Possible Termination
Three (3) or more Occurrences	Four (4) or more Occurrences	Six (6) or more Occurrences	Eight (8) or more Occurrences	Nine (9) or more Occurrences

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- 3. Employees are not guaranteed a right to corrective action prior to termination and can be terminated at any time. CalOptima may, at its sole and complete discretion, apply corrective action guidelines on a case by case basis; however, no formal order or system is necessary. CalOptima may terminate an employee at any time without following any particular series of steps.

1 **IV. ATTACHMENTS**

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3 Not Applicable

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5 **V. REFERENCES**

- 6
7 A. California Labor Code, §§230.8, 233, and 246 et seq.
8 B. CalOptima Code of Conduct
9 C. CalOptima Employee Handbook - Attendance, Tardiness and Reporting Absences
10 D. CalOptima Policy GA.8018: Paid Time Off (PTO)
11 E. CalOptima Policy GA.8022: Performance and Behavior Standards
12 F. CalOptima Policy GA.8037: Leave of Absence
13 G. CalOptima Policy GA.8038: Personal Leave of Absence
14 H. CalOptima Policy GA.8040: FMLA and CFRA Leaves of Absence
15 I. CalOptima Policy GA.8041: Worker's Compensation Leave of Absence
16 J. Healthy Workplaces, Healthy Families Act of 2014 (Labor Code §245 et seq.)
17 K. Title 29, Code of Federal Regulations (C.F.R.), §541.710

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19 **VI. REGULATORY AGENCY APPROVALS**

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21 None to Date

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23 **VII. BOARD ACTIONS**

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25 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors

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27 **VIII. REVIEW/REVISION HISTORY**

28

Version	Date	Policy Number	Policy Title
Effective	09/06/2018	GA.8059PP	Attendance and Timekeeping

29

1 IX. GLOSSARY
 2

Term	Definition
Absence	The state of being away or not being present for a portion of or the entire scheduled shift.
Authorized Absence	<p>An absence or deviation from a scheduled shift is authorized when all of the following are met:</p> <ol style="list-style-type: none"> 1) The employee provides sufficient notice (a minimum of one (1) hour prior to the start of the scheduled work time or within the specific time frame defined by the department) to his/her immediate supervisor prior the commencement of his/her shift; 2) The employee provides a valid reason acceptable to his/her immediate supervisor; 3) Such absence request is approved by his/her immediate supervisor; and 4) The employee has: <ol style="list-style-type: none"> a) Sufficient accrued PTO to cover such absence unless otherwise allowed by CalOptima policy (i.e., leave of absence, bereavement, jury duty); or b) The immediate supervisor or manager waives this requirement and allows the absence based on the circumstances; or c) Exceptions as defined by the department.
Central Worksite	CalOptima’s primary physical location of business applicable to the employee, which is either CalOptima’s administration building at 505 City Parkway West or the PACE building.
Child Related Activities	Participation in activities at child’s school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of his or her child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima.
Home Office	A designated workspace within the Teleworker’s residence.
Leave/Leaving Early	An early departure from the scheduled end time of a work shift and/or the scheduled meal break.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.
Occurrence	An incident of (1) a period of Unauthorized Absence; (2) Tardiness or late arrival; (3) Leaving Early without prior approval; or (4) Excessive Missed Clocking In or Out.
Scheduled Absence	Any absence planned and approved in advance with notice consistent with applicable CalOptima policies.
Remote Work Location	The employee’s Home Office or designated pre-approved work location.
Tardiness	The failure of an employee to report on time at the scheduled time of a work shift or return on time from breaks or meal breaks.

Term	Definition
Teleworker	An employee who meets CalOptima's Teleworker eligibility criteria and is approved to routinely work their regularly scheduled work hours from a Remote Work Location, unless business needs require otherwise.
Timekeeping	Process of recording and reporting work arrival, meal breaks, and leave time.
Unauthorized Absence	Any absence when an employee misses one (1) hour or more of his/her scheduled shift without prior approval and when one (1), or more, of the four (4) conditions listed under Authorized Absence are not met.
Unscheduled Absence	An unplanned Absence, Tardiness or Leaving Early without sufficient notice or approval.

1

DRAFT

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

9. Consider Authorizing Employee and Retiree Group Health Insurance for Calendar Year 2019

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into contracts and/or amendments to existing contracts, as necessary, to continue to provide group health insurance, including medical, dental, vision, for CalOptima employees and retirees (and their dependents), and basic employee life insurance and accidental death and dismemberment, short-term and long-term disability, employee assistance program, and flexible spending accounts for Calendar Year (CY) 2019 in an amount not to exceed \$18.5 million;
2. Authorize an increase to CalOptima's contributions to absorb the increase to premium rates of 1.3%, increasing costs to CalOptima in an amount not to exceed \$135,375, which will maintain employee contributions at the same dollar amount as CY 2018;
3. Authorize employer contributions in the estimated amount of \$161,250 to fully fund Health Savings Accounts on 1/1/2019 for employees or retirees enrolled in the CalOptima Cigna high deductible health plan (HDHP) for CY 2019 in anticipation of eliminating the Cigna PPO plan in CY 2020;
4. Authorize the continuation of a Spousal Surcharge of \$50 per pay period (for 24 pay periods) for those employees/retirees whose spouses or Registered Domestic Partners: (a) have access to other medical plans through their own employers or other sources, but choose to be enrolled under the CalOptima plan; or (b) are enrolled in their own medical plan, and elect to also enroll under the CalOptima plan; and
5. Authorize the transition to a 4-tier rate structure for Medical, Dental, and Vision at a cost of approximately \$82,874 to allow for identification of enrolled employee spouses and child/children.

Background

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

By statute, the Board may authorize payment of all, or such portion as it may elect, of premiums for these health and welfare benefits. CalOptima currently pays a portion of the premiums for health and welfare benefits for officers, employees, and eligible retired employees, as well as their eligible dependents. In plan year 2015, there was no increase to the employee contributions because CalOptima received a rate decrease, which in effect decreased CalOptima’s contributions towards the premiums. In plan year 2016, there was an increase in premium rates, wherein CalOptima shared in the costs of premium rate increases, paying a small portion and passing along the remaining increase to employees, averaging roughly 3% to 4% to employee contributions for Kaiser HMO, Cigna HMO, Cigna HDHP, Cigna PPO and Cigna Dental PPO. In plan year 2017, there was an increase in premium rates, wherein CalOptima absorbed the 2.6% or \$375,794 costs of premium rate increases. In plan year 2018, there was an increase in premium rates, wherein CalOptima shared in the costs of premium rate increases.

Discussion

Relation marketed the group health benefits on behalf of CalOptima for the renewal of CalOptima’s health benefit insurance policies, and the total group health benefit insurance package cost, combined with the costs associated with the transition from a 3-tier rate structure to a 4-tier rate structure, will result in an annual increase of 1.3% for CY 2019, totaling \$218,250 (assuming CalOptima absorbs 100% of the increase and employee contributions remain the same as current). The proposed premium increase falls well below the regional average increase range of 8% to 15%. Overall annual premium cost impact to CalOptima is \$135,375. The recommended changes are summarized below:

Benefit Plan	CY 2018	CY 2019	\$ Change
Medical	\$16,006,573	\$16,099,721	\$93,149
Dental	\$1,295,145	\$1,337,307	\$42,162
Vision	\$185,143	\$185,207	\$64
Basic	\$65,377	\$65,377	\$0
Employee Life & AD&D			
Short Term Disability	\$426,552	\$426,552	\$0
Long Term Disability	\$225,512	\$225,512	\$0
Employee Assistance Program	\$35,312	\$35,312	\$0
Flexible Spending Accounts	\$31,092	\$31,092	\$0
Total	\$18,270,706	\$18,406,081	\$135,375
\$ -	\$16,429,608	\$16,647,223	\$218,250
CalOptima’s Share			
Employees’ Share	\$1,841,097	\$1,758,223	(\$82,874)

Please find below additional details by benefit plan for CY 2019:

Medical

Cigna: Relation negotiated a proposed 7.0% increase for active employees/eligible retirees. Cigna's wellness fund will be \$20,000 in 2019. Switch to 4-tier rates.

Kaiser: Kaiser proposed decrease of -5.0% for active employees/eligible retirees and -.76% for Medicare Retirees. Switch to 4-tier rates.

AmWINS PPO: Rates for 2019 will not be available until mid to end of September. AmWINS is for PPO Supplemental Medicare-eligible retirees.

Dental

Cigna Dental: Relation negotiated a final offer of 3.2% increase to the PPO and 4.1% increase to the DHMO for active employees/eligible retirees. Switch to 4-tier rates.

Vision

VSP: Rate pass for active employees/eligible retirees. Switch to 4-tier rates.

Other Ancillary Plans

Cigna Life & Disability: Rate pass.

Employee Assistance Program: Rate pass.

Health Savings Account

CalOptima offers a Health Savings Account for employees enrolled in the Cigna HDHP medical plan. CalOptima first started offering this HDHP medical plan in 2014, and funded the Health Savings Account 100% that same year as an incentive for employees to transition to the HDHP plan. The HDHP medical plan is more cost effective and offers the same benefits as the PPO plan CalOptima currently offers. CalOptima currently has 40 employees enrolled in the more expensive PPO plan. Staff is considering eliminating the more expensive PPO plan in CY 2020. To provide employees with a transition period and to incentivize an early transition to the HDHP medical plan, staff is recommending that CalOptima fund the Health Savings Accounts 100% on 1/1/19 for employees who elect the HDHP medical plan to encourage movement from the PPO plan to the less expensive HDHP plan. Even with CalOptima's funding of the Health Savings Accounts, the anticipated annual savings for CalOptima is \$180,000 for CY 2019, assuming all 40 employees enrolled in the PPO plan transition to the HDHP medical plan.

Transition from 3-Tiers to 4-Tiers

Currently, CalOptima's health benefit rates are arranged in a 3-tier structure, which includes: Employee Only, Employee + 1, and Employee + Family. Staff is recommending a transition to a 4-tier structure to include: Employee Only, Employee + Spouse, Employee + Child(ren), and Employee + Family. The purpose is to identify spousal coverage vs. child coverage. The additional cost to CalOptima for this change is \$82,874 as there will be a reduction in employee contributions when the employees who are currently enrolled in the employee + family tier, and who do not enroll a spouse, transition to the new employee + children tier. Employees who opt for coverage for their child(ren), without adding a spouse, will see a decrease in their contribution dollar amounts, and employees who elect coverage for their

entire family, including their spouse and child(ren), will see an increase in their contribution dollar amounts.

Spousal Surcharge

In CY 2018, the Board authorized a Spousal Surcharge of \$50 per pay period (for 24 pay periods) for employees whose spouses or Registered Domestic Partners (1) have access to other medical plans through their own employers or other sources, but choose to be enrolled under the CalOptima plan, or (2) are enrolled in their own medical plan, and elect to also enroll under the CalOptima plan. This spousal surcharge also applied to retirees. Staff recommends that CalOptima continue to deduct the Spousal Surcharge for CY 2019 and require that employees submit an attestation substantiating the enrollment of their spouse/Registered Domestic Partner.

Comparison

CalOptima's and individual employee's share of the premiums differ depending on the employee's elections. As set forth in the attached presentation, employer contributions for full time employees range from 79.6% to 95.5%. The methodology used to calculate the employer and employee contributions is intended to aid management in attracting and retaining talented employees. CalOptima's group health benefits insurance are comparable to the County of Orange with an average of 89% employer contribution rate for CalOptima's employee only coverage, in comparison to the County's 90% employer contribution rate. However, CalOptima's employer contribution for employees with dependents is higher at an average of 85% employer contribution rate compared to the County's 75% employer contribution rate.

Staff Recommendations

Staff explored and considered the option to increase CalOptima's contributions to absorb only a portion of the increase to premium rates of 0.3%, increasing costs to CalOptima for CY 2019 in an amount not to exceed \$45,007, which would increase the dollar amount employees contribute, but maintain the same percentage distribution between employer and employee share of costs. However, after considering these options, staff recommends that CalOptima absorb the entire rate increase for CY 2019 and maintain employee contribution levels consistent with the CY 2019 levels. This recommendation, along with the other recommended actions, are made based on a thorough review by CalOptima's Human Resources Department to ensure that CalOptima remains competitive with market trends and meets its ongoing obligation to provide a comprehensive benefits package to attract and retain talent.

Fiscal Impact

The recommended action to provide group health insurance policies for employees for the period of January 1, 2019, through June 30, 2019, and associated anticipated expenditures are within the budgeted amounts included in the CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018.

The fiscal impact for group health insurance policies for CalOptima employees in CY 2019 is estimated at a total cost not to exceed \$18.5 million. The employer cost to absorb the increased premiums and transition from a 3-tier structure to a 4-tier structure totals \$218,250 for CY 2019, or \$109,125 for the remainder of FY 2018-19, covering the period of January 1, 2019, through June 30, 2019. Management will include funding for group health insurance policies for the period of July 1, 2019, through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

The fiscal impact to fund the Health Savings Account 100% for employees enrolled in the HDHP medical plan is estimated at \$161,250, depending on the number of employees who enroll in the HDHP medical plan. This fiscal impact will be offset by the cost savings associated with employees transitioning from the PPO plan to the HDHP medical plan.

The fiscal impact to continue the spousal surcharge of \$50 per pay period (for 24 pay periods) is estimated at \$193,200 in savings for CY 2019.

Concurrence

Gary Crockett, Chief Counsel

Attachment

CalOptima Presentation – January 2019 Renewal Meeting

/s/ Michael Schrader
Authorized Signature

8/29/2018
Date



A Public Agency

CalOptima
Better. Together.

January 2019 Renewal Meeting



[Back to Agenda](#)



Based on current enrollment, CalOptima's **2019** NET insurance costs will increase by 1.3% or \$218,250

- ▶ Rates for medical, dental and vision will change to a 4-tier rate structure in order to identify enrolled spouse vs. child
- ▶ CalOptima to fund 100% of the Health Savings Accounts on 1/1/2019 for anyone enrolled in the Cigna HDHP medical plan; incentive to move enrollment from the more expensive PPO to the less expensive HDHP; estimated annual savings is \$180,000
- ▶ Cigna Medical – initial renewal increase was 9.2%. Relation negotiated a final no-bid offer from Cigna that reduces the renewal down to 7.0%; Cigna's wellness fund will remain at \$20,000 for 2019; switch to 4-tier rates
 - Currently 35.5% participation and carriers require 50% or more alongside Kaiser (last year was 36.6%)
- ▶ Kaiser Medical – renewal is a decrease of **-5.0%** for Actives and Early Retirees and a decrease of **-0.76%** for Medicare Retirees; switch to 4-tier rates
- ▶ Cigna Dental – initial renewal increase was 4.2% on the PPO and 5.1% on the DHMO. Relation negotiated a final offer from Cigna of 3.2% on the PPO and 4.1% on the DHMO; switch to 4-tier rates
- ▶ VSP Vision – currently in a rate guarantee; switch to 4-tier rates
- ▶ Cigna Life & Disability – currently in a rate guarantee
- ▶ ACI EAP – currently in a rate guarantee
- ▶ WageWorks FSA – renewal pending
- ▶ AmWINS PPO (Medicare Retirees)– pending; rates for 2019 will be available in September



Recommendation



Total Cost Summary

		2018 Current	2019 4-tier Rates Status Quo Renewal	\$ Change	% Change
All Medical	1136	\$16,006,573	\$16,099,721	\$93,149	0.58%
Kaiser HMO Actives (FT)	648	\$8,374,779	\$7,987,808	(\$386,971)	-4.62%
Kaiser HMO Early Retirees (Pre-65)	7	\$165,111	\$151,938	(\$13,173)	-7.98%
Kaiser HMO Medicare Retirees (Post-65)	17	\$87,701	\$87,035	(\$666)	-0.76%
Cigna HMO Actives & Early Retirees (Pre-65)	354	\$5,586,616	\$5,973,856	\$387,240	6.93%
Cigna PPO Actives & Early Retirees (Pre-65)	40	\$847,008	\$905,840	\$58,832	6.95%
Cigna HDHP Actives Only	43	\$694,701	\$742,588	\$47,887	6.89%
Amwins PPO Medicare Retirees (Post-65)	27	\$184,584	\$184,584	\$0	0.00%
HSA Administration	43	\$2,322	\$2,322	\$0	0.00%
HSA Funding (\$1,250 single / \$2,500 with depts)	43	\$83,750	\$83,750	\$0	0.00%
Wellness Funding		(\$20,000)	(\$20,000)	\$0	0.00%
All Ancillary		\$2,264,133	\$2,306,360	\$42,227	1.87%
Cigna Dental PPO Actives & Retirees	865	\$1,194,795	\$1,232,828	\$38,033	3.18%
Cigna Dental HMO Actives & Retirees	288	\$100,350	\$104,479	\$4,129	4.11%
VSP Vision Actives & Retirees	1,159	\$185,143	\$185,207	\$64	0.03%
Cigna Basic Employee Life & AD&D	1,207	\$65,377	\$65,377	\$0	0.00%
Cigna Short Term Disability	1,206	\$426,552	\$426,552	\$0	0.00%
Cigna Long Term Disability	1,206	\$225,512	\$225,512	\$0	0.00%
ACI Employee Assistance Program	1,206	\$35,312	\$35,312	\$0	0.00%
WageWorks Flexible Spending Accounts	484	\$31,092	\$31,092	\$0	0.00%



Total Cost Summary

CalOptima absorbs 100% of the increase and employees contribution is same dollar amount as current.

	2018 Current	2019 4-tier Rates Status Quo Renewal
Monthly - Estimated	\$1,522,559	\$1,533,840
Annual - Estimated	\$18,270,706	\$18,406,081
Differences		
Versus Current - \$		\$135,375
Versus Current - %		0.7%
Annual Employee Contributions (same \$ as current)	\$1,841,097	\$1,758,223
NET Annual -Estimated (Employer - EE Contribs)	\$16,429,608	\$16,647,858
NET Differences (Employer - EE Contribs)		
Versus Current - \$		\$218,250
Versus Current - %		1.3%



Employee Contributions (same \$ as current)

Full-Time Actives and Early Retirees

FULL TIME ACTIVES & EARLY RETIREES	Enrollment	2018 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Early Retirees		Cigna HMO				
Employee	112	\$616.30	\$34.98	5.7%	\$581.32	94.3%
Employee + One	73	\$1,294.23	\$88.29	6.8%	\$1,205.94	93.2%
Employee + Family	169	<u>\$1,787.26</u>	<u>\$127.81</u>	7.2%	<u>\$1,659.45</u>	92.8%
MONTHLY TOTAL	354	\$465,551	\$31,963		\$433,589	
Actives & Early Retirees		Cigna PPO				
Employee	18	\$988.58	\$187.02	18.9%	\$801.56	81.1%
Employee + One	13	\$2,075.98	\$445.30	21.5%	\$1,630.68	78.6%
Employee + Family	9	<u>\$2,866.87</u>	<u>\$667.98</u>	23.3%	<u>\$2,198.89</u>	76.7%
MONTHLY TOTAL	40	\$70,584	\$15,167		\$55,417	
Actives		Cigna HDHP				
Employee	19	\$748.92	\$102.13	13.6%	\$646.79	86.4%
Employee + One	9	\$1,589.68	\$275.52	17.3%	\$1,314.16	82.7%
Employee + Family	15	<u>\$1,957.01</u>	<u>\$498.18</u>	25.5%	<u>\$1,458.83</u>	74.5%
MONTHLY TOTAL	43	\$57,892	\$11,893		\$45,999	
Actives		Kaiser HMO				
Employee	246	\$581.29	\$34.98	6.0%	\$546.31	94.0%
Employee + One	151	\$1,162.58	\$88.29	7.6%	\$1,074.29	92.4%
Employee + Family	251	<u>\$1,511.36</u>	<u>\$127.81</u>	8.5%	<u>\$1,383.55</u>	91.5%
MONTHLY TOTAL	648	\$697,898	\$54,017		\$643,881	
Early Retirees		Kaiser HMO				
Employee	0	\$870.84	\$34.98	4.0%	\$835.86	96.0%
Employee + One	4	\$1,741.68	\$88.29	5.1%	\$1,653.39	94.9%
Employee + Family	3	<u>\$2,264.19</u>	<u>\$127.81</u>	5.6%	<u>\$2,136.38</u>	94.4%
MONTHLY TOTAL	7	\$13,759	\$737		\$13,023	

FULL TIME ACTIVES & EARLY RETIREES	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Early Retirees		Cigna HMO				
Employee	112	\$659.47	\$34.98	5.3%	\$624.49	94.7%
Employee + Spouse	66	\$1,443.08	\$88.29	6.1%	\$1,354.79	93.9%
Employee + Child(ren)	45	\$1,303.43	\$79.75	6.1%	\$1,223.68	93.9%
Employee + Family	131	<u>\$2,061.55</u>	<u>\$127.81</u>	6.2%	<u>\$1,933.74</u>	93.8%
MONTHLY TOTAL	354	\$497,821	\$30,077		\$467,745	
Actives & Early Retirees		Cigna PPO				
Employee	18	\$1,057.81	\$187.02	17.7%	\$870.79	82.3%
Employee + Spouse	11	\$2,291.60	\$445.30	19.4%	\$1,846.30	80.6%
Employee + Child(ren)	4	\$2,072.70	\$402.76	19.4%	\$1,669.94	80.6%
Employee + Family	7	<u>\$3,278.24</u>	<u>\$667.98</u>	20.4%	<u>\$2,610.26</u>	79.6%
MONTHLY TOTAL	40	\$75,487	\$14,552		\$60,935	
Actives		Cigna HDHP				
Employee	19	\$801.37	\$102.13	12.7%	\$699.24	87.3%
Employee + Spouse	5	\$1,609.35	\$275.52	17.1%	\$1,333.83	82.9%
Employee + Child(ren)	6	\$1,453.61	\$248.86	17.1%	\$1,204.75	82.9%
Employee + Family	13	<u>\$2,299.07</u>	<u>\$498.18</u>	21.7%	<u>\$1,800.89</u>	78.3%
MONTHLY TOTAL	43	\$61,882	\$11,288		\$50,595	
Actives		Kaiser HMO				
Employee	246	\$518.54	\$34.98	6.7%	\$483.56	93.3%
Employee + Spouse	77	\$1,037.08	\$88.29	8.5%	\$948.79	91.5%
Employee + Child(ren)	124	\$985.23	\$79.75	8.5%	\$905.48	91.9%
Employee + Family	201	<u>\$1,659.33</u>	<u>\$127.81</u>	7.7%	<u>\$1,531.52</u>	92.3%
MONTHLY TOTAL	648	\$663,110	\$50,982		\$612,128	
Early Retirees		Kaiser HMO				
Employee	0	\$776.78	\$34.98	4.5%	\$741.80	95.5%
Employee + Spouse	4	\$1,553.56	\$88.29	5.7%	\$1,465.27	94.3%
Employee + Child(ren)	1	\$1,475.89	\$79.75	5.4%	\$1,396.14	94.6%
Employee + Family	2	<u>\$2,485.70</u>	<u>\$127.81</u>	5.1%	<u>\$2,357.89</u>	94.9%
MONTHLY TOTAL	7	\$12,662	\$689		\$11,973	



Employee Contributions (same \$ as current)

Part-Time Actives and Medicare Retirees

PART TIME ACTIVES	Enrollment	2018 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Cigna HMO						
Employee	0	\$616.30	\$69.97	11.4%	\$546.33	88.6%
Employee + One	0	\$1,294.23	\$176.57	13.6%	\$1,117.66	86.4%
Employee + Family	0	<u>\$1,787.26</u>	<u>\$255.63</u>	14.3%	<u>\$1,531.63</u>	85.7%
MONTHLY TOTAL	0	\$0	\$0		\$0	
Cigna PPO						
Employee	0	\$988.58	\$374.04	37.8%	\$614.54	62.2%
Employee + One	0	\$2,075.98	\$890.62	42.9%	\$1,185.36	57.1%
Employee + Family	0	<u>\$2,866.87</u>	<u>\$1,335.93</u>	46.6%	<u>\$1,530.94</u>	53.4%
MONTHLY TOTAL	0	\$0	\$0		\$0	
Cigna HDHP						
Employee	0	\$748.92	\$204.25	27.3%	\$544.67	72.7%
Employee + One	0	\$1,589.68	\$551.03	34.7%	\$1,038.65	65.3%
Employee + Family	0	<u>\$1,957.01</u>	<u>\$996.37</u>	50.9%	<u>\$960.64</u>	49.1%
MONTHLY TOTAL	0	\$0	\$0		\$0	
Kaiser HMO						
Employee	3	\$581.29	\$69.97	12.0%	\$511.32	88.0%
Employee + One	1	\$1,162.58	\$176.57	15.2%	\$986.01	84.8%
Employee + Family	0	<u>\$1,511.36</u>	<u>\$255.63</u>	16.9%	<u>\$1,255.73</u>	83.1%
MONTHLY TOTAL	4	\$2,906	\$386		\$2,520	
		\$15,703,093	\$1,369,952		\$14,333,142	
MEDICARE RETIREES	Enrollment	2018 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Amwins PPO						
Retiree (Medicare)	13	\$375.17	\$90.49	24.1%	\$284.68	75.9%
Retiree + 1 (2 Medicare)	14	<u>\$750.34</u>	<u>\$215.24</u>	28.7%	\$535.10	71.3%
MONTHLY TOTAL	27	\$15,382	\$4,190		\$11,192	
Kaiser HMO						
Subscriber with Medicare	7	\$213.45	\$12.85	6.0%	\$200.60	94.0%
Subscriber with Medicare + Spouse Non-Medicare	2	\$1,084.29	\$82.35	7.6%	\$1,001.94	92.4%
Subscriber with Medicare + Spouse Medicare	6	\$426.90	\$32.42	7.6%	\$394.48	92.4%
Subscriber Non-Medicare + Spouse Medicare	1	\$1,084.29	\$91.69	8.5%	\$992.60	91.5%
Subscriber with Medicare and children Non-Medicare	1	<u>\$1,606.80</u>	<u>\$135.88</u>	8.5%	<u>\$1,470.92</u>	91.5%
MONTHLY TOTAL	17	\$8,915	\$677		\$8,239	

PART TIME ACTIVES	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Cigna HMO						
Employee	0	\$659.47	\$69.97	10.6%	\$589.50	89.4%
Employee + Spouse	0	\$1,443.08	\$176.57	12.2%	\$1,266.51	87.8%
Employee + Child(ren)	0	\$1,303.43	\$159.50	12.2%	\$1,143.93	87.8%
Employee + Family	0	<u>\$2,061.55</u>	<u>\$255.63</u>	12.4%	<u>\$1,805.92</u>	87.6%
MONTHLY TOTAL	0	\$0	\$0		\$0	
Cigna PPO						
Employee	0	\$1,057.81	\$374.04	35.4%	\$683.77	64.6%
Employee + Spouse	0	\$2,291.60	\$890.62	38.9%	\$1,400.98	61.1%
Employee + Child(ren)	0	\$2,072.70	\$805.52	38.9%	\$1,267.18	61.1%
Employee + Family	0	<u>\$3,278.24</u>	<u>\$1,335.93</u>	40.8%	<u>\$1,942.31</u>	59.2%
MONTHLY TOTAL	0	\$0	\$0		\$0	
Cigna HDHP						
Employee	0	\$801.37	\$204.25	25.5%	\$597.12	74.5%
Employee + Spouse	0	\$1,609.35	\$551.03	34.2%	\$1,058.32	65.8%
Employee + Child(ren)	0	\$1,453.61	\$497.72	34.2%	\$955.89	65.8%
Employee + Family	0	<u>\$2,299.07</u>	<u>\$996.37</u>	43.3%	<u>\$1,302.70</u>	56.7%
MONTHLY TOTAL	0	\$0	\$0		\$0	
Kaiser HMO						
Employee	3	\$518.54	\$69.97	13.5%	\$448.57	86.5%
Employee + Spouse	0	\$1,037.08	\$176.57	17.0%	\$860.51	83.0%
Employee + Child(ren)	1	\$985.23	\$159.50	16.2%	\$825.73	83.8%
Employee + Family	0	<u>\$1,659.33</u>	<u>\$255.63</u>	15.4%	<u>\$1,403.70</u>	84.6%
MONTHLY TOTAL	4	\$2,541	\$369		\$2,171	
		\$15,762,031	\$1,295,465		\$14,466,565	
MEDICARE RETIREES	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Amwins PPO						
Retiree (Medicare)	13	\$375.17	\$90.49	24.1%	\$284.68	75.9%
Retiree + 1 (2 Medicare)	14	<u>\$750.34</u>	<u>\$215.24</u>	28.7%	\$535.10	71.3%
MONTHLY TOTAL	27	\$15,382	\$4,190		\$11,192	
Kaiser HMO						
Subscriber with Medicare	7	\$216.85	\$14.63	6.7%	\$202.22	93.3%
Subscriber with Medicare + Spouse Non-Medicare	2	\$1,044.25	\$88.90	8.5%	\$955.35	91.5%
Subscriber with Medicare + Spouse Medicare	6	\$433.70	\$36.92	8.5%	\$396.78	91.5%
Subscriber Non-Medicare + Spouse Medicare	1	\$1,044.25	\$80.43	7.7%	\$963.82	92.3%
Subscriber with Medicare and children Non-Medicare	1	<u>\$1,540.69</u>	<u>\$118.67</u>	7.7%	<u>\$1,422.02</u>	92.3%
MONTHLY TOTAL	17	\$8,794	\$701		\$8,093	



Employee Contributions (same \$ as current)

Dental and Vision for All

FULL TIME DENTAL & VISION	Enrollment	2018 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Retirees Dental PPO						
Employee	314	\$47.48	\$5.20	11.0%	\$42.28	89.0%
Employee + One	254	\$96.74	\$15.72	16.2%	\$81.02	83.8%
Employee + Family	360	<u>\$166.24</u>	<u>\$31.54</u>	19.0%	<u>\$134.70</u>	81.0%
MONTHLY TOTAL	928	\$99,327	\$16,980		\$82,347	
Actives & Retirees Dental HMO						
Employee	104	\$12.56	\$0.00	0.0%	\$12.56	100.0%
Employee + One	65	\$25.23	\$0.00	0.0%	\$25.23	100.0%
Employee + Family	124	<u>\$43.23</u>	<u>\$0.00</u>	0.0%	<u>\$43.23</u>	100.0%
MONTHLY TOTAL	293	\$8,307	\$0		\$8,307	
Actives & Retirees VSP Vision						
Employee	451	\$7.37	\$0.00	0.0%	\$7.37	100.0%
Employee + One	307	\$11.45	\$1.00	8.7%	\$10.45	91.3%
Employee + Family	470	<u>\$18.15</u>	<u>\$2.00</u>	11.0%	<u>\$16.15</u>	89.0%
MONTHLY TOTAL	1,228	\$15,370	\$1,247		\$14,123	
PART TIME DENTAL & VISION	Enrollment	2018 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives Dental PPO						
Employee	3	\$47.48	\$10.40	21.9%	\$37.08	78.1%
Employee + One	1	\$96.74	\$31.44	32.5%	\$65.30	67.5%
Employee + Family	0	<u>\$166.24</u>	<u>\$63.08</u>	37.9%	<u>\$103.16</u>	62.1%
MONTHLY TOTAL	4	\$239	\$63		\$177	
Actives Dental HMO						
Employee	1	\$12.56	\$0.00	0.0%	\$12.56	100.0%
Employee + One	0	\$25.23	\$0.00	0.0%	\$25.23	100.0%
Employee + Family	1	<u>\$43.23</u>	<u>\$0.00</u>	0.0%	<u>\$43.23</u>	100.0%
MONTHLY TOTAL	2	\$56	\$0		\$56	
Actives VSP Vision						
Employee	4	\$7.37	\$0.00	0.0%	\$7.37	100.0%
Employee + One	1	\$11.45	\$2.00	17.5%	\$9.45	82.5%
Employee + Family	1	<u>\$18.15</u>	<u>\$4.00</u>	22.0%	<u>\$14.15</u>	78.0%
MONTHLY TOTAL	6	\$59	\$6		\$53	

Plus Spousal Surcharge \$193,200 (\$193,200)
 CalOptima HSA Funding (\$1,250 single / \$2,500 family) \$0 \$83,750

MONTHLY TOTAL	\$1,456,246	\$153,425	\$1,309,800
ANNUAL TOTAL	\$17,474,948	\$1,841,097	\$15,717,601

% Share of Premium 10.5% 89.9%

FULL TIME DENTAL & VISION	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Retirees Dental PPO						
Employee	314	\$48.26	\$5.20	10.8%	\$43.06	89.2%
Employee + Spouse	169	\$95.88	\$15.72	16.4%	\$80.16	83.6%
Employee + Child(ren)	187	\$123.18	\$20.20	16.4%	\$102.98	83.6%
Employee + Family	258	<u>\$186.34</u>	<u>\$31.54</u>	16.9%	<u>\$154.80</u>	83.1%
MONTHLY TOTAL	928	\$102,468	\$16,203		\$86,264	
Actives & Retirees Dental HMO						
Employee	104	\$12.76	\$0.00	0.0%	\$12.76	100.0%
Employee + Spouse	33	\$25.34	\$0.00	0.0%	\$25.34	100.0%
Employee + Child(ren)	72	\$32.56	\$0.00	0.0%	\$32.56	100.0%
Employee + Family	84	<u>\$49.25</u>	<u>\$0.00</u>	0.0%	<u>\$49.25</u>	100.0%
MONTHLY TOTAL	293	\$8,645	\$0		\$8,645	
Actives & Retirees VSP Vision						
Employee	451	\$7.37	\$0.00	0.0%	\$7.37	100.0%
Employee + Spouse	150	\$11.45	\$1.00	8.7%	\$10.45	91.3%
Employee + Child(ren)	227	\$11.93	\$1.50	12.6%	\$10.43	87.4%
Employee + Family	400	<u>\$19.06</u>	<u>\$2.00</u>	10.5%	<u>\$17.06</u>	89.5%
MONTHLY TOTAL	1,228	\$15,373	\$1,291		\$14,083	
PART TIME DENTAL & VISION	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives Dental PPO						
Employee	3	\$48.26	\$10.40	21.5%	\$37.86	78.5%
Employee + Spouse	0	\$95.88	\$31.44	32.8%	\$64.44	67.2%
Employee + Child(ren)	1	\$123.18	\$40.39	32.8%	\$82.79	67.2%
Employee + Family	0	<u>\$186.34</u>	<u>\$63.08</u>	33.9%	<u>\$123.26</u>	66.1%
MONTHLY TOTAL	4	\$268	\$72		\$196	
Actives Dental HMO						
Employee	1	\$12.76	\$0.00	0.0%	\$12.76	100.0%
Employee + Spouse	0	\$25.34	\$0.00	0.0%	\$25.34	100.0%
Employee + Child(ren)	0	\$32.56	\$0.00	0.0%	\$32.56	100.0%
Employee + Family	1	<u>\$49.25</u>	<u>\$0.00</u>	0.0%	<u>\$49.25</u>	100.0%
MONTHLY TOTAL	2	\$62	\$0		\$62	
Actives VSP Vision						
Employee	4	\$7.37	\$0.00	0.0%	\$7.37	100.0%
Employee + Spouse	0	\$11.45	\$2.00	17.5%	\$9.45	82.5%
Employee + Child(ren)	1	\$11.93	\$3.00	25.1%	\$8.93	74.9%
Employee + Family	1	<u>\$19.06</u>	<u>\$4.00</u>	21.0%	<u>\$15.06</u>	79.0%
MONTHLY TOTAL	6	\$60	\$7		\$53	

Plus Spousal Surcharge \$193,200 (\$193,200)
 CalOptima HSA Funding (\$1,250 single / \$2,500 family) \$0 \$83,750

MONTHLY TOTAL	\$1,464,554	\$146,519	\$1,325,015
ANNUAL TOTAL	\$17,574,652	\$1,758,223	\$15,900,180
\$ Difference From Current	\$99,704	(\$82,875)	\$182,579

% Share of Premium 10.0% 90.5%



Option



Total Cost Summary

		2018 Current	2019 4-tier Rates Status Quo Renewal	\$ Change	% Change
All Medical	1136	\$16,006,573	\$16,099,721	\$93,149	0.58%
Kaiser HMO Actives (FT)	648	\$8,374,779	\$7,987,808	(\$386,971)	-4.62%
Kaiser HMO Early Retirees(Pre-65)	7	\$165,111	\$151,938	(\$13,173)	-7.98%
Kaiser HMO Medicare Retirees(Post-65)	17	\$87,701	\$87,035	(\$666)	-0.76%
Cigna HMO Actives & Early Retirees (Pre-65)	354	\$5,586,616	\$5,973,856	\$387,240	6.93%
Cigna PPO Actives & Early Retirees (Pre-65)	40	\$847,008	\$905,840	\$58,832	6.95%
Cigna HDHP Actives Only	43	\$694,701	\$742,588	\$47,887	6.89%
Amwins PPO Medicare Retirees (Post-65)	27	\$184,584	\$184,584	\$0	0.00%
HSA Administration	43	\$2,322	\$2,322	\$0	0.00%
HSA Funding (\$1,250 single / \$2,500 with depts)	43	\$83,750	\$83,750	\$0	0.00%
Wellness Funding		(\$20,000)	(\$20,000)	\$0	0.00%
All Ancillary		\$2,264,133	\$2,306,360	\$42,227	1.87%
Cigna Dental PPO Actives & Retirees	865	\$1,194,795	\$1,232,828	\$38,033	3.18%
Cigna Dental HMO Actives & Retirees	288	\$100,350	\$104,479	\$4,129	4.11%
VSP Vision Actives & Retirees	1,159	\$185,143	\$185,207	\$64	0.03%
Cigna Basic Employee Life & AD&D	1,207	\$65,377	\$65,377	\$0	0.00%
Cigna Short Term Disability	1,206	\$426,552	\$426,552	\$0	0.00%
Cigna Long Term Disability	1,206	\$225,512	\$225,512	\$0	0.00%
ACI Employee Assistance Program	1,206	\$35,312	\$35,312	\$0	0.00%
WageWorks Flexible Spending Accounts	484	\$31,092	\$31,092	\$0	0.00%



Total Cost Summary

CalOptima shares the increase with employees; employees contribution is same percentage as current.

	2018 Current	2019 4-tier Rates Status Quo Renewal
Monthly - Estimated	\$1,522,559	\$1,533,840
Annual - Estimated	\$18,270,706	\$18,406,081
Differences		
Versus Current - \$		\$135,375
Versus Current - %		0.7%
Annual Employee Contributions (same % as current)	\$1,841,097	\$1,931,466
NET Annual -Estimated (Employer - EE Contribs)	\$16,429,608	\$16,474,615
NET Differences (Employer - EE Contribs)		
Versus Current - \$		\$45,007
Versus Current - %		0.3%



Employee Contributions (same % as current)

Full-Time Actives and Early Retirees

FULL TIME ACTIVES & EARLY RETIREES	Enrollment	2018 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Early Retirees Cigna HMO						
Employee	112	\$616.30	\$34.98	5.7%	\$581.32	94.3%
Employee + One	73	\$1,294.23	\$88.29	6.8%	\$1,205.94	93.2%
Employee + Family	169	<u>\$1,787.26</u>	<u>\$127.81</u>	7.2%	<u>\$1,659.45</u>	92.8%
MONTHLY TOTAL	354	\$465,551	\$31,963		\$433,589	
Actives & Early Retirees Cigna PPO						
Employee	18	\$988.58	\$187.02	18.9%	\$801.56	81.1%
Employee + One	13	\$2,075.98	\$445.30	21.5%	\$1,630.68	78.6%
Employee + Family	9	<u>\$2,866.87</u>	<u>\$667.98</u>	23.3%	<u>\$2,198.89</u>	76.7%
MONTHLY TOTAL	40	\$70,584	\$15,167		\$55,417	
Actives Cigna HDHP						
Employee	19	\$748.92	\$102.13	13.6%	\$646.79	86.4%
Employee + One	9	\$1,589.68	\$275.52	17.3%	\$1,314.16	82.7%
Employee + Family	15	<u>\$1,957.01</u>	<u>\$498.18</u>	25.5%	<u>\$1,458.83</u>	74.5%
MONTHLY TOTAL	43	\$57,892	\$11,893		\$45,999	
Actives Kaiser HMO						
Employee	246	\$581.29	\$34.98	6.0%	\$546.31	94.0%
Employee + One	151	\$1,162.58	\$88.29	7.6%	\$1,074.29	92.4%
Employee + Family	251	<u>\$1,511.36</u>	<u>\$127.81</u>	8.5%	<u>\$1,383.55</u>	91.5%
MONTHLY TOTAL	648	\$697,898	\$54,017		\$643,881	
Early Retirees Kaiser HMO						
Employee	0	\$870.84	\$34.98	4.0%	\$835.86	96.0%
Employee + One	4	\$1,741.68	\$88.29	5.1%	\$1,653.39	94.9%
Employee + Family	3	<u>\$2,264.19</u>	<u>\$127.81</u>	5.6%	<u>\$2,136.38</u>	94.4%
MONTHLY TOTAL	7	\$13,759	\$737		\$13,023	

FULL TIME ACTIVES & EARLY RETIREES	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Early Retirees Cigna HMO						
Employee	112	\$659.47	\$37.43	5.7%	\$622.04	94.3%
Employee + Spouse	66	\$1,443.08	\$98.45	6.8%	\$1,344.63	93.2%
Employee + Child(ren)	45	\$1,303.43	\$88.92	6.8%	\$1,214.51	93.2%
Employee + Family	131	<u>\$2,061.55</u>	<u>\$147.42</u>	7.2%	<u>\$1,914.13</u>	92.8%
MONTHLY TOTAL	354	\$497,821	\$34,003		\$463,818	
Actives & Early Retirees Cigna PPO						
Employee	18	\$1,057.81	\$200.12	18.9%	\$857.69	81.1%
Employee + Spouse	11	\$2,291.60	\$491.55	21.5%	\$1,800.05	78.6%
Employee + Child(ren)	4	\$2,072.70	\$444.59	21.5%	\$1,628.11	78.6%
Employee + Family	7	<u>\$3,278.24</u>	<u>\$763.83</u>	23.3%	<u>\$2,514.41</u>	76.7%
MONTHLY TOTAL	40	\$75,487	\$16,134		\$59,352	
Actives Cigna HDHP						
Employee	19	\$801.37	\$109.28	13.6%	\$692.09	86.4%
Employee + Spouse	5	\$1,609.35	\$278.93	17.3%	\$1,330.42	82.7%
Employee + Child(ren)	6	\$1,453.61	\$251.94	17.3%	\$1,201.67	82.7%
Employee + Family	13	<u>\$2,299.07</u>	<u>\$585.25</u>	25.5%	<u>\$1,713.82</u>	74.5%
MONTHLY TOTAL	43	\$61,882	\$12,591		\$49,291	
Actives Kaiser HMO						
Employee	246	\$518.54	\$37.43	7.2%	\$481.11	92.8%
Employee + Spouse	77	\$1,037.08	\$98.45	9.5%	\$938.63	90.5%
Employee + Child(ren)	124	\$985.23	\$88.92	9.5%	\$896.31	91.0%
Employee + Family	201	<u>\$1,659.33</u>	<u>\$147.42</u>	8.9%	<u>\$1,511.91</u>	91.1%
MONTHLY TOTAL	648	\$663,110	\$57,446		\$605,663	
Early Retirees Kaiser HMO						
Employee	0	\$776.78	\$37.43	4.8%	\$739.35	95.2%
Employee + Spouse	4	\$1,553.56	\$98.45	6.3%	\$1,455.11	93.7%
Employee + Child(ren)	1	\$1,475.89	\$88.92	6.0%	\$1,386.97	94.0%
Employee + Family	2	<u>\$2,485.70</u>	<u>\$147.42</u>	5.9%	<u>\$2,338.28</u>	94.1%
MONTHLY TOTAL	7	\$12,662	\$778		\$11,884	



Employee Contributions (same % as current)

Part-Time Actives and Medicare Retirees

PART TIME ACTIVES	Enrollment	2018 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Cigna HMO						
Employee	0	\$616.30	\$69.97	11.4%	\$546.33	88.6%
Employee + One	0	\$1,294.23	\$176.57	13.6%	\$1,117.66	86.4%
Employee + Family	0	<u>\$1,787.26</u>	<u>\$255.63</u>	14.3%	<u>\$1,531.63</u>	85.7%
MONTHLY TOTAL	0	\$0	\$0		\$0	
Cigna PPO						
Employee	0	\$988.58	\$374.04	37.8%	\$614.54	62.2%
Employee + One	0	\$2,075.98	\$890.62	42.9%	\$1,185.36	57.1%
Employee + Family	0	<u>\$2,866.87</u>	<u>\$1,335.93</u>	46.6%	<u>\$1,530.94</u>	53.4%
MONTHLY TOTAL	0	\$0	\$0		\$0	
Cigna HDHP						
Employee	0	\$748.92	\$204.25	27.3%	\$544.67	72.7%
Employee + One	0	\$1,589.68	\$551.03	34.7%	\$1,038.65	65.3%
Employee + Family	0	<u>\$1,957.01</u>	<u>\$996.37</u>	50.9%	<u>\$960.64</u>	49.1%
MONTHLY TOTAL	0	\$0	\$0		\$0	
Kaiser HMO						
Employee	3	\$581.29	\$69.97	12.0%	\$511.32	88.0%
Employee + One	1	\$1,162.58	\$176.57	15.2%	\$986.01	84.8%
Employee + Family	0	<u>\$1,511.36</u>	<u>\$255.63</u>	16.9%	<u>\$1,255.73</u>	83.1%
MONTHLY TOTAL	4	\$2,906	\$386		\$2,520	
		\$15,703,093	\$1,369,952		\$14,333,142	
MEDICARE RETIREES	Enrollment	2018 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Amwins PPO						
Retiree (Medicare)	13	\$375.17	\$90.49	24.1%	\$284.68	75.9%
Retiree + 1 (2 Medicare)	14	<u>\$750.34</u>	<u>\$215.24</u>	28.7%	<u>\$535.10</u>	71.3%
MONTHLY TOTAL	27	\$15,382	\$4,190		\$11,192	
Kaiser HMO						
Subscriber with Medicare	7	\$213.45	\$12.85	6.0%	\$200.60	94.0%
Subscriber with Medicare + Spouse Non-Medicare	2	\$1,084.29	\$82.35	7.6%	\$1,001.94	92.4%
Subscriber with Medicare + Spouse Medicare	6	\$426.90	\$32.42	7.6%	\$394.48	92.4%
Subscriber Non-Medicare + Spouse Medicare	1	\$1,084.29	\$91.69	8.5%	\$992.60	91.5%
Subscriber with Medicare and children Non-Medicare	1	<u>\$1,606.80</u>	<u>\$135.88</u>	8.5%	<u>\$1,470.92</u>	91.5%
MONTHLY TOTAL	17	\$8,915	\$677		\$8,239	

PART TIME ACTIVES	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Cigna HMO						
Employee	0	\$659.47	\$74.87	11.4%	\$584.60	88.6%
Employee + Spouse	0	\$1,443.08	\$196.88	13.6%	\$1,246.20	86.4%
Employee + Child(ren)	0	\$1,303.43	\$177.83	13.6%	\$1,125.60	86.4%
Employee + Family	0	<u>\$2,061.55</u>	<u>\$294.86</u>	14.3%	<u>\$1,766.69</u>	85.7%
MONTHLY TOTAL	0	\$0	\$0		\$0	
Cigna PPO						
Employee	0	\$1,057.81	\$400.23	37.8%	\$657.58	62.2%
Employee + Spouse	0	\$2,291.60	\$983.12	42.9%	\$1,308.48	57.1%
Employee + Child(ren)	0	\$2,072.70	\$889.21	42.9%	\$1,183.49	57.1%
Employee + Family	0	<u>\$3,278.24</u>	<u>\$1,527.63</u>	46.6%	<u>\$1,750.61</u>	53.4%
MONTHLY TOTAL	0	\$0	\$0		\$0	
Cigna HDHP						
Employee	0	\$801.37	\$218.56	27.3%	\$582.81	72.7%
Employee + Spouse	0	\$1,609.35	\$557.85	34.7%	\$1,051.50	65.3%
Employee + Child(ren)	0	\$1,453.61	\$503.86	34.7%	\$949.75	65.3%
Employee + Family	0	<u>\$2,299.07</u>	<u>\$1,170.53</u>	50.9%	<u>\$1,128.54</u>	49.1%
MONTHLY TOTAL	0	\$0	\$0		\$0	
Kaiser HMO						
Employee	3	\$518.54	\$74.87	14.4%	\$443.67	85.6%
Employee + Spouse	0	\$1,037.08	\$196.88	19.0%	\$840.20	81.0%
Employee + Child(ren)	1	\$985.23	\$177.83	18.0%	\$807.40	82.0%
Employee + Family	0	<u>\$1,659.33</u>	<u>\$294.86</u>	17.8%	<u>\$1,364.47</u>	82.2%
MONTHLY TOTAL	4	\$2,541	\$402		\$2,138	
		\$15,762,031	\$1,456,260		\$14,305,770	
MEDICARE RETIREES	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Amwins PPO						
Retiree (Medicare)	13	\$375.17	\$90.49	24.1%	\$284.68	75.9%
Retiree + 1 (2 Medicare)	14	<u>\$750.34</u>	<u>\$215.24</u>	28.7%	<u>\$535.10</u>	71.3%
MONTHLY TOTAL	27	\$15,382	\$4,190		\$11,192	
Kaiser HMO						
Subscriber with Medicare	7	\$216.85	\$15.65	7.2%	\$201.20	92.8%
Subscriber with Medicare + Spouse Non-Medicare	2	\$1,044.25	\$99.13	9.5%	\$945.12	90.5%
Subscriber with Medicare + Spouse Medicare	6	\$433.70	\$41.17	9.5%	\$392.53	90.5%
Subscriber Non-Medicare + Spouse Medicare	1	\$1,044.25	\$92.78	8.9%	\$951.47	91.1%
Subscriber with Medicare and children Non-Medicare	1	<u>\$1,540.69</u>	<u>\$136.88</u>	8.9%	<u>\$1,403.81</u>	91.1%
MONTHLY TOTAL	17	\$8,794	\$785		\$8,009	



Employee Contributions (same % as current)

Dental and Vision for All

FULL TIME DENTAL & VISION	Enrollment	2018 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Retirees Dental PPO						
Employee	314	\$47.48	\$5.20	11.0%	\$42.28	89.0%
Employee + One	254	\$96.74	\$15.72	16.2%	\$81.02	83.8%
Employee + Family	360	<u>\$166.24</u>	<u>\$31.54</u>	19.0%	<u>\$134.70</u>	81.0%
MONTHLY TOTAL	928	\$99,327	\$16,980		\$82,347	
Actives & Retirees Dental HMO						
Employee	104	\$12.56	\$0.00	0.0%	\$12.56	100.0%
Employee + One	65	\$25.23	\$0.00	0.0%	\$25.23	100.0%
Employee + Family	124	<u>\$43.23</u>	<u>\$0.00</u>	0.0%	<u>\$43.23</u>	100.0%
MONTHLY TOTAL	293	\$8,307	\$0		\$8,307	
Actives & Retirees VSP Vision						
Employee	451	\$7.37	\$0.00	0.0%	\$7.37	100.0%
Employee + One	307	\$11.45	\$1.00	8.7%	\$10.45	91.3%
Employee + Family	470	<u>\$18.15</u>	<u>\$2.00</u>	11.0%	<u>\$16.15</u>	89.0%
MONTHLY TOTAL	1,228	\$15,370	\$1,247		\$14,123	
PART TIME DENTAL & VISION	Enrollment	2018 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives Dental PPO						
Employee	3	\$47.48	\$10.40	21.9%	\$37.08	78.1%
Employee + One	1	\$96.74	\$31.44	32.5%	\$65.30	67.5%
Employee + Family	0	<u>\$166.24</u>	<u>\$63.08</u>	37.9%	<u>\$103.16</u>	62.1%
MONTHLY TOTAL	4	\$239	\$63		\$177	
Actives Dental HMO						
Employee	1	\$12.56	\$0.00	0.0%	\$12.56	100.0%
Employee + One	0	\$25.23	\$0.00	0.0%	\$25.23	100.0%
Employee + Family	1	<u>\$43.23</u>	<u>\$0.00</u>	0.0%	<u>\$43.23</u>	100.0%
MONTHLY TOTAL	2	\$56	\$0		\$56	
Actives VSP Vision						
Employee	4	\$7.37	\$0.00	0.0%	\$7.37	100.0%
Employee + One	1	\$11.45	\$2.00	17.5%	\$9.45	82.5%
Employee + Family	1	<u>\$18.15</u>	<u>\$4.00</u>	22.0%	<u>\$14.15</u>	78.0%
MONTHLY TOTAL	6	\$59	\$6		\$53	

Plus Spousal Surcharge **\$193,200**
 CalOptima HSA Funding (\$1,250 single / \$2,500 family) **\$0** **(\$193,000)**
\$83,750

MONTHLY TOTAL	\$1,456,246	\$153,425	\$1,309,817
ANNUAL TOTAL	\$17,474,948	\$1,841,097	\$15,717,801

% Share of Premium **10.5%** **89.9%**

FULL TIME DENTAL & VISION	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Retirees Dental PPO						
Employee	314	\$48.26	\$5.29	11.0%	\$42.97	89.0%
Employee + Spouse	169	\$95.88	\$15.58	16.2%	\$80.30	83.8%
Employee + Child(ren)	187	\$123.18	\$20.02	16.2%	\$103.16	83.8%
Employee + Family	258	<u>\$186.34</u>	<u>\$35.35</u>	19.0%	<u>\$150.99</u>	81.0%
MONTHLY TOTAL	928	\$102,468	\$17,157		\$85,311	
Actives & Retirees Dental HMO						
Employee	104	\$12.76	\$0.00	0.0%	\$12.76	100.0%
Employee + Spouse	33	\$25.34	\$0.00	0.0%	\$25.34	100.0%
Employee + Child(ren)	72	\$32.56	\$0.00	0.0%	\$32.56	100.0%
Employee + Family	84	<u>\$49.25</u>	<u>\$0.00</u>	0.0%	<u>\$49.25</u>	100.0%
MONTHLY TOTAL	293	\$8,645	\$0		\$8,645	
Actives & Retirees VSP Vision						
Employee	451	\$7.37	\$0.00	0.0%	\$7.37	100.0%
Employee + Spouse	150	\$11.45	\$1.00	8.7%	\$10.45	91.3%
Employee + Child(ren)	227	\$11.93	\$1.50	12.6%	\$10.43	87.4%
Employee + Family	400	<u>\$19.06</u>	<u>\$2.00</u>	10.5%	<u>\$17.06</u>	89.5%
MONTHLY TOTAL	1,228	\$15,373	\$1,291		\$14,083	
PART TIME DENTAL & VISION	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives Dental PPO						
Employee	3	\$48.26	\$10.57	21.9%	\$37.69	78.1%
Employee + Spouse	0	\$95.88	\$31.16	32.5%	\$64.72	67.5%
Employee + Child(ren)	1	\$123.18	\$40.03	32.5%	\$83.15	67.5%
Employee + Family	0	<u>\$186.34</u>	<u>\$70.71</u>	37.9%	<u>\$115.63</u>	62.1%
MONTHLY TOTAL	4	\$268	\$72		\$196	
Actives Dental HMO						
Employee	1	\$12.76	\$0.00	0.0%	\$12.76	100.0%
Employee + Spouse	0	\$25.34	\$0.00	0.0%	\$25.34	100.0%
Employee + Child(ren)	0	\$32.56	\$0.00	0.0%	\$32.56	100.0%
Employee + Family	1	<u>\$49.25</u>	<u>\$0.00</u>	0.0%	<u>\$49.25</u>	100.0%
MONTHLY TOTAL	2	\$62	\$0		\$62	
Actives VSP Vision						
Employee	4	\$7.37	\$0.00	0.0%	\$7.37	100.0%
Employee + Spouse	0	\$11.45	\$2.00	17.5%	\$9.45	82.5%
Employee + Child(ren)	1	\$11.93	\$3.00	25.1%	\$8.93	74.9%
Employee + Family	1	<u>\$19.06</u>	<u>\$4.00</u>	21.0%	<u>\$15.06</u>	79.0%
MONTHLY TOTAL	6	\$60	\$7		\$53	

Plus Spousal Surcharge **\$193,200**
 CalOptima HSA Funding (\$1,250 single / \$2,500 family) **\$0** **(\$193,200)**
\$83,750

MONTHLY TOTAL	\$1,464,554	\$160,955	\$1,310,578
ANNUAL TOTAL	\$17,574,652	\$1,931,466	\$15,726,937
\$ Difference From Current	\$99,704	\$90,368	\$9,136

% Share of Premium **11.0%** **89.5%**



Renewal & Open Enrollment Timeline

September/October

- **September 18th** - All decisions must be made in order to provide rates, contributions & benefits to Dayforce for system update for Open Enrollment
- **September 18th – October 26th**
 - Communications developed & distributed
 - Dayforce system updated, tested, ready for Open Enrollment
 - Required notices/documentation prepared & distributed
 - Carriers notified of decisions
- **October 29th – November 9th** – Open Enrollment

November/December

- Carriers update systems with new elections, produce & distribute new ID cards as needed

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

10. Consider Ratification of Amendment to Contract with the California Department of Health Care Services (DHCS) for the California Technical Assistance Program (CTAP) Grant and CTAP Policy; Consider Retirement of CalOptima Regional Extension Center (COREC) Policies

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400

Recommended Actions

1. Ratify amendment to the contract with DHCS for the CTAP grant award agreement for a two-year extension through June 30, 2020;
2. Ratify CTAP policy; and
3. Retire COREC policies.

Background

On February 17, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law. Title XIII of Division A and Title IV of Division B of ARRA, together cited as the Health Information Technology for Economic and Clinical Health Act (HITECH Act), includes provisions to promote Meaningful Use of health information technology to improve the quality and value of American health care. The HITECH Act authorizes incentive payments to eligible Medicare and Medicaid providers for Meaningful Use of certified EHR technology. By 2015, providers were expected to have adopted and be actively utilizing an EHR in compliance with the Meaningful Use definition or they would potentially be subject to financial penalties under Medicare (per Sections 4101(b) and 4102 (b) of ARRA).

On May 28, 2015, DHCS announced a Notice of Funding Opportunity (NFO 15-001) to support physicians in reaching the next stage of Meaningful Use or to assist providers who did not qualify for assistance under the federal Regional Extension Center program, which CalOptima previously participated in to assist primary care providers in implementing electronic health record systems as part of the CalOptima Regional Extension Center (COREC) program. On June 4, 2015, the CalOptima Board of Directors authorized CalOptima to apply for NFO 15-001 funding. On June 12, 2015, CalOptima submitted its application for the California Technical Assistance Program (CTAP), and on June 26, 2015, DHCS notified CalOptima that it was awarded a grant in the amount of \$4,325,000.

On August 6, 2015, the CalOptima Board of Directors approved the execution of the agreements with DHCS for this grant program. The agreement was fully executed by both CalOptima and DHCS as of October 27, 2015. When the CTAP agreement was executed, the program was anticipated to run through June 30, 2018. CalOptima staff developed a policy for the new CTAP program, a program similar to the prior COREC program. Ratification of the new CTAP policy and retirement of the COREC policies is now also sought.

Discussion

In May 2018, DHCS offered CalOptima, and the other three awardees of this grant, an opportunity to extend their respective agreements and the program through June 30, 2020. This offer was the result of input from the grant recipients indicating that the assistance to the provider community was still in progress and not set to be completed prior to the end of the existing contract cycle. Some of the objectives that are required to achieve the various stages of Meaningful Use present time consuming and operational challenges for the clinical professionals (e.g., establishment of a patient portal, secure messaging, interface to the immunization registry, ability to exchange EHR data, etc.). The current DHCS deadline to enroll in the program is August 30, 2018, although the support will continue until the work for all enrolled professionals is completed (no later than June 30, 2020). DHCS may choose to further extend the enrollment deadline.

Due to timing, and because the existing contract was set to expire on June 30, 2018, CalOptima Management signed the amendment with DHCS for the extension on June 12, 2018. Management is now requesting ratification of this contract extension.

Fiscal Impact

The recommended action to ratify the amendment with DHCS is budget neutral to CalOptima, as the only substantive change made to the existing grant agreement was to extend the end date from June 30, 2018 to June 30, 2020. Administrative costs related to the CTAP grant is budgeted under the Fiscal Year (FY) 2018-19 CalOptima Operating Budget approved by the Board on June 7, 2018.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima TechAssist Program Process Policy
2. Board Action dated June 4, 2015, Consider Authorizing Application for Grant Funding for a Medi-Cal Electronic Health Records Incentive Program from the California Department of Health Care Services.
3. Board Action dated August 6, 2015, Authorize Execution of Agreements with the California Department of Health Care Services Related to Medi-Cal Electronic Health Records Incentive Program.

/s/ Michael Schrader
Authorized Signature

8/29/2018
Date



Policy #: _____
Title: **CalOptima TechAssist Program Process**
Department: **Information Services**
Section: **CalOptima TechAssist Program (COTAP)**

CEO Approval: **Michael Schrader** _____

Effective Date: **08/02/18**
Last Review Date: **Not Applicable**
Last Revised Date: **Not Applicable**

1 **I. PURPOSE**

2
3 This policy outlines the eligibility qualifications for eligible professionals (EPs) participating in the
4 CalOptima TechAssist Program (COTAP). It also addresses the need for COTAP Service Partners to
5 follow COTAP contract/amendments, which adhere to the Department of Health Care Services'
6 (DHCS) CTAP contractual requirements.
7

8 **II. POLICY**

9
10 A. It is the policy of COTAP to fully meet all DHCS amendment program requirements under the
11 California Technical Assistance Program (CTAP) in order to maximize the benefits available to EPs
12 servicing the Orange County Community in CalOptima.
13

14 **III. PROCEDURE**

15
16 A. Eligibility Criteria for COTAP EP's that are participating in the DHCS CTAP Program:

- 17
18 1. To be an Eligible Professional (EP) to participate in COTAP, a provider must meet the
19 following requirements:
20
21 a. Be a physician (MD or DO), obstetrician/gynecologist (OB/GYN), physician assistant (PA),
22 nurse practitioner (NP), certified nurse midwife (CNM), dentist (DDS), optometrist, or
23 board-certified or board-eligible professionals.
24
25 i. Only PAs working in a Federally Qualified Health Center (FQHC), FQHC look-alike,
26 or Rural Health Clinic (RHC) that is led by a PA will qualify for assistance.
27
28 b. Have thirty percent (30%) Medi-Cal patient volume or higher (twenty percent (20%) Medi-
29 Cal patient volume or higher for pediatrics) during a ninety (90)-calendar day representative
30 period in the preceding calendar year.
31
32 c. Be an eligible professional within CalOptima's Community Network and or be affiliated
33 with a Health Network and or have an existing vendor relationship with COTAP's Service
34 Partner.

1
2 B. COTAP Technical Assistance Agreements/Acknowledgments
3

- 4 1. Because CTAP reimbursement is based on the attainment of milestones by individual EPs,
5 signed Eligible Professional Technical Assistance Acknowledgments (EPTAA) must be
6 received for every professional for whom COTAP claims payment. COTAP may receive
7 payment for the technical assistance agreement/acknowledgment, Health Information Exchange
8 (HIE), and specialist milestones by initially submitting a Practice Representative Technical
9 Assistance Agreement (PRTAA) that is signed by a practice representative and lists the names of
10 EPs that are practice members. All other COTAP milestones, solo, Adopt Implement Upgrade
11 (AIU), and Meaningful Use (MU), require that the professional has signed an EPTAA before a
12 milestone detail report (MDR) is submitted. An EP's signature on a CTAP section in an AIU or
13 MU attestation submitted to the State Level Registry (SLR) will be considered equivalent to
14 submission of a signed EPTAA form.
15
16 2. Practices can add new EPs to their practice by submitting a signed PRTAA Addendum.
17
18 3. EPs that have not received an EHR incentive payment from the DHCS Medi-Cal or other state
19 Medicaid EHR incentive program are not considered eligible EPs in the Medi-Cal EHR
20 Incentive Program and thus do not qualify for COTAP/CTAP services.
21

22 C. Specialist under COTAP/CTAP
23

- 24 1. For the purposes of the CTAP program, specialists are defined as eligible professionals who are
25 board-certified or board-eligible for a specialty or subspecialty recognized by the American
26 Board of Medical Specialties or the American Osteopathic Association. Eligible Specialist are
27 referenced in the following link [https://www.abms.org/member-boards/specialty-subspecialty-](https://www.abms.org/member-boards/specialty-subspecialty-certificates/)
28 [certificates/](https://www.abms.org/member-boards/specialty-subspecialty-certificates/). Eligible professionals with specialties in family medicine, internal medicine,
29 pediatrics, and obstetrics and gynecology are not considered specialists unless they are also
30 certified in a subspecialty. Dentists and optometrists are also considered specialists for the
31 purposes of the COTAP/CTAP program.
32
33 2. COTAP may receive a specialist or solo practitioner payment for an EP, but not both.
34

35 D. Solo Providers under COTAP/CTAP
36

- 37 1. For the purposes of the COTAP/CTAP program, a solo practitioner must practice fifty percent
38 (50%) or more of their time in a location at which they are the only professional of any of the
39 following types: physician (MD or DO), NP, DDS, CNM, optometrist, or PA. Only PAs
40 working in a Federally Qualified Health Center (FQHC), FQHC look-alike, or Rural Health
41 Clinic (RHC) that is led by a PA will qualify for assistance.
42
43 2. For COTAP solo practitioner payments, EPs must submit an electronic copy of a signed
44 EPTAA (EPTAA-Individual only) on which the EP has initialed that they are a solo
45 practitioner.
46
47 3. COTAP may receive a specialist or solo practitioner payment for an EP, but not both.
48

49 E. 2014 Flexibility Rule
50

1. For the purposes of CTAP payments, an EP who used the Flexibility Rule in 2014 to attest to Stage 1 meaningful use rather than their first year of Stage 2, will be considered to be attesting to a new meaningful use stage when they first attest to Stage 2 in a subsequent program year.

F. EPs must sign an EPTAA to continue to participate for COTAP services

1. Every EP receiving CTAP services must complete an EPTAA regardless of whether the CTAP contractor has exceeded the maximum number of contract milestone payments for which payment can be received.

G. Practice Representative and/or EP Signature Requirement

1. The PRATA, PRATA Addendum, EPTAA or CTAP section in an AIU or MU attestation must be manually signed by the practice representative or EP, as appropriate.

H. Service Partner Contractual Obligations

1. Service Partner will need to adhere to their contractual/amendment obligations and any changes made to DHCS' policies and procedures.

IV. ATTACHMENTS

- A. CTAP Policy and Procedures Guidance
- B. Practice Representative Technical Assistance Agreement (EP & Group/Clinic)
- C. Practice Representative Technical Assistance Agreement Addendum
- D. Eligible Technical Assistance Acknowledgment (Group/Clinic)
- E. Eligible Technical Assistance Acknowledgment (EP)
- F. DHCS-OHIT Template Invoice Summary Statement
- G. DHCS-OHIT Milestone Detail Report
- H. Service Partner 160606 (e2o Health) Contract
- I. Service Partner 160606 (e2o Health) Amendment No. 1

V. REFERENCES

- A. CTAP Policy and Procedures Guidance
- B. Service Partner Amendment

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

- A. 08/02/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/02/2018	IS.1500PP	CalOptima TechAssist Program	Administrative Medi-Cal

1 IX. GLOSSARY
2

Term	Definition
Adopt, Implement Upgrade (AIU)	Adopt – to acquire, purchase, or secure access to certified EHR technology (e.g., can show proof of purchase). Implement – to install or start using a certified EHR technology (e.g., provide staff training or data entry of patient demographic information into EHR). Upgrade – to expand the available functionality of certified EHR technology (e.g., upgrade to certified EHR technology or ad.
Department Health Care Services (DHCS)	For purposes of this policy, the State agency that oversees California's Medicaid program, known as Medi-Cal
Meaningful Use (MU)	1) The use of a Certified Electronic Health Record (CEHR) in a meaningful manner, such ePrescribing; 2) the use of CEHR technology for electronic exchange of health information to improve quality of health care; and 3) the use of CEHR technology to submit clinical quality and other measures.
California Technical Assistance Program (CTAP)	A program designed to continue the work of the Regional Extension Center Program in adopting, implementing, upgrading and meaningfully using certified electronic health record technology
CTAP Solo	For the purposes of the COTAP/CTAP program, a solo practitioner must practice fifty percent (50%) or more of their time in a location at which they are the only professional of any of the following types: physician (MD or DO), NP, DDS, CNM, optometrist, or PA. Only PAs working in a Federally Qualified Health Center (FQHC), FQHC look-alike, or Rural Health Clinic (RHC) that is led by a PA will qualify for assistance.
CTAP Specialist	For the purposes of the CTAP program, specialists are defined as eligible professionals who are board-certified or board-eligible for a specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association. Eligible Specialist are referenced in the following link https://www.abms.org/member-boards/specialty-subspecialty-certificates/ .
Office of Health Information Technology (OHIT)	An entity established within DHCS to develop goals and metrics for the program, establish policies and procedures, and to implement systems to disburse, track, and report the incentive payments.
Practice Technical Assistance Attestation (PRTAA)	An attestation required to enroll eligible professionals to CTAP.
PRTAA Addendum	An attestation required to enroll any new eligible professionals to CTAP. This form is to be submitted for eligible professionals that join a practice after a PRTAA is processed with DHCS.
Eligible Professional (EP)	A physician (MD or DO), obstetrician/gynecologist (OB/GYN), physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), dentist (DDS), optometrist, or board-certified or board-eligible professionals.
Eligible Professional Technical Assistance Acknowledgement (EPTAA)	An acknowledgement required to pay for AIU, MU, solo milestones under CTAP.

Term	Definition
Milestone Detail Report (MDR)	(The template used to invoice DHCS/Service Partner for CTAP services.
State Level Registry (SLR)	The mechanism to provide incentive payments to eligible Medi-Cal providers and hospitals to adopt, implement, and upgrade the use of certified EHR technology.
American Board of Medical Specialties (ABMS)	A non-profit organization of approved medical boards ,which represent twenty-four (24) broad areas of specialty medicine.
Service Partner	An entity who has an established contractual agreement with COTAP and provides technical service assistance tied to the achievement of Meaningful Use milestones.
National Plan and Provider Enumeration System (NPPES)	The system by which individuals or organizations apply for a National Provider Identifier (NPI)
National Provider Identifier (NPI)	A unique identification number for covered health care providers.
Certified Electronic Health Record (EHR)	A digital version of a patient's paper chart. The Office of the National Coordinator (ONC) in collaboration with Authorized Temporary Certification Bodies (ATCB) has created a product specific certification process. Eligible Professionals that participate in COTAP must use a CEHR.

1

CTAP Policy and Procedure Guidance

The information provided below is intended to clarify program requirements delineated in the Notice of Funding Opportunity (NFO) for the California Technical Assistance Program (CTAP). This information will be updated as needed, and each section labeled as “new” or “revised” on a specific date for tracking purposes.

1. Technical Assistance Agreements/Acknowledgments

- A. Because CTAP reimbursement is based on the attainment of milestones by individual eligible professionals (EPs), signed Eligible Professional Technical Assistance Acknowledgments (EPTAA¹) must be received for every professional for whom the CTAP contractor claims payment. The CTAP contractor may receive payment for the technical assistance agreement/acknowledgment, HIE and specialist milestones by initially submitting a Practice Representative Technical Assistance Agreement (PRTAA) that is signed by a practice representative and lists the names of EPs that are practice members. All other CTAP milestones (solo, AIU and MU) require that the professional has signed an EPTAA before a milestone detail report (MDR) is submitted. An EP’s signature of a CTAP section in an AIU or MU attestation submitted to the SLR will be considered equivalent to submission of a signed EPTAA form. The CTAP section of the AIU or MU attestation does not have to be generated by the SLR, as long as it is signed, dated and has the exact same language as that generated by the SLR. OHIT will send a list of EPs that have signed the CTAP section in AIU or MU attestations to CTAP contractors approximately weekly.
- B. If the CTAP contractor does not subsequently submit a signed EPTAA or a signed CTAP section in an AIU or MU attestation for EPs listed on a PRTAA by March 31, 2018, the CTAP contractor will be required to refund all CTAP payments received for that EP. Refunded payments will not count toward the maximum amount of funds the CTAP contractor can receive during the term of the CTAP program and can be replaced by satisfying requirements for CTAP payments for other EPs.
- C. In order for the CTAP contractor to retain CTAP payments after March 31, 2018 for EPs listed on a PRTAA, the EP must have signed an EPTAA or a CTAP section in an AIU or MU attestation and also have demonstrated eligibility in one of the following ways:
 - 1) The EP has successfully attested to AIU or MU for the prior program year (beginning with attestations in program year 2015) or successfully attests to AIU or MU in the current or succeeding program year (before or on March 31, 2018) for which a CTAP milestone payment(s) is submitted.
 - 2) The EP has been prequalified by DHCS for the program year in which CTAP milestone payments are submitted.
 - 3) The EP is a member of a prequalified clinic that has completed Step 5 for the program year that CTAP milestone payments are submitted.

¹ Unless otherwise specified, EPTAA refers to EPTAA-Individual or EPTAA-Group

- 4) The EP is a member of a group/clinic that has completed Step 5 in the SLR and OHIT has reviewed and approved the group/clinic's eligibility for the program year in which CTAP milestone payments are submitted.
 - 5) The EP has successfully completed Step 2 in the SLR for 2016 or 2017 but has not completed Step 5. This will require that OHIT staff review and approve their individual eligibility for this purpose.
- D. Practices can add professionals to PRTAAs by submitting a signed PRTAA Addendum. OHIT must receive the PRTAA Addendum prior to or along with the contractor's submission of a MDR for these additional EPs.
 - E. To qualify for payments for an EP's AIU or MU milestones, a PRTAA/PRTAA Addendum (that lists the professional), a CTAP section in an AIU or MU attestation or EPTAA must be signed by the practice representative or EP, as appropriate, prior to or on the date that the EP submits an attestation for AIU or MU.
 - F. A signed EPTAA or a CTAP section in an AIU or MU attestation is required to be submitted prior to or along with a MDR for the AIU, MU, and Solo milestones
 - G. Beginning with Program Year 2017, CTAP contractors cannot receive payments for technical Assistance Agreements/Acknowledgments, solo, specialist, or HIE milestones for providers that have not received EHR incentive payments in a prior year from the Medi-Cal or other state Medicaid EHR incentive program. These providers are not considered eligible providers in the Medi-Cal EHR Incentive Program and thus are not considered eligible to received technical assistance services.

(Revised 11-2-17)

2. Specialists

- A. For the purposes of the CTAP program, specialists are defined as physicians who are board- certified or board-eligible for a specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association. Physicians with specialties in family medicine, internal medicine, pediatrics, and obstetrics and gynecology are not considered specialists unless they are also certified in a subspecialty. Dentists and optometrists are also considered specialists for the purposes of the CTAP program.
- B. CTAP payments for specialists who are physicians require that the CTAP contractor has submitted a copy of documentation of board certification or board eligibility. This can be a screen print from the American Board of Medical Specialties website (www.certificationmatters.org), a screen print from an individual specialty board website, or a copy of a diploma or certification or similar documents. A health plan provider

directory can also be used for documentation if the health plan certifies that the specialty or subspecialty status of listed providers has been verified as part of its official credentialing process. Information from the NPPES website is not sufficient for specialty certification documentation. A signed EPTAA or completion of Step 2 in the SLR is not required for submission of an invoice for CTAP specialist payments.

- C. CTAP specialist payments for optometrists and dentists do not require submission of additional documentation.
- D. The CTAP contractor may receive a specialist or solo practitioner payment for an EP, but not both.

(Revised 9-27-17)

3. Solo Practitioners

- A. For the purposes of the CTAP program, a solo practitioner must practice 50% or more of their time in a location at which they are the only professional of any of the following types: physician, nurse practitioner, dentist, certified nurse midwife, optometrist, or physician assistant.
- B. For solo practitioner payments, CTAP contractors must submit a MDR and an electronic copy of a signed EPTAA (EPTAA-Individual only) on which the EP has initialed that they are a solo practitioner. Completion of Step 2 in the SLR is not required.
- C. The CTAP contractor may receive a specialist or solo practitioner payment for an EP, but not both.

(Revised 6-13-16)

4. Health Information Exchange

- A. To be eligible for an HIE payment the TA contractor must assure that the EP or the EP's practice group has a contract/agreement with an HIE that is a signatory of the CalDURSA and is a participant in good standing with CTEN. The HIE contract/agreement must have been signed on the same day or after the EPTAA or the PRTAA or PRTAA Addendum was signed unless the EP or practice group has an existing HIE agreement and the HIE subsequently becomes a CalDURSA signatory and an active CTEN participant in good standing.
- B. EPs who individually or with their practice group have an agreement with an HIE that is not a CalDURSA signatory and/or CTEN participant will not be countable toward the payment until the HIE signs the CalDURSA and is an active CTEN participant in good standing. A new HIE agreement will not be required in this instance.
- C. EPs who join a practice group that has already signed a qualified HIE contract will not be countable toward the HIE payment to the TA contractor.

- D. An EP who changes practice settings and (after signing an EPTAA or being listed on a PRTAA or PRTAA Addendum) the new practice setting gains new access to a qualifying HIE, is countable toward the TA payment regardless of his/her previous experience with HIEs.
- E. An EP changing HIEs (but not practice setting) are not countable for the TA payment if his/her previous HIE was a CalDURSA signatory and CTEN participant.
- F. An electronic copy of the practice's or EPs HIE agreement must be submitted for each EP. The complete agreement does not have to be submitted, but the documentation must include:
 - 1) The letterhead of the HIE organization.
 - 2) Effective date—the date when the practice signed an HIE agreement or the HIE became a CTEN participant—whichever is later.
 - 3) The name of the HIE organization and the name of the practice and/or the individual EP.
 - 4) Because of prior policy, if the EP's name was not on a practice's HIE agreement signed before February 8, 2016 and the practice has not submitted a PRTAA with the EP's name—a signed letter from the practice verifying that the EP is an active member of the practice may be submitted. Beginning February 8, 2016 all EPs must have been listed on a PRTAA or PRTAA Addendum or have signed an EPTAA prior to the effective date of the HIE agreement.
 - 5) Signature with date.
 - 6) Optional: A screen shot of the CAHIE webpage at <http://www.ca-hie.org/projects/cten/participants> which documents that the HIE is a CTEN participant in good standing on the date of the MDR submission. OHIT staff are able to view the website to confirm that a HIE has been a CTEN participant after a specific date, but if the HIE ceased being a CTEN participant after the date of the invoicing and prior to OHIT review, OHIT staff will need a screen shot taken on the day of invoice submission for verification purposes. For this reason, it is recommended that CTAP contractors submit such a screenshot.

(Revised 6-13-16)

5. **2014 Flexibility Rule**

- A. For the purposes of CTAP payments, an EP who used the Flexibility Rule in 2014 to attest to Stage 1 meaningful use rather than their first year of Stage 2, will be considered to be attesting to a new meaningful use stage when they first attest to Stage 2 in a subsequent program year.

(New 11-20-15)

6. **Payments**

- A. The number of EPs for which the CTAP contractor was awarded funding serves as the maximum number of payments a CTAP contractor may receive for each milestone (except for all MU milestones), regardless of how many individual EPs receive CTAP services. Every EP receiving CTAP services must complete an EPTAA regardless of whether the CTAP contractor has exceeded the maximum number of contract milestone payments for which payment can be received.
- B. If a CTAP-enrolled professional changes locations, another CTAP contractor can newly enroll the professional and receive enrollment, solo, specialist, and HIE milestone payments for the professional if eligibility requirements for the milestones are satisfied. Only the CTAP contractor providing TA services at the time of attestation for AIU and MU, can receive payments for achievement of AIU or MU milestones.

(Revised 9-27-17)

7. Invoicing

A. General Invoice Information

- 1) MDRs shall be submitted no later than sixty (60) days after the milestone achievement occurred, except in the case of the solo and specialist milestones.
- 2) OHIT will review MDRs and respond to the appropriate contractor within three (3) business days (excluding State Holidays).
- 3) Once a MDR has been approved by OHIT, additional charges on the final invoice for payment will not be allowed. Additional charges must be submitted in future invoices.
- 4) If a final invoice is received with any discrepancies, it will be denied and returned to the appropriate Contractor.

B. Invoicing for AIU or MU

- 1) CTAP contractors will employ the Steps Report to ascertain which EPs may be submitted for AIU or MU milestone payments. In the Steps Report column entitled 'Step', only the following statuses will satisfy the requirement for AIU or MU invoicing: CMS Approved (D-16); Invoice Generated; Invoice Printed; Incentive Payment (D18) Submitted, Payment Complete.
- 2) OHIT staff will provide expedited review of AIU or MU applications for which an EPTAA, PRTAA or PRTAA Addendum has been submitted to OHIT. However, if an EP's application is determined to be deficient, it will be reassigned and processed in accordance with normal processing guidelines for the Medi-Cal EHR Incentive Program. The CTAP contractor will be notified of this action such that they can assist the EP in remediating said deficiencies in a timely manner.

C. Process for Submitting Milestone and Invoice Documentation

- 1) All documents, except final invoices, must be submitted to OHIT by email to:
EHR_TA@dhcs.ca.gov
- 2) Final invoices (including MDR and Summary Statement) must be submitted to OHIT by US Mail to:

**Department of Health Care Services Contract
Manager: Errin Horstkorta
1700 K Street-Mail Station Code 0004
P.O. Box 997413 Sacramento, CA
95899-7413**

- 3) Final invoices **must** include the following required information:
 - a) Date
 - b) Contract Number
 - c) The Contractor's name as shown in the contract.
 - d) The billing and/or performance period covered by the invoice.
 - e) Summary Statement-must include an original signature in blue ink (an electronic signature is **not** acceptable per the State Controller's Office).
 - f) Approved MDR

(New: 12-11-15)

8. Signature Requirement

- A. The PRATA, PRATA Addendum, EPTAA or CTAP section in an AIU or MU attestation must be manually signed by the practice representative or EP, as appropriate. Also, all final invoices must be manually signed in blue ink by the CTAP organization. All other signatures on documents do not have to be manually signed, and can be mechanically or electronically signed.

(Revised 6-13-16)

9. Overlap of CTAP and Regional Extension Center (REC) Enrollees

- A. If a CTAP contractor submits an invoice for a CTAP payment for an EP and subsequently submits a payment request for that EP with the REC program, OHIT will recoup all CTAP payments made to the CTAP contractor for that EP.
- B. If a CTAP contractor received a REC Program Milestone 3 payment for an EP by using the M-3 tool instead of attesting to meaningful use in the SLR, the CTAP contractor will not be eligible for a CTAP payment for subsequently attesting to AIU or first year stage 1 MU in the SLR for the EP. However, the CTAP contractor will be eligible for CTAP milestone payments if the EP attests to meaningful use for subsequent years and stages.

10. CTAP Drop/Offset/Recoupment Process

The following offset guidelines and process shall be used by CTAP contractors when becoming aware of eligible professionals (EPs) for whom they will **not** obtain signed EPTAA's or CTAP sections in an AIU or MU attestation by March 31, 2018.

A. EP Drop/Offset Invoice Guidelines

- 1) Services delivered to enrolled EPs must be billed prior to drop. Once an EP is listed as a drop, retroactive billing for services delivered prior to the drop date will not be permitted.
- 2) If an EP is enrolled by a CTAP contractor after being officially dropped by another CTAP contractor, the "new" CTAP contractor will be permitted to invoice for all milestones up to their awarded amount, with the exception of AIU/MU milestone(s) that were previously achieved.
- 3) If an EP is dropped by a CTAP contractor but later re-enrolled as a member of a new practice by the same CTAP contractor, a new EPTAA is not required. The CTAP contractor will not be able to receive duplicate contract, solo or specialist milestone payments for this EP, unless they had not previously obtained a signed EPTAA for the EP and had offset these payments. AIU and MU milestones previously achieved cannot be billed.

B. Milestone Payment Offsets through March 31, 2018

- 1) If the CTAP contractor is unable to secure a signed EPTAA or a CTAP section in an AIU or MU attestation from a contracted EP by March 31, 2018, the CTAP contractor is not eligible to retain paid milestone payments for that EP. In order to facilitate repayment, the OHIT will allow CTAP contractors to offset these milestone payments prior to March 31, 2018, against new invoiced milestones. In order to do this, CTAP contractors shall:
 - a) CTAP contractors may offset milestone payments by submitting a preliminary MDR.
 - b) Paid milestones for EPs dropped shall be included in the invoice as negative amounts.
 - c) All new billable milestones and offset milestones on the preliminary MDR must total a positive amount or zero payable amount.
 - d) DHCS Accounting will not accept a net negative total amount.
 - e) The date of the approved preliminary MDR will be the effective date of the EP status change.
 - f) To ensure prompt reimbursement, contractors are encouraged to review the preliminary MDR for accuracy.

C. Recoupments

- 1) CTAP contractors will be invoiced for any paid milestones attributable to contracted professionals for whom OHIT has not received a signed EPTAA or a CTAP section in an AIU or MU attestation form by close of business March 31, 2018.

- a) Several months prior to March 31, 2018, the OHIT shall identify and prepare a list of all EPs for whom a signed EPTAA has not been received. The list shall exclude EPs whom have been dropped and whose milestone payments have been offset or for whom the contractor has reimbursed the Department.
 - b) This list shall be shared with the appropriate CTAP contractors, advising that signed EPTAAs have not been received for listed EPs.
 - c) The list shall include the EP name, NPI, and organization NPI along with milestones, which have been paid.
 - d) CTAP contractors shall be instructed to review and confirm the accuracy of the lists, and provide required copies of signed EPTAAs where a discrepancy is identified. CTAP contractors will also be encouraged to secure signed EPTAAs from remaining EPs prior to the March 31, 2018 deadline.
 - e) This list will be generated and distributed in February, June, and monthly September 2017 through February 2018. The last list shall be distributed no later than February 28, 2018.
 - f) The OHIT will accept outstanding signed EPTAAs or signed CTAP sections in an AIU or MU attestation no later than March 31, 2018.
- 2) Soon after March 31, 2018, OHIT staff shall prepare a final list of all EPs for whom a signed EPTAA or a signed CTAP section in an AIU or MU attestation has not been received. The list shall include EP names, NPIs, and milestones paid. CTAP contractors will receive a copy of this list along with a draft invoice; identifying paid milestones, which shall be recouped due to failure to submit signed EPTAAs or CTAP sections in AIU or MU attestations.
- a) CTAP contractors shall have 30 calendar days from the date of the draft invoice, to confirm the accuracy of the list and invoice amount.
 - b) In the instance of a dispute, the CTAP contractor, within the same 30 days, shall:
 - i. Present to the OHIT in writing, a notice of dispute
 - ii. Include a detailed summary of disputed adjustments
 - iii. Include for consideration, valid documentation supporting disputed adjustments, such as evidence that signed EPTAA agreements were submitted to OHIT no later than March 31, 2018.
 - c) The OHIT shall review and consider the CTAP contractor's supporting documentation.
 - d) The OHIT shall prepare and provide a schedule of milestone payment adjustments, and invoice the CTAP contractor accordingly.
- 3) CTAP contractors shall have 45 calendar days from the date of invoice to submit payments.

(Revised 10-24-17)

Medi-Cal EHR Incentive Program California Technical Assistance Program Practice Representative Technical Assistance Agreement

Name of Practice Representative	
Name of Practice Group/Clinic	NPI of Practice Group/Clinic
Name of Technical Assistance Representative	Name of Technical Assistance Organization

The California Technical Assistance Program (CTAP) is designed to assist Eligible Professionals (EPs) and their practice groups in participation in the Medi-Cal EHR Incentive Program and the installation and use of EHRs to attain meaningful use. Services are free-of-charge for EPs, with funding provided by the federal government and the State of California for the years 2015-2018. Participating professionals may receive services in the areas described on page 2.

Practice Representative Statement: The EPs listed below are eligible for the Medi-Cal EHR Incentive Program, meeting the Medi-Cal definition of an EP. This includes physicians, nurse practitioners, dentists, certified nurse midwives, optometrists, and physician assistants (at a PA-Led FQHC or RHC) who individually or with a group, meet the 30% Medicaid encounter volume (20% for pediatricians) required for the Medi-Cal EHR Incentive Program. These EPs have been fully informed of technical assistance services that have or will be supplied to them. Each EP will sign an Eligible Professional Technical Assistance Agreement within one year of the signing of this Practice Representative Technical Assistance Agreement. Failure to submit a signed Eligible Professional Technical Assistance Agreement by this date will result in loss of any payments made to the technical assistance organization for services to this EP.

EP Name	EP NPI	EP License	EP Type

_____ Additional Pages Attached

Practice Representative Signature	Date
Technical Assistance Representative Signature	Date

Technical Assistance Services

- **Education and Outreach**—dissemination of knowledge about effective strategies to select, implement, and meaningfully use certified EHR technology.
- **Medi-Cal Incentive Program Guidance**—assistance in understanding and meeting all requirements of the Medi-Cal EHR Incentive Program, Ensure eligible professionals and groups successfully submit applications to the State Level Registry.
- **EHR Implementation**—assistance with project management, planning and support over the entire EHR implementation process, including on-site coaching, consultation, troubleshooting, and other activities. The assistance will assure that the professional is able to assess and enhance organizational readiness, remediate gaps in IT infrastructure, configuration of the software to meet practice needs, and training on software use.
- **Practice and Workflow Redesign**—support for practice and workflow redesign necessary to achieve meaningful use of EHR technology. This may involve working with eligible professionals, their staff, and the EHR vendors. Assistance may include mapping and redesigning work processes, updating roles for professionals and support staff, and rapid cycle continuous quality improvement activities.
- **Progress toward Meaningful Use**—assistance in attaining and advancing in the stages of meaningful use. Review of utilization of EHRs by professionals will be provided and feedback provided to improve low rates of utilization of features required for meaningful use. Professionals will be supported in implementing best practices to protect privacy and security.
- **Health Information Exchange**—assistance to professionals in connecting to available health information exchange infrastructure, including community HIOs, enterprise HIOs and point-to-point health information exchange.
- **Other Services (Fee-based)**—your technical assistance organization may offer assistance in additional areas for a fee. Please talk with your technical assistance organization about this.

EP Name	EP NPI	EP License	EP Type

Medi-Cal EHR Incentive Program California Technical Assistance Program Practice Representative Technical Assistance Agreement Addendum

Name of Practice Representative	
Name of Practice Group/Clinic	NPI of Practice Group/Clinic
Name of Technical Assistance Representative	Name of Technical Assistance Organization

This is an addendum to the Practice Representative Technical Assistance Agreement (PRTAA) signed on _____. The eligible professionals (EPs) listed below or on the attached EP Roster (***) are being added to the practice for the purpose of receiving services from the California Technical Assistance Program. These EPs have been fully informed of technical assistance services that have or will be supplied to them. Each EP identified will complete and sign an Eligible Professional Technical Assistance Acknowledgement within one year of the signing of this PRTAA Addendum. Failure to submit a complete and signed Eligible Professional Technical Assistance Acknowledgement by this date will result in loss of any payments made to the technical assistance organization for services to this EP.

Practice Representative Signature	Date
Technical Assistance Representative Signature	Date

EP Name	EP NPI	EP License	EP Type

_____ Additional Pages Attached

*** Practice may create their own roster, ensuring the above four categories are included.

Technical Assistance Services

- **Education and Outreach**—dissemination of knowledge about effective strategies to select, implement, and meaningfully use certified EHR technology.
- **Medi-Cal Incentive Program Guidance**—assistance in understanding and meeting all requirements of the Medi-Cal EHR Incentive Program, Ensure eligible professionals and groups successfully submit applications to the State Level Registry.
- **EHR Implementation**—assistance with project management, planning and support over the entire EHR implementation process, including on-site coaching, consultation, troubleshooting, and other activities. The assistance will assure that the professional is able to assess and enhance organizational readiness, remediate gaps in IT infrastructure, configuration of the software to meet practice needs, and training on software use.
- **Practice and Workflow Redesign**—support for practice and workflow redesign necessary to achieve meaningful use of EHR technology. This may involve working with eligible professionals, their staff, and the EHR vendors. Assistance may include mapping and redesigning work processes, updating roles for professionals and support staff, and rapid cycle continuous quality improvement activities.
- **Progress toward Meaningful Use**—assistance in attaining and advancing in the stages of meaningful use. Review of utilization of EHRs by professionals will be provided and feedback provided to improve low rates of utilization of features required for meaningful use. Professionals will be supported in implementing best practices to protect privacy and security.
- **Health Information Exchange**—assistance to professionals in connecting to available health information exchange infrastructure, including community HIOs, enterprise HIOs and point-to-point health information exchange.
- **Other Services (Fee-based)**—your technical assistance organization may offer assistance in additional areas for a fee. Please talk with your technical assistance organization about this.

EP Name	EP NPI	EP License	EP Type

**Medi-Cal EHR Incentive Program
California Technical Assistance Program
Eligible Professional Technical Assistance Acknowledgement—Group**

Name of Practice Group/Clinic	NPI of Practice Group/Clinic
CTAP Technical Assistance Representative	CTAP Technical Assistance Organization
CTAP Technical Assistance Organization Signature	

The California Technical Assistance Program (CTAP) is designed to assist Eligible Professionals (EPs) and their practice groups in participation in the Medi-Cal EHR Incentive Program with the installation and use of EHRs to attain meaningful use. Services are free-of-charge for EPs, with funding provided by the federal government and the State of California for the years 2015-2018. Participating EPs may receive services in the following areas: *Education and Outreach, Medi-Cal EHR Incentive Program Guidance, EHR Implementation, Practice and Workflow Redesign, Progress Toward Meaningful Use, Health Information Exchange*. For further information:

[http://www.dhcs.ca.gov/provgovpart/Pages/California_Technical_Assistance_Program_\(CTAP\).aspx](http://www.dhcs.ca.gov/provgovpart/Pages/California_Technical_Assistance_Program_(CTAP).aspx)

EP Signature: By signing below I acknowledge that I am a physician, nurse practitioner, dentist, certified nurse midwife, optometrist, or physician assistant (at a PA-Led FQHC or RHC) who individually or with a group, meet the 30% Medicaid encounter volume (20% for pediatricians) required for the Medi-Cal EHR Incentive Program. I acknowledge that I have been fully informed of the technical assistance services that have or will be provided to me.

EP Name	EP NPI	EP License #	EP Type	EP Signature	Date

Medi-Cal EHR Incentive Program California Technical Assistance Program Eligible Professional Technical Assistance Acknowledgement—Individual

The California Technical Assistance Program (CTAP) is designed to assist Eligible Professionals (EPs) and their practice groups in participation in the Medi-Cal EHR Incentive Program with the installation and use of EHRs to attain meaningful use. Services are free-of-charge for EPs, with funding provided by the federal government and the State of California for the years 2015-2018. Participating EPs may receive services in the following areas: *Education and Outreach, Medi-Cal EHR Incentive Program Guidance, EHR Implementation, Practice and Workflow Redesign, Progress Toward Meaningful Use, Health Information Exchange*. For further information:

[http://www.dhcs.ca.gov/provgovpart/Pages/California Technical Assistance Program \(CTAP\).aspx](http://www.dhcs.ca.gov/provgovpart/Pages/California_Technical_Assistance_Program_(CTAP).aspx)

EP includes physicians, nurse practitioners, dentists, certified nurse midwives, optometrists, and physician assistants (at a PA- Led FQHCs or RHCs) who, individually or with a group, meet the 30% Medicaid encounter volume (20% for pediatricians) requirement for the Medi-Cal EHR Incentive Program. EPs will be required to demonstrate eligibility when registering for the Medi-Cal EHR Incentive Program.

Specialists include dentists, optometrists, or board-certified or board eligible physicians other than family practice, OB/GYN, pediatrics, or internal medicine.

Please fill out the below table with your enrollment information.

Name of Eligible Professional	EP Type
Individual NPI	EP License Number
Initial	I am a solo practitioner. I work 50% or more of my time at a location at which I am the only professional of the following types: physician, dentist, nurse practitioner, certified nurse midwife, optometrist, or physician assistant.
Eligible Professional Signature	Date
CTAP Technical Assistance Representative Signature	Date

CTAP Invoice Summary Statement

Date:

Contract Number: 15-92211

Invoice Number:

Billing Period:

Please find the attached invoice in the amount of \$_____.

I certify that to the best of my knowledge and belief that the attached invoice being claimed represents actual milestone achievements met for the service performed under this contract.

All items invoiced herein are for services to providers that are not being assisted under the federal government's Regional Extension Center program.

Authorized Signature

Nora Onishi

Director, Information Services

Application Management

Date Signed

Please Remit Payment To:

CalOptima

ATTN:

505 City Parkway West

Orange, CA 92868

Date:	
Invoice #	
Contract #	15-92211
Billing Period:	

Orange County Health Authority, a public agency
dba CalOPTIMA
505 City Parkway West
Orange, CA 92868
PH. (714) 246-8400

Mail to :
Contract Manager: Errin Horstkorta
Department of Health Care Services
Mail Station Code 0004
1700 K Street
P.O. Box 997413
Sacramento, CA 95899-7413

Verify all required milestone documents have been submitted prior to invoicing.*

Provider First Name	Provider Last Name	Provider NPI	Group NPI (If Applicable)	Signed TA Agreement**	HIE Enrollment	Solo Practitioner	Specialist	AIU	Stage 1 MU First Year	Stage 2 MU First Year	Stage 3 MU First Year	Subsequent MU Year Stage	Recoupment	Total	Subsequent MU Stage	Subsequent MU Program Year
Amounts Payable:				\$500	\$500	\$750	\$750	\$1,500	\$2,250	\$2,250	\$2,250	\$1,500				
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Subtotal:				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		

Page 1 Subtotal	\$0.00
Payable Amount Invoice Total ****	\$0.00

***All MDR's that include offsets must have a positive payable amount and/or zero payable amount, no negative amounts will be accepted per DHCS Accounting.

Business Associate Agreement

This Business Associate Agreement (“Agreement”) is entered into by and between the Orange County Health Authority, a California local public agency, doing business as CalOptima (“Plan”), and e2o Health, Inc _____, a California Corporation, _____ (“Business Associate”), effective October 27, 2015 (Effective Date).

RECITALS

WHEREAS, the parties have executed an agreement(s) whereby Business Associate provides services to Plan, and Business Associate creates, receives, maintains, uses or transmits Protected Health Information in order to provide those services (“Services Agreement(s)”);

WHEREAS, as a Covered Entity, Plan is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act (“HIPAA”) of 1996, Public Law 104-191, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations Parts 160 and Subparts A and E of 45 C.F.R. Part 164 (“Privacy Regulations”) and the Security Standards for Electronic Protected Health Information (“Security Regulations”) at 45 Code of Federal Regulations Parts 160 and Subparts A and C of 45 C.F.R. Part 164, as amended by the Health Information Technology for Economic and Clinical Health Act (“HITECH Act”) of 2009, Public Law 111-0005, and promulgated thereunder including the Breach Notification Regulations at 45 Code of Federal Regulations Subpart D of 45 C.F.R. Part 164, and is subject to certain State privacy laws;

WHEREAS, as a Business Associate, VENDOR is subject to certain provisions of HIPAA, and regulations promulgated thereunder, as required by the HITECH Act and regulations promulgated thereunder;

WHEREAS, the Plan and Business Associate are required to enter into a contract in order to mandate certain protections for the privacy and security of Protected Health Information;

WHEREAS, the Plan’s regulator(s) have adopted certain administrative, technical and physical safeguards deemed necessary and appropriate by it/them to safeguard regulators’ Protected Health Information and have required that Plan incorporate such requirements in its business associate agreements with subcontractors that require access to the regulators’ Protected Health Information;

NOW, THEREFORE, in consideration of the foregoing, and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties agree as follows:

I. DEFINITIONS

1.1 “Breach” means, unless expressly excluded under 45 C.F.R. § 164.402, the acquisition, access, use, or disclosure of PHI in a manner not permitted under Subpart E of 45 C.F.R. Part 164 of the Code of Federal Regulations which compromises the security or privacy of the PHI and as more particularly defined under 45 C.F.R. § 164,402.,

1.2 “Disclose” and “Disclosure” mean, with respect to PHI, the release, transfer, provision of access to, or divulging in any other manner of PHI outside the entity holding the information.

1.3 “Electronic Media” means:

- (a) Electronic storage material on which data is or may be recorded electronically including, memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or
- (b) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable /transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

1.4 “Electronic Health Record” shall have the meaning set forth in the HITECH Act, including but not limited to 42 U.S.C. § 17921 and implementing regulations.

1.5 “Electronic Protected Health Information” or “ePHI” means Individually Identifiable Health Information that is transmitted or maintained in electronic media including, but not limited to, electronic media as set forth in 45 C.F.R. § 160.103.

1.6 “HHS” means the federal Department of Health and Human Services.

1.7 “Information System” means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

1.8 “Individual” means the person who is the subject of PHI and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.9 “Individually Identifiable Health Information” means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR section 160.103.

1.10 “Personal Information” or “PI” has the meaning set forth in California Civil Code § 1798.29.

1.11 “Protected Health Information” or “PHI” means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR section 160.103.

1.12 “Required By Law” means a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the

production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

1.13 “Secretary” means the Secretary of HHS or the Secretary’s designee.

1.14 “Security Incident” means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI, PI or confidential data or interference with system operations in an Information System which contains Electronic Protected Health Information.

1.15 “Services” has the same meaning as in the Services Agreement(s).

1.16 “Use” or “Uses” mean, with respect to PHI, the sharing, employment, application, utilization, examination or analysis of such information within the entity that maintains such information.

1.17 “Unsecured Protected Health Information” or “Unsecured PHI” means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary.

1.18 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in HIPAA, the HITECH Act and regulations promulgated thereunder.

II. OBLIGATIONS OF BUSINESS ASSOCIATE

2.1 HITECH Compliance. Business Associate will comply with the requirements of Title XIII, Subtitle D, of the HITECH Act, which are applicable to business associates, and will comply with all regulations issued by HHS to implement these referenced statutes, as of the date by which business associates are required to comply with such referenced statutes and HHS regulations.

2.2 Permitted Uses and Disclosures of Protected Health Information.

- (a) Use and Disclosure for Services. Business Associate may Use and Disclose PHI as necessary to perform the Services under the Services Agreement(s). Business Associate may not Use or further Disclose PHI in a manner that would violate the Privacy Regulations if done by the Plan, except as provided in (c) and (d) below.
- (b) Disclosure to Plan. Business Associate shall Disclose PHI to Plan upon request.
- (c) Use for Management and Administration of Business Associate: Business Associate may Use and Disclose PHI for the proper management and administration of the Business Associate provided that such disclosures are required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.
- (d) Data Aggregation: If authorized as part of the Services, Business Associate may Use PHI to provide data aggregation services to Plan. Data aggregation means the combining of PHI created or received by the Business Associate on behalf of Plan with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of Plan.

- (c) Performance of Covered Entity Obligations. To the extent that Business Associate is to carry out the Plan's obligations under Subpart E of 45 C.F.R. Part 164, it shall comply with the requirements of such Subpart that apply to the Plan in the performance of such obligations. Business Associate shall not Use or Disclose PHI for any other purpose.

2.3 Prohibited Uses and Disclosures of Protected Health Information.

- (a) Restrictions on Certain Disclosures to Health Plans. Business Associate shall not Disclose PHI about an Individual to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the Individual requests such restriction in accordance with HIPAA and the HITECH Act, including 45 CFR § 164.522(a).
- (b) Prohibition on Sale of PHI; No Remuneration. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written authorization of Plan and Plan's regulators and then, only as permitted by HIPAA and the HITECH Act.

2.4 Adequate Safeguards for Protected Health Information.

- (a) Business Associate warrants that it shall implement and maintain appropriate safeguards to prevent the Use or Disclosure of PHI in any manner other than as permitted by this Agreement.
- (b) Business Associate shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI, including ePHI, that it creates, receives, maintains, uses or transmits on behalf of Plan and to prevent Use or Disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of Subpart C of 45 C.F.R. Part 164. Business Associate shall maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size of Business Associate's operations and the nature and scope of its activities.
- (c) Business Associate is required to take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum: (i) complying with all of the data system security precautions listed in Attachment A to this Agreement; (ii) achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement; (iii) providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III - Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies. In case of a conflict between any of the security standards contained in any of these enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Business Associate must comply with changes to these standards that occur after the effective date of this Agreement.

2.5 Limited Data Set and Minimum Necessary. Permitted Uses and Disclosures should, to the extent practicable be limited to the limited data set as defined in 45 CFR § 164.514(c)(2), or, if needed, to the minimum necessary to accomplish the intended purpose of such Use or Disclosure as specified in 45 C.F.R. § 164.502(b).

2.6 Social Security Data. If Business Associate receives data from Plan that was provided by the Social Security Administration to the Department of Health Services (“SSA Data”), Business Associate shall provide a list of all employees, contractors and agents who have access to such data, including employees, contractors and agents of any subcontractors upon the Plan’s or its regulator’s request for SSA Data.

2.7 Notification of Breach. During the term of this Agreement:

- (a) Immediate Notice: Discovery of Breach of Unsecured PHI and Certain Security Incidents. Business Associate agrees to notify Plan immediately by telephone call plus e-mail upon the discovery of a Breach of unsecured PHI or PI in electronic media form, if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon discovery of a suspected Security Incident that involves SSA Data.
- (b) 24-Hour Notice: Discovery of Suspect Security Incident, Intrusion or Unauthorized Access, Use or Disclosure or Loss of Data. Business Associate agrees to notify Plan within 24 hours by e-mail or fax of the discovery of any suspected Security Incident, intrusion, or unauthorized access, Use or Disclosure of PHI or PI in violation of this Agreement or potential loss of confidential data. A Breach shall be treated as discovered by Business Associate as of the first day on which the Breach is known, or by exercising reasonable diligence would have been known to any person who is an employee, officer or other agent of Business Associate (excepting the person committing the Breach). Business Associate shall comply with Plan’s form and content requirements for reporting such privacy incident.
- (c) Contact Information for Notices under (a) and (b) above. Notification shall be provided to the Plan’s Privacy Officer (Plan’s Executive Director of Compliance) as provided in (a) and (b) above at the following: telephone number (714) 246-8400 (ask the operator to connect to Privacy Officer); facsimile number: (714) 481-6457; e-mail address: privacy@caloptima.org

2.8 Investigations, Corrective Actions and Reports.

- (a) Corrective Actions. Business Associate shall take:
 - (i) Prompt corrective action to mitigate any risks or damages involved with the Breach, Security Incident, intrusion or unauthorized Use or Disclosure of PHI or potential or actual loss of confidential data and to protect the operating environment. Notwithstanding the foregoing, all corrective actions are subject to the approval of Plan and the Plan’s regulator(s).
 - (ii) Any action pertaining to such Breach, Security Incident, intrusion or unauthorized Use or Disclosure of PHI or potential or actual loss of confidential data required by applicable Federal and State laws and regulations.
 - (iii) Any additional corrective actions required by Plan or Plan’s regulator(s).

- (b) Investigation of Suspected or Actual Breach, Security Incident, Intrusion or Unauthorized Use or Disclosure of PHI or Loss of Confidential Data: Business Associate agrees to immediately investigate such Security Incident, Breach, or unauthorized Use or Disclosure of PHI or potential or actual loss of confidential data and within forty-eight (48) hours of the discovery to notify Plan of the matters described below. Business Associate shall comply with Plan's additional form and content requirements for reporting such privacy incident.
- (i) The identification of each individual whose unsecured PHI has been, or is reasonably believed by Business Associate to have been accessed, acquired, used or disclosed during the Breach;
 - (ii) The nature of the data elements involved and the extent of the data involved in the breach;
 - (iii) A description of the unauthorized persons known or reasonably believed to have improperly Used or Disclosed PHI or confidential data;
 - (iv) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized;
 - (v) A description of the probable causes of the improper Use or Disclosure;
 - (vi) Any other available information that the Business Associate is required to include in notification to the Individual under 45 C.F.R. § 164.404(c);
 - (vii) Whether the PHI or confidential data that is the subject of the Security Incident, Breach, or unauthorized Use or Disclosure of PHI or confidential data included Unsecured Protected Health Information;
 - (viii) Whether a law enforcement official has requested a delay in notification of individuals of the Security Incident, Breach, or unauthorized Use or Disclosure of PHI or confidential data because such notification would impede a criminal investigation or damage national security and whether such notice is in writing; and
 - (ix) Whether Section 13402 of the HITECH Act (codified at 42 U.S.C. § 17932), Civil Code sections 1798.29 or 1798.82 or any other Federal or State laws requiring individual notifications of breaches are triggered.
- (c) Written Report. Business Associate shall provide a comprehensive written report to Plan no later than seven (7) working days after discovery of the Security Incident, breach, or other unauthorized Use or Disclosure of PHI or confidential data, providing a comprehensive discussion of the above matters identified in section above and the matters below. Business Associate shall comply with Plan's additional form and content requirements for reporting such privacy incident.
- (i) The potential impacts of the incident, e.g. potential misuse of date, identity theft, etc;
 - (ii) The steps taken in mitigation to reduce the harmful effects of the breach; and

- (iii) A corrective action plan describing how Business Associate will prevent reoccurrence of the incident in the future. Notwithstanding the foregoing, all corrective actions are subject to the approval of Plan and the Plan's regulator(s).

2.9 Mitigation of Harmful Effects. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

2.10 Notification of Breach to Individuals. Business Associate shall comply with Federal and State laws requiring notice to Individuals of breaches of PHI, PI or confidential data including, without limitation, Section 13402 of the HITECH Act, codified at 42 U.S.C. § 17932 and applicable State privacy laws. All such notifications shall be coordinated with Plan and Plan shall approve the time, manner, content and method for notice including, without limitation, requiring Business Associate to directly send and pay for such notices at Plan's discretion. Business Associate acknowledges that Plan's regulators must approve the time, manner and content of such notices before the notifications are made.

2.11 Media Notification and Reporting of Breaches. If the cause of a Breach of PHI or PI is attributable to Business Associate or its agents, subcontractors or vendors, Plan shall make all required reports, if any, of the Breach as specified in 42 U.S.C. § 17932 and its implementing regulations, including notification to media outlets and to the Secretary.

2.12 Indemnification. Business Associate will immediately indemnify and pay Plan for and hold it harmless from (i) any and all fees and expenses Plan incurs in investigating, responding to, and/or mitigating a breach of PHI, PI or confidential data caused by Business Associate or its subcontractors or agents; (ii) any damages, attorneys' fees, costs, liabilities or other sums actually incurred by Plan due to a claim, lawsuit, or demand by a third party arising out of a breach of PHI, PI or confidential data caused by Business Associate or its subcontractors or agents; and/or (iii) for fines, assessments and/or civil penalties assessed or imposed against Plan by any government agency/regulator based on a breach of PHI, PI or confidential data caused by Business Associate or its subcontractors or agents. Such fees and expenses may include, without limitation, attorneys' fees and costs and costs for computer security consultants, credit reporting agency services, postal or other delivery charges. Acceptance by Plan of any insurance certificates and endorsements required under the Service Agreement(s) does not relieve Business Associate from liability under this indemnification provision. This provision shall apply to any damages or claims for damages whether or not such insurance policies shall have been determined to apply.

III. AVAILABILITY OF INFORMATION TO GOVERNMENT AGENCIES AND PLAN

3.1 Availability of Internal Practices, Books and Records to Government Agencies. Business Associate agrees to make its internal practices, books and records relating to the Use and Disclosure of PHI available to the California Department of Health Care Services ("DHCS") and the Secretary for purposes of determining Plan's compliance with HIPAA, the HITECH Act and implementing regulations. Business Associate also agrees to make its internal practices, books and records relating to the Use and Disclosure of Protected Health Information available to DHCS, the Plan and the Secretary of HHS for purposes of determining Business Associate's compliance with applicable HIPAA, the HITECH Act and implementing regulations. Business Associate shall immediately notify Plan of any requests made by DHCS or the Secretary and provide Plan with copies of any documents produced in response to such request.

3.2 Plan Audits, Inspection and Enforcement. From time to time, Plan or its regulators may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of any provision of this Agreement

and shall certify the same to the Plan in writing. The fact that Plan or its regulators inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Agreement, nor does the Plan's or its regulators': (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of Plan's enforcement rights under the Service Agreement(s) and this Agreement.

3.3 Government Audits and Proceedings.

- (a) Government Audits. If Business Associate is the subject of an audit, compliance review, or complaint investigation by HHS that is related to the performance of its obligations pursuant to this Agreement, Business Associate shall notify Plan immediately upon notice of such review. Business Associate is responsible for civil penalties and damages, if any, assessed due to an audit or investigation of Business Associate.
- (b) Criminal Proceedings. Business Associate shall notify plan immediately if Business Associate is named as a defendant in a criminal proceeding for an alleged violation of HIPAA, Plan may immediately terminate this Agreement if Business Associate is found guilty of a criminal violation of HIPAA.
- (c) Other Proceedings. Business Associate shall notify Plan immediately if Business Associate is named as a defendant in any administrative or civil proceeding, including any action brought by a third party or class of third parties. Plan may immediately terminate this Agreement if a judgment, finding, or stipulation that Business Associate has violated any standard or requirement of HIPAA or other security or privacy laws is entered or made in any administrative or civil proceeding in which Business Associate is a party or has been joined.

IV. AVAILABILITY OF INFORMATION TO INDIVIDUALS

4.1 Access to Protected Health Information. Business Associate shall, to the extent Plan determines that any PHI constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make the PHI specified by Plan available to the Individual(s) identified by Plan as being entitled to access and copy that PHI. Business Associate shall provide such access for inspection of that PHI within thirty (30) calendar days after receipt of request from Plan. Business Associate shall also provide copies of that PHI ten (10) calendar days after receipt of request from Plan. If Business Associate maintains an Electronic Health Record with PHI, and an Individual requests a copy of such information in electronic format, Business Associate shall make such information available in that format as required under the HITECH Act and 45 C.F.R. § 164.524(c)(2)(ii).

4.2 Amendment of Protected Health Information. Business Associate shall, to the extent Plan determines that any PHI constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make any amendments to PHI that are requested by Plan in the time and manner designated by Plan.

4.3 Accounting of Disclosures. Business Associate shall document and make available to Plan or (at the direction of Plan) to an Individual, such Disclosures of PHI and information related to such Disclosures, necessary to respond to a proper request by the subject individual for an accounting of Disclosures of PHI in accordance with HIPAA, the HITECH Act and implementing regulations. Unless directed by Plan to make available to an Individual, Business Associate shall provide to Plan, within thirty (30) calendar days after receipt of request from Plan, information collected in accordance with this Section to permit Plan to respond to a request by an Individual for an accounting of disclosures of PHI in

accordance with 45 C.F.R. § 164.528. Any accounting provided by Business Associate under this Section shall include:

- (a) The date of the Disclosure;
- (b) The name, and address if known, of the entity or person who received the Protected Health Information;
- (c) A brief description of the Protected Health Information disclosed; and
- (d) A brief statement of the purpose of the Disclosure.

For each Disclosure that could require an accounting under this Section, Business Associate shall document the information specified in (a) through (d), above, and shall securely maintain the information for six (6) years from the date of the Disclosure (but beginning no earlier than April 14, 2003).

V. TERM AND TERMINATION

5.1 **Term.** This Agreement shall remain in effect as long as any Service Agreement(s) is in effect and shall extend beyond the termination of any Service Agreement(s) and shall terminate when all the PHI provided by Plan to Business Associate, or created or received by Business Associate on behalf of Plan is destroyed or returned to Plan, in accordance with Section 5.3 of this Agreement.

5.2 **Termination for Cause.** In addition to and notwithstanding the termination provisions set forth in the Services Agreement(s), upon Plan's knowledge of a material breach by Business Associate, Plan shall either:

- (a) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Plan; or
- (b) Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible.

5.3 **Disposition of Protected Health Information upon Termination or Expiration.**

- (a) **Return or Destruction.** Except as provided in paragraph (b) of this section, upon termination for any reason of this Agreement and the Services Agreement(s), Business Associate shall return or destroy all PHI received from Plan, or created or received by Business Associate on behalf of Plan in accordance with data destruction methods specified in Attachment A to this Agreement. This provision shall apply to PHI, in any form, that is in the possession of Business Associate and subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.
- (b) **Return or Destruction Infeasible.** In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Plan notification of the conditions that make it infeasible. Subject to the approval of Plan's regulator(s) if necessary, if return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further Uses and Disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

VI. OBLIGATIONS OF PLAN

6.1 Notice of Privacy Practices. Plan shall provide Business Associate with Notice of Privacy Practices, including changes thereto, relevant to this Agreement. To view the most current DHCS Notice of Privacy Practices see: <http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx> or the DHCS website at www.dhcs.ca.gov (select "Privacy" in the left column and "Notice of Privacy Practices" on the right side of the page). To view the most current Plan Notice of Privacy Practices see: https://www.caloptima.org/en/Members/Medi-Cal/YourRightsAndResponsibilities/~media/Files/CalOptimaOrg/Members/Medical/YourRightsandResponsibilities/NoticeofPrivacyPractices_English_508.ashx or the Plan website at www.CalOptima.org (select "Updated Notice of Privacy Practices" at the bottom of the right column under "Quick Links").

6.2 Permission by Individuals for Use and Disclosure of PHI. Plan shall provide Business Associate with any changes in, or revocation of, permission by an Individual to Use or Disclose PHI, if such changes affect the Business Associate's permitted or required Uses and Disclosures.

6.3 Notification of Restrictions. Plan shall notify Business Associate of any restriction to the Use or Disclosure of PHI that has been agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect the Business Associate's Use or Disclosure of PHI.

6.4 Notification of SSA Data. Plan shall notify Business Associate if Business Associate receives data that is SSA Data.

VII. MISCELLANEOUS

7.1 Use of Subcontractors and Agents. Business Associate shall require each of its agents and subcontractors that create, receive, maintain, use or transmit PHI from Business Associate, or create PHI for Business Associate, on behalf of Plan, to execute a written agreement obligating the agent or subcontractor to comply with all the terms of this Agreement including, implementation of reasonable and appropriate administrative, physical and technical safeguards to protect such PHI and PI and requirements that Security Incidents and Breaches of Unsecured PHI or PI be reported to the Plan. Business Associate shall implement and maintain sanctions against any agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation. Business Associate shall notify Plan of any subcontractors or agents who are working on Plan's behalf and which have access to Plan PHI or PI.

7.2 Regulatory References. A reference in this Agreement to a section in the Privacy, Security and Breach Regulations means the section as in effect or as amended.

7.3 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Plan to comply with HIPAA, the HITECH Act and implementing regulations.

7.4 Amendment. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Plan to comply with the requirements of HIPAA, the HITECH Act and implementing regulations.

7.5 Disclaimer. Plan makes no warranty or representation that compliance by Business Associate with this Agreement or HIPAA will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate is or will be secure from unauthorized Use or Disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safekeeping of PHI.

7.6 Assistance in Litigation or Administrative Proceeding. Business Associate shall make itself any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under the Services Agreement, available to Plan at no cost to Plan to testify as witnesses, or otherwise in the event of litigation or administrative proceedings being commenced against Plan, its directors, officers or employees based upon claimed violation of HIPAA, the HITECH Act and/or implementing regulations and/or State privacy laws, which involve actions or inactions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is named as an adverse party.

7.7 No Third-Party Beneficiaries. Nothing express or implied in the terms and conditions of this Agreement is intended to confer, nor shall anything herein confer, upon any person or entity other than Plan or Business Associate and their approved respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

7.8 No Waiver of Obligations. No change, waiver or discharge of any liability or obligations hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

7.9 Injunctive Relief. Notwithstanding any rights or remedies provided in this Agreement, Plan retains all rights to seek injunctive relief to prevent or stop the unauthorized Use or Disclosure of PHI or PI by Business Associate or any agent, subcontractor, employee or third party that received PHI or PI.

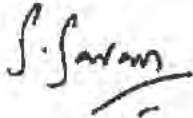
VIII. EXECUTION

8.1 Subject to the execution of the State Contract or amendments thereto by CalOptima and the State, this Agreement shall become effective on the Effective Date.

In witness thereof, the parties have executed this Agreement:

Business Associate
Sunny Saran

Print Name



Signature

CEO

Title

2/5/2016

Date

CalOptima

Michael Schrader

Print Name

Signature

CEO

Title

2-12-16

Date

Attachment A

Business Associate Data Security Requirements Subcontractors with Access to DHCS Data and PHI/PI

DEFINITIONS

- A. "DHCS Data" means for purposes of this Attachment A, all information provided by DHCS to the Plan which is accessed by Business Associate under the Services Agreement.
- B. "DHCS PHI or PI" means for purposes of this Attachment A, Protected Health Information and Personal Information and a subset of DHCS Data.

I. GENERAL SECURITY CONTROLS

- 1.1 Employee Training and Discipline. Business Associate agrees, at its expense, to train all workforce members who assist in the performance of functions or activities on behalf of Plan, or access or disclose DHCS PHI or PI on privacy and security requirements at least annually. Each workforce member who receives information privacy and security training must sign a certification, indicating that the person's name and date on which the training was completed. These certifications must be retained for a period of six (6) years following Agreement termination. Business Associate agrees to discipline such employees, volunteers and subcontractors who fail to comply with privacy policies and procedures or any provisions of this Agreement, including by termination of employment where appropriate.
- 1.2 Confidentiality Statement. All persons that will be working with DHCS PHI or PI must sign a confidentiality statement that includes, at a minimum, general use, security and privacy safeguards, unacceptable use and enforcement policies. The statement must be signed by the workforce member prior to access to DHCS PHI or PI. Business Associate shall retain each person's written confidentiality statement for inspection by Plan or Plan regulators for a period of six (6) years following Agreement termination.
- 1.3 Background Check. Before a member of the Business Associate's workforce may access DHCS PHI or PI, Business Associate must conduct a thorough background check of that worker and evaluate the results to assure that there is no indication that the worker may present a risk for theft of confidential data. The Business Associate shall retain each workforce member's background check documentation for inspection by Plan or Plan regulators for a period of three (3) years following Agreement termination.
- 1.4 Workstation/Laptop encryption. All workstations and laptops that process and/or store DHCS PHI or PI must be encrypted using a FIPS 140-2 certified algorithm which is a 128 bit or higher such as Advanced Encryption Standard. The encryption solution must be full disk unless approved by the DHCS Information Security Office (ISO).
- 1.5 Server Security. Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in place to protect the data, based upon a risk assessment/system security review.
- 1.6 Minimum Necessary. Only the minimum necessary amount of DHCS PHI or PI may be downloaded to a laptop or hard drive when absolutely necessary for current business purposes.

1.7 Removable Media Devices. All electronic files that contain DHCS PHI or PI must be encrypted when stored on any removable media type device (i.e. USB thumb drives, floppies, CD/DVD, etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128 bit or higher, such as AES.

1.8 Email Security. All emails that include DHCS PHI must be sent in an encrypted method, Encryption must be a FIPS 140-2 certified algorithm which is 128 bit or higher, such as AES.

1.9 Antivirus Software. All workstations, laptops and other systems that process and/or store DHCS PHI must have a commercial third-party anti-virus software solution with a minimum daily automatic update.

1.10 Patch Management. All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within thirty (30) days of vendor release.

1.11 User IDs and Password Controls. All users must be issued a unique user name for accessing DHCS PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared, must be at least eight characters, be a non-dictionary word, stored in readable format on the computer, changed every ninety (90) days, but preferably every sixty (60) days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)
- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

1.12 Data Destruction. All DHCS PHI or PI must be wiped from systems when the data is no longer necessary. The wipe method must conform to Department of Defense standards for data destruction DoD 5220.22-M (7 Pass) standard or by degaussing. Media may also be physically destroyed in accordance with NIST Special Publication 800-88. Other methods require prior written permission of Plan's regulators.

1.13 Remote Access. Any remote access to DHCS PHI must be executed over an Approved Technical Encryption Solution. All remote access must be limited to minimum necessary and least privilege principles.

II. SYSTEM SECURITY CONTROLS

2.1 System Timeout. The system providing access to DHCS PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.

2.2 Warning Banners. All systems containing DHCS PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only. Users must be directed to log off the system if they do not agree with these requirements.

2.3 System Logging. The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DHCS PHI or PI, or which alters DHCS PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read

only, and must be restricted to authorized users. If DHCS PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least three (3) years after occurrence.

2.4 Access Controls. The system providing access to DHCS PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.

2.5 Transmission Encryption. All data transmissions of DHCS PHI or PI outside the secured network must be encrypted using a FIPS 140-2 certified algorithm which is 128 bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI or PI in motion such as website access, file transfer and e-mail.

2.6 Intrusion Detection. All systems involved in accessing, holding, transporting and protecting DHCS PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

III. AUDIT CONTROLS

3.1 System Security Review. All systems processing and/or storing DHCS PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

3.2 Log Reviews. All systems processing and/or storing DHCS PHI or PI must have a routine procedure in place to review system logs for unauthorized access.

3.3 Change Control. All systems processing and/or storing DHCS PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. BUSINESS CONTINUITY / DISASTER RECOVERY CONTROLS

4.1 Emergency Mode Operation Plan. Business Associate must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic DHCS PHI or PI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under the Services Agreement(s) for more than 24 hours.

4.2 Data Backup Plan. Business Associate must have established documented procedures to backup DHCS PHI or PI to maintain retrievable exact copies of DHCS PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and the amount of time to restore DHCS PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of data.

V. PAPER DOCUMENT CONTROLS

5.1 Supervision of Data. DHCS PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

5.2 Escorting Visitors. Visitors to areas where DHCS PHI or PI is contained shall be escorted and DHCS PHI or PI shall be kept out of sight while visitors are in the area.

5.3 Confidential Destruction. DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing. Once DHCS PHI or PI is destroyed, Plan shall be notified.

5.4 Removal of Data. If Plan provides Business Associate with access to DHCS PHI or PI to perform services off-site (i.e., not at Plan's business premises), Business Associate shall not remove DHCS PHI to any overseas or offshore location. In the event that Business Associate is permitted to deliver DHCS PHI or PI to any party as part of its obligations under the Services Agreement(s), then Business Associate shall comply with all safeguard requirements related to the transmission and/or delivery of DHCS PHI or PI set forth in this Attachment.

5.5 Faxing. Faxes containing DHCS PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending.

5.6 Mailing. Mailings of DHCS PHI or PI shall be sealed and secured from damage or inappropriate viewing of PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of DHCS PHI or PI in a single package shall be sent using a tracked mailing method which ensures verification of delivery and receipt, unless prior written permission of Plan's regulator to use another method is obtained.

AMENDMENT NO. 1 TO CONTRACT NO. 160606
BY AND BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
DBA ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE,
DBA CALOPTIMA
(CalOptima)
AND
E20 HEALTH
(CONTRACTOR)

AMENDMENT NO. 1 to this CONTRACT is entered into as of February 10th, 2016, with respect to the following facts:

- A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 160606 on October 27th, 2015 for CalOptima's TechAssist Program Services.
- B. The Parties desire to amend the Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

- 1. Amend Exhibit B of the Original Contract to add Section I below:
 - I. If the CONTRACTOR does not subsequently submit a signed Eligible Professional Technical Assistance Acknowledgement and the Eligible Professional does not successfully complete Step 2 in the State Level Registry within Twelve (12) months of the signature date of the Practice Representative Technical Assistance Agreement, the CONTRACTOR will be required to refund all payments received for that Eligible Professional. "Successfully completed" is defined as the State Level Registry reporting "Step 2 completed (eligibility)", and that DHCS has reviewed and approved eligibility. Refund payments must be made within thirty (30) days of notification from the CalOptima TechAssist Program or can be replaced by satisfying requirements for payment for another Eligible Professional.
- 2. Amend Exhibit B-1 of the Original Contract to add the following:

"CONTRACTOR will be responsible for Section 2, b and receive payment of the indicated amounts in Exhibit B-1 minus 15% after submission of a signed Eligible Professional Technical Assistance Acknowledgement and successful completion of Step 2 in the State Level Registry within 12 months of the signature date of Practice Representative Technical Assistance Agreement."
- 3. All other terms and conditions of the Contract remain unchanged.

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment on the day and year last shown below.

E20 HEALTH

CALOPTIMA

Name: Sunny Saran _____

Name: _____

Signature:  _____

Signature: _____

Title: CEO _____

Title: _____

Date: 2/17/16 _____

Date: _____

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2015 **Regular Meeting of the CalOptima Board of Directors**

Report Item

VIII. J. Consider Authorizing Application for Grant Funding for a Medi-Cal Electronic Health Records (EHR) Incentive Program from the California Department of Health Care Services

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to apply for Notice of Funding Opportunity (NFO 15-001) issued by the California Department of Health Care Services (DHCS) titled Medi-Cal Electronic Health Records (EHR) Incentive Program.

Background

On February 17, 2009, the President signed the American Recovery and Reinvestment Act of 2009 (ARRA). Title XIII of Division A and Title IV of Division B of ARRA, together cited as the Health Information Technology for Economic and Clinical Health Act (HITECH Act), include provisions to promote meaningful use of health information technology to improve the quality and value of American health care. The HITECH Act authorizes incentive payments to eligible Medicare and Medicaid providers for meaningful use of certified EHR technology. In 2015, providers are expected to have adopted and be actively utilizing an EHR in compliance with the meaningful use definition or they will be subject to financial penalties under Medicare (per Sections 4101(b) and 4102(b) of ARRA).

Providers seeking to meaningfully use EHR technology face a variety of challenging tasks. These tasks include assessing needs, selecting and negotiating with a system applicant or reseller, implementing project management, and instituting workflow changes to improve clinical performance and ultimately, patient outcomes. To help providers address these challenges the Office of the National Coordinator for Health IT (ONC) funded the establishment of Regional Extension Centers (RECs). Four RECs were funded in California, including COREC, the CalOptima Regional Extension Center, which is part of the CalOptima Foundation. Since program inception, the four California RECs have provided assistance to over 10,000 providers. COREC is nearing 1,000 providers in Orange County. However, these RECs were restricted in their funding to assist only primary care providers and were not funded to assist specialists or to assist providers practicing in groups with more than 10 providers.

If awarded, this proposed funding opportunity will bring additional dollars to Orange County to support physicians in reaching the next stage of Meaningful Use or assist those providers who did not qualify for assistance under the federal COREC grant award.

Discussion

With Centers for Medicare and Medicaid Services (CMS) payments shifting from volume to outcomes based, the benefits of EHR technology in physician practices have become more and more important. While almost 1,000 Orange County primary care physicians (PCPs) have successfully attested to

Meaningful Use 1 with the assistance of COREC, there are many other types of physicians and practices who were not able to receive assistance.

The DHCS NFO’s purpose is to continue the type of technical assistance services previously provided by the RECs, while also expanding the scope of services to include specialists and providers practicing in medium or large size practice settings. DHCS is encouraging applications from entities that will work with Medi-Cal Managed Care Plans and entities that provide practice management and quality assurance support for providers. Successful grant funding applicants will be expected to not only work with individual practitioners but also with health care organizations such as, independent practice associations (IPAs), management services organizations (MSOs), clinics, professional associations and other health care entities to promote the adoption and meaningful use of health information technology by a target population of providers.

Currently, CalOptima has 4,649 providers contracted in its network. Staff is proposing to assist 1,000 to 1,200 providers through this program, pending DHCS approval. Dollars from this program cannot be used to cover services that were paid for by the REC grant. However, the same providers who participated under the REC grant can continue to get assistance to reach the next stage of Meaningful Use. Other providers that can benefit from this program include:

- Eligible professionals (EP) - physicians, nurse practitioners, dentists, certified nurse midwives, optometrists, and physician assistants who, individually or with a group, meet the 30% Medicaid encounter volume (20% for pediatricians) requirement for the Medi-Cal (EHR) Incentive Program;
- Solo Practice – For purposes of this NFO, where a provider performs 50% or more of their care in a setting at which there is only one of the following professionals: physician, nurse practitioner, dentist, certified nurse midwife, optometrist, or physician assistant;
- Specialist – a dentist, optometrist, or physician who is board certified by a specialty board which is a member of the American Board of Medical Specialties (except family practice, obstetrics and gynecology, pediatrics, and general internal medicine)
- Providers of any size are eligible to participate – there are no practice group size restrictions.

The application/program timeline is as follows:

Event	Date
NFO Released	05/28/2015
Questions Due no later than	06/04/2015
CalOptima Board Approval to Apply	06/04/2015
Application Completion	06/10/2015
Application Due – Written submission only	06/12/2015, 4:00 PM PDT
Award Notices Released	06/25/2015
Proposed Program Start Date	07/01/2015
Proposed Program End Date	06/30/2018

As the timeline indicates, from the NFO release last Thursday, May 28, 2015, applicants have approximately two weeks to submit their applications.

Fiscal Impact

The recommended action to submit this grant application is budget neutral to CalOptima. There is no requirement for CalOptima to provide a match of funds, in-kind or direct, as was required in the REC award.

The administrative cost to support this grant is estimated at \$250,000 annually, covering staffing and support. This staffing and support cost exists within the current CalOptima budget. There are vacant positions currently, as the initial COREC grant is coming to an end, and the volume of work had reduced. These vacant positions were to be filled to support upcoming work, including the sustainability plan for the original 1,000 providers supported – and to launch support of Specialists in achievement of their next stage of Meaningful Use. Upon receipt of this grant award, the existing planned staff will be hired and used for this program.

CalOptima anticipates DHCS will provide incentives based on milestone achievements and attestations, including:

- \$500 for a signed technical assistant contract between CalOptima and the EP;
- \$750 for a newly signed EP participation agreement for a Health Information Exchange (HIE);
- \$750 for an EP specialist attestation;
- \$750 for an EP solo practitioner attestation;
- \$1,500 for implementation of an EHR solution;
- \$2,250 for completion of the EP’s first year Stage 1, 2, and/or 3 Meaningful Use attestation;
and
- \$500 for completion of the EP’s subsequent Stage, 1, 2, and/or 3 Meaningful Use attestation.

This program will allow CalOptima to continue to assist more physicians in the implementation of an EHR solution as well as help them prepare for Medi-Cal incentive payments. This will further reduce the technology gaps for patient care in Orange County.

Rationale for Recommendation

The recommendation will allow CalOptima to assist additional providers in Orange County with EHR implementation and connectivity to better serve CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

DHCS Notice of Funding Opportunity (NFO 15-001)

/s/ Michael Schrader
Authorized Signature

6/2/2015
Date



JENNIFER KENT
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

May 28, 2015

Dear Interested Parties,

The purpose of this letter is to announce the release of the attached Notice of Funding Opportunity (NFO) Number #15-001 entitled, "Medi-Cal Electronic Health Record Incentive Program: Technical Assistance Program" (EHR).

The Department of Health Care Services (DHCS) is releasing electronically the NFO #15-001 to solicit applications from interested parties regarding the EHR program. The purpose of the EHR program is to provide technical assistance services to eligible professionals to encourage meaningful use of certified EHR technology. This NFO will seek to continue the technical services provided by Regional Extension Centers (RECs) and seeks to expand the current scope to include additional provider types. Interested parties may now download the NFO from the Office of Medi-Cal Procurement (OMCP) web site at:

http://www.dhcs.ca.gov/ProvGovPart/rfa_rfp/Pages/OMCPHomePage.aspx.

To ensure that your application is fully considered regarding this NFO, please submit by close of business on or before June 12, 2015 at 4:00 p.m. Please submit your questions and/or comments on or before June 4, 2015 to omcprfp4@dhcs.ca.gov.

All agreements entered into with the State of California will include, by reference, General Terms and Conditions (GTC) and Contractor Certification Clauses (CCC) that may be viewed and downloaded at this Internet site <http://www.ols.dgs.ca.gov/Standard+Language/default.htm>. If any prospective Applicant lacks Internet access, a CD-R copy can be obtained by contacting OMCP at (916) 552-8006 or omcprfp4@dhcs.ca.gov.

Thank you for your interest in the Department's service needs.

Sincerely,

Original Signed by *Kevin Morrill*

Kevin Morrill, Chief
Office of Medi-Cal Procurement



**Office of Health Information Technology
Notice of Funding Opportunity (NFO)
#15-001**

Medi-Cal Electronic Health Records (EHR) Incentive Program
Technical Assistance

Department of Health Care Services
Office of Health Information Technology
MS Code 0004
1501 Capitol Ave, MS0004
P. O. Box 77413
Sacramento, CA 95899-7413

[Back to Agenda](#)

Table of Contents

A. Introduction and Background..... 6

 1. Introduction..... 6

 2. Background 6

B. Funding Purpose and Objectives 6

C. Funding Availability..... 7

 1. Funding Amount 7

 2. Number of Awards 7

 3. Funding Restrictions/Allowances 8

D. Agreement Term 8

E. Eligibility Criteria 8

 1. Eligible Applicants..... 8

 2. Ineligible Applicants 9

F. Proposed Award Schedule 9

G. Applicant Questions 10

 1. What to include in an inquiry 10

 2. Question Deadline 11

 3. How to submit questions 11

 4. Verbal questions 11

H. Pre-Application Conference..... 11

I. Scope of Work / Project Description 11

J. Eligibility Requirements 11

K. Application Format and Content Requirements 13

 1. General Instructions..... 13

 2. Format Requirements 13

 3. Application Content Requirements..... 14

 a. Application Cover Page..... 14

 b. Table of Contents..... 14

 c. Narrative 14

 d. Applicant Capability section 15

 e. Work Plan section 16

 1) Overview 16

 2) Rejection or alteration of activities, tasks, or functions..... 16

 3) Work Plan content 16

 f. Management Plan Section 17

 g. Budget section 18

 h. Appendix section..... 20

- i. Financial Stability – Minimum Financial Criteria..... 20
 - j. Forms section 22
 - L. Application Submission** **24**
 - 1. Submission Instructions 24
 - 2. Proof of timely receipt 25
 - 3. Applicant costs..... 25
 - M. Evaluation** **26**
 - 1. Stage 1 – Application Checklist Evaluation 26
 - 2. Stage 2 – Application Evaluation..... 26
 - N. Application Evaluation Factors** **27**
 - 1. Narrative 27
 - 2. Applicant Capability 27
 - 3. Work Plan 28
 - 4. Management Plan..... 29
 - 5. Budget 29
 - O. Procurement Requirements and Information** **29**
 - 1. Nonresponsive applications 29
 - 2. Withdrawal and/or Resubmission of Applications 30
 - a. Withdrawal deadlines 30
 - b. Submitting a withdrawal request..... 30
 - c. Resubmitting an application 31
 - 3. Awards and appeals 31
 - a. Awards..... 31
 - b. Appeals..... 31
 - 1) Who can appeal 31
 - 2) Grounds for appeal..... 31
 - 3) Appeal content 31
 - 4) Appeal Timelines..... 31
 - 5) Submitting an appeal..... 32
 - 6) Appeal process 32
 - 4. Disposition of Applications 33
 - 5. Inspecting or obtaining copies of applications 33
 - a. Who can inspect or copy application materials 33
 - b. What can be inspected and when 33
 - c. Requesting Applicant Materials 33
 - 6. Verification of Applicant information 34
 - 7. DHCS rights..... 34
 - a. NFO clarification / correction / alteration..... 34

- b. Insufficient responsive applications / additional awards / altered awards..... 34
- c. Collecting information from Applicants 35
- d. Immaterial application defects..... 35
- e. Correction of clerical or mathematical errors 35
- f. Right to remedy errors 36
- g. No contract award or NFO cancellation..... 36
- h. Agreement amendments after award 36
- i. Proposed use of subcontractors and/or independent consultants..... 36
- j. Staffing changes after award..... 36
- k. Funding..... 36
- P. Federal Certification Clauses 37**
 - 1. Debarment and Suspension Certification 37
 - 2. Lobbying Restrictions and Disclosure 37
- Q. Contractual Terms and Conditions 38**
 - 1. Sample contract forms / exhibits 38
 - 2. Resolution of language conflicts (NFO vs. final agreement)..... 39
- T. Required Attachments**

Attachment #	Attachment Name
Attachment 1	Application Cover Page
Attachment 2	Application Checklist
Attachment 3	Client References
Attachment 4	NFO Clause Certification
Attachment 5	CCC 307 - Certification
Attachment 6	Payee Data Record
Attachment 7	Follow-on Consultant Contract Disclosure
Attachment 8	Darfur Contracting Act Certification
Attachment 9	Iran Contracting Act Certification
Attachment 10	Conflict of Interest Compliance Certificate
Attachment 11	Applicant Response Guide
Attachment 12	Work Plan
Attachment 13	Budget Detail Worksheet (Year 1)

Attachment #	Attachment Name
Attachment 14	Subcontractor Budgets (Year 1)
Attachment 15	Budget Detail Worksheet(Year 2)
Attachment 16	Subcontractor Budgets (Year 2)
Attachment 17	Budget Detail Worksheet(Year 3)
Attachment 18	Subcontractor Budgets (Year 3)

U. Sample Contract Forms/Exhibits

Exhibit #	Exhibit Name
Exhibit A	Scope of Work
Exhibit B	Budget Detail and Payment Provisions
Exhibit C	General Terms and Conditions (GTC 610).
Exhibit D(f)	Special Terms and Conditions
Exhibit E	Additional Provisions
Exhibit F	Contractor's Release
Exhibit G	HIPAA Business Associate Addendum
Exhibit H	Information Confidentiality and Security Requirements
Exhibit I	ARRA Terms and Conditions
Exhibit J	Program Glossary

A. Introduction and Background

1. Introduction

The California Department of Health Care Services (DHCS), Office of Health Information Technology (OHIT), is pleased to announce the availability of funds through this Notice of Funding Opportunity (NFO) and is soliciting applications from eligible organizations that are able to perform the services outlined in the section entitled, “Scope of Work” (SOW).

2. Background

On February 17, 2009, the President signed the American Recovery and Reinvestment Act of 2009 (ARRA). Title XIII of Division A and Title IV of Division B of ARRA, together cited as the Health Information Technology for Economic and Clinical Health Act (HITECH Act), include provisions to promote meaningful use of health information technology to improve the quality and value of American health care. The HITECH Act authorizes incentive payments to eligible Medicare and Medicaid providers for meaningful use of certified electronic health record (EHR) technology. In 2015, providers are expected to have adopted and be actively utilizing an EHR in compliance with the “meaningful use” definition or they will be subject to financial penalties under Medicare (per Sections 4101(b) and 4102(b) of ARRA). For access to the most current publicly available information about meaningful use, please visit: <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>

Providers seeking to meaningfully use EHR technology face a variety of challenging tasks. These tasks include assessing needs, selecting and negotiating with a system applicant or reseller, implementing project management, and instituting workflow changes to improve clinical performance and ultimately, patient outcomes. To help providers address these challenges the Office of the National Coordinator for Health IT (ONC) funded the establishment of Regional Extension Centers (RECs). Four RECs were funded in California. Since program inception they have provided assistance to over 10,000 providers. Although the RECs have been essential in launching the EHR Incentive Programs, their funding will expire in the coming months. RECs were not funded to assist specialists or to assist providers practicing in groups with more than 10 providers.

B. Funding Purpose and Objectives

OHIT intends to make awards to eligible and responsive organizations that can best meet its program goals and objectives. Awards will be made to eligible applicants for the establishment of new programs, continued funding for existing programs, and/or expansion of existing programs that continue the type of technical assistance services previously provided by the RECs. This funding opportunity expands the scope of services to include specialists and providers practicing in medium or large size practice settings. DHCS is encouraging applications from Applicants that will work with Medi-Cal Managed Care Plans and entities that provide practice management and quality assurance support for providers. Successful Applicants will be expected to not only work with individual practitioners but also with health care organizations such as, independent practice associations (IPAs), management services organizations (MSOs), clinics, professional associations and other health care entities to promote the adoption and meaningful use of health information technology by a target population of eligible professionals (EP).

In any successful Applicant’s target group(s), many EPs will have already acquired and/or implemented EHR technology, with some EPs having met meaningful use criteria. In such cases, the technical assistance should be focused on attaining the next stage of meaningful use of EHR technology as defined by the Centers for Medicare and Medicaid Services (CMS). The ultimate measure of an Applicant’s effectiveness will be whether it has assisted EPs in adopting Certified

Electronic Health Record Technology (CEHRT), becoming meaningful users of CEHRT, or advancing to the next meaningful use stage, and attesting to the Medi-Cal EHR Incentive Program as defined by the CMS final rule. It is expected that each Applicant will provide technical assistance to the minimum number of EPs projected in the Applicant's submission, which should not be less than 1,000. OHIT may entertain Applicant submissions to address targeted groups of less than 1,000 if there is a compelling reason to do so; as an example, a specific, underrepresented EP type or a specific rural region. The Applicant is advised to substantiate their need to address a target group(s) of less than 1,000.

C. Funding Availability

1. Funding Amount

A maximum funding amount of \$37,500,000 is available over three years (FY 15/16 through FY 17/18) to fund the awards resulting from this NFO.

This funding will be released by DHCS based on the number of identified EPs that have achieved specific milestones as listed in Exhibit B, Section D., 1., a-g.

Subject to applicable approvals, DHCS reserves the right to initiate amendments as necessary to redistribute funds between fiscal years to meet the needs of the State.

a. Limitation of State Liability

Payment for performance under the resulting agreement may be dependent upon the availability of future appropriations by the State Legislature or Congress for the purposes of the resulting agreement. No legal liability on the part of the State for any payment may arise under the resulting agreement until funds are made available through an annual appropriation and the Contractor is notified accordingly. If an agreement is executed before ascertaining available funding and funding does not become available, DHCS will cancel the agreement.

b. Funding Reductions in Subsequent Budget Years

If an agreement is executed and full funding does not become available for the second or a subsequent state fiscal year, DHCS will either cancel the agreement or amend it to reflect reduced funding and reduced activities. Continuation of services beyond the first State fiscal year is also subject to successful performance.

c. Unobligated Funds

Unobligated funds at the end of the budget/project period or upon cancellation of a contract may be redistributed or may remain in the account for future disposition, according to DHCS's determination of the best interest of the Technical Assistance Program.

2. Number of Awards

DHCS expects to make up to 10 awards to eligible and qualified applicants. If the number of eligible and qualified applicants exceeds funding availability, DHCS reserves the right to determine the appropriate funding level and number of awards to be awarded to eligible and qualified applicants. DHCS may request that applicants modify their target group(s) after submission if DHCS determines that there is an overlap of target group(s) with other applicants. Agreements will include terms and conditions reserving the ability of DHCS to negotiate during the course of the awarded project period further modifications to any applicant target group(s) in the best interest of the program.

Applicants may be considered qualified but not selected for funding because of such factors, including , but not limited to, limitation of funds, number of qualified applicants, and overlap of target group(s).

3. Funding Restrictions/Allowances

Funds under this announcement have the following restrictions:

- a. Funding cannot be issued for achievement of milestones that have previously been paid for or will be paid for by the federal government or other sources.

D. Agreement Term

The term of a resulting agreement is expected to be [36] months. The agreement term may change if DHCS makes the awards earlier than expected or if DHCS cannot execute agreements in a timely manner due to unforeseen delays.

The resulting agreement or subsequent amendments or changes will be of no force or effect until signed by DHCS and all parties. The Contractor is cautioned not to commence performance until all approvals are obtained. Should performance commence before all approvals are obtained, said services may be considered to have been volunteered if all approvals are not obtained.

DHCS reserves the right to extend the term of the resulting agreement via a formal contract amendment as necessary to complete or continue services. Agreement extensions are subject to satisfactory performance, funding availability, and approval by DHCS and CMS. DHCS offers no assurance that an extension will occur or that funding will be continued at the same level in future years.

For this agreement, one (1) or two (2), contract extension(s) of one (1) year each may be executed at the sole discretion of DHCS. Contract extensions are subject to satisfactory performance and funding availability for the program.

E. Eligibility Criteria

1. Eligible Applicants

Federal funding is an integral component of this program. Therefore, any entity submitting an application for this award must be a United States-based institution or organization, or group thereof and eligible for receipt of federal funds.

One of the principal goals of the applicant organization must be to promote the use of health information technology (HIT) to improve health care quality and efficiency through the authorized and secure electronic exchange and use of electronic health information.

Applicants may apply for funding as an individual organization or as a consortium of multiple organizations defined for the purposes of this NFO as a “collaborative”. A collaborative involves the joint effort of two or more eligible organizations that together intend to implement the project.

A collaborative application must be submitted by a single eligible organization that applies on behalf of itself and its collaborating partners and will act as the lead agency. The lead agency shall be solely responsible for overall financial administration and project coordination and implementation. When determining qualification and other application requirements for a collaborative, DHCS will jointly consider the combined experience, efforts, and resources of all participating organizations. If a collaborative application is funded, the resulting agreement will be entered into between DHCS and the applicant or lead agency.

An applicant can apply for funding as an individual organization or as part of a collaborative but not both. However, a single organization can apply for funding as a collaborating partner in more than one joint application.

2. Ineligible Applicants

- a. The following entities are not eligible to apply for funding through this NFO:
- 1) EHR Applicants who sell their own EHR product exclusively.
 - 2) Organizations that have been deemed ineligible for California contracts or grants by the Department of Fair Employment and Housing due to a failure to comply with California's nondiscrimination laws and reporting requirements.
 - 3) Organizations that have been debarred or decertified from contracting by the federal or State government.
 - 4) Recipients of incentive payments under the Medi-Cal EHR Incentive Program and/or Medicare EHR Incentive Program.
 - 5) Have within a three (3) year period preceding this Proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or Contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
 - 6) Are presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Section P of the NFO Main.
 - 7) Have not within a three (3) year period preceding this application/Proposal had one (1) or more public transactions (Federal, State or local) terminated for cause or default.
 - 8) EHR Applicant that knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.
 - 9) Any organization whose name appears on either list of the 500 largest tax delinquencies pursuant to Section 7063 or 19195 of the Revenue and Taxation Code. Any contract entered into in violation of this subdivision is void and unenforceable.
- b. If the Contractor is unable to certify to any of the statements in Attachment 2, the Contractor shall submit an explanation to DHCS funding this Contract.

F. Proposed Award Schedule

Below is the tentative schedule for this procurement. All applicants are advised of the following schedule and will be expected to adhere to the required dates and timelines.

Event	Date	Time (If applicable)
NFO Released	05/28/15	
Questions Due	06/04/15	
Applications Due	06/12/15	4:00 p.m. (Pacific Time)
Award Notices Released	06/25/15	
Proposed Agreement Start Date	07/01/15	
Intent to Appeal Due	07/02/15	
Appeals Due	07/07/15	5:00 p.m. (Pacific Time)
Decisions on Appeals	08/18/15	

G. Applicant Questions

Immediately notify DHCS if clarification is needed regarding the services sought or questions arise about the NFO and/or its accompanying materials, instructions, or requirements. Inquiries must be put in writing and transmitted to DHCS as instructed below. At its discretion, DHCS reserves the right to contact an inquirer to seek clarification or respond to any inquiry received. If DHCS, at its discretion responds to an inquirer, we will post the response on the OMCP website.

Applicants that fail to report a known or suspected problem with the NFO and/or its accompanying materials or fail to seek clarification and/or correction of the NFO and/or its accompanying materials shall submit an application at their own risk. In addition, if an award is made, the successful Applicant shall not be entitled to additional compensation for any additional work caused by such problem, including any ambiguity, conflict, discrepancy, omission, or error.

1. What to include in an inquiry

- a. Name of inquirer, name of organization being represented, mailing address, area code and telephone number, fax number, and email address (if applicable).
- b. A description of the subject, concern, or issue in question or NFO discrepancy found.
- c. NFO section, page number or other information useful in identifying the specific problem, concern, or issue in question.
- d. Proposed remedy sought or suggested, if any.

2. Question Deadline

Notwithstanding the question submission deadline, DHCS will accept questions or inquiries about the following issues if such inquiries are received prior to the proposal submission deadline.

- a. The reporting of NFO errors or irregularities.

3. How to submit questions

Submit inquiries using the following email address:

Email: omcprfp4@dhcs.ca.gov

Insert “**Questions - NFO 15-001**” in the subject line of each emailed inquiry.

4. Verbal questions

Verbal inquiries will not be accepted. All inquiries must be transmitted via email according to above instructions.

H. Pre-Application Conference

No Pre-Application Conference will be held for this NFO.

I. Scope of Work / Project Description

See Exhibit A entitled, “Scope of Work” SOW that is included in the Sample Contract Forms and Exhibits section of this NFO. Exhibit A contains a detailed description of the services and work to be performed as a result of this NFO.

J. Eligibility Requirements

Failure to meet the following requirements will be grounds for DHCS to deem an Applicant nonresponsive and/or ineligible for funding. By submitting an application in response to this NFO, each Applicant acknowledges it meets the following requirements.

Failure of a collaborative Applicant to meet the following requirements will be grounds for DHCS to deem an applicant nonresponsive and/or ineligible for funding. By submitting an application in response to this NFO, each collaborative applicant acknowledges that the lead agency and its participating partners jointly meet the following requirements.

1. A minimum of three (3) consecutive years of the experience types listed below. It is required that an organization’s experience occurred within the past five (5) years. It is possible to attain the experience types listed below during the same time period. Applicants must have experience with:
 - a. Assisting groups and eligible professionals with EHR implementation.
 - b. Workflow redesign and clinical quality improvement.
 - c. Outreach, education, and on-site direct technical assistance with EHR adoption, implementation, meaningful use.

- d. Establishing and maintaining effective working relationships with Medi-Cal Managed Care Plans, Medi-Cal providers, independent practice associations (IPAs), management services organizations (MSOs), clinics, professional associations, and/or other health care entities to promote the adoption and meaningful use of health information technology.

2. Corporations Partnerships, Limited Liability Companies

Corporations Partnerships, Limited Liability Companies must certify they are in good standing and submit evidence they are qualified to conduct business in California.

3. Nonprofit organizations

Nonprofit organizations must certify they are eligible to claim nonprofit status and must submit proof that they are qualified to conduct business in California.

4. Compliance with Contract Terms and Conditions

Applicant must be willing and able to comply with all terms and conditions outlined in the NFO section entitled “Contractual Terms and Conditions” and those appearing in the cited exhibits accompanying this NFO.

5. Financial Stability

Applicants must certify they are financially stable and solvent and have adequate cash reserves to meet all financial obligations while awaiting reimbursement from the State.

6. Darfur Contracting Act Certification

This NFO is exempt from the Darfur Contracting Act Certification (PCC 10475-10481) per the exemptions provided in WIC 14046.3. The Darfur Contracting Act Certification language has been retained as a placeholder to maintain the cohesiveness of this NFO.

7. Iran Contracting Act Certification

Pursuant to Public Contract Code Sections 2202-2208, prior to bidding on, submitting a proposal or executing a contract or renewal for a State of California contract for goods or services of one million dollars (\$1,000,000) or more, a bidder/Proposer/respondent must either:

- a) Certify it is **not** on the current list of persons engaged in investment activities in Iran created by the DGS pursuant to PCC Section 2203(b) and is not a financial institution extending twenty million dollars (\$20,000,000) or more in credit to another person, for forty-five (45) days or more, if that other person will use the credit to provide goods or services in the energy sector in Iran and is identified on the current list of persons engaged in investment activities in Iran created by DGS; or
- b) Demonstrate it has been exempted from the certification requirement for that solicitation or contract pursuant to PCC Section 2203(c) or (d).

To comply with this requirement, read and complete **Attachment 9**, Iran Contract Act Certification.

8. Conflict of Interest Certification **Attachment 10**

Applicants must certify and/or submit proof that no prohibited conflict of interest exists.

9. Identify at least three (3) client references that the proposing firm has serviced in the past five (5) years that can confirm their satisfaction with the services and confirm if the proposing firm provided timely and effective services or deliverables. Use the Client References form (**Attachment 3**) for this purpose. DHCS will contact references and identified references should be prepared to respond to questions. DHCS reserves the right to require additional references upon request. **Place the completed Client References form in the Forms Section of the application.**

10. Applicant Response Guide

To insure that each applicant is evaluated on the full merits of the information provided, please complete the Applicant Response Guide, as provided (**Attachment 11** and accompanying instructions).

11. Liability Insurance Requirement

Successful Applicants must supply, before contract execution, proof of liability insurance that meets the requirements of Provision J of Exhibit E entitled, Additional Provisions.

K. Application Format and Content Requirements

1. General Instructions

- a. Develop applications by following all NFO instructions and/or clarifications issued by DHCS in the form of question and answer notices, clarification notices, Administrative Bulletins, or NFO addenda.
- b. Before submitting an application, seek timely written clarification of any requirements or instructions that seem vague, unclear or that are not fully understood.
- c. In preparing an application, all narrative portions should be straightforward, detailed and precise. DHCS will determine the responsiveness of an application by its quality, not its volume, packaging or colored displays.
- d. Arrange for the timely delivery of the application package(s) to the address specified in this NFO. It is advisable to not delay until shortly before the deadline to submit the application.

2. Format Requirements

- a. Format the narrative portion of the application as follows:
 - 1) Use one-inch (1") margins at the top, bottom, and both sides.
 - 2) Use a font size of not less than eleven (11) points.
 - 3) Print on white paper.
 - 4) Sequentially paginate the pages in each section. It is not necessary to paginate items in the Forms Section or Appendix Section.
- b. Bind each application set in a way that enables easy page removal. Loose leaf or three-ring binders are acceptable.
- c. All NFO attachments that require a signature must be signed in ink, preferably in blue ink. Signatures may be omitted from the accompanying CD/DVD.

- 1) Have a person who is authorized to bind the applicant sign each NFO attachment that requires a signature. Signature stamps are not acceptable.
- 2) Place the originally signed attachments in the application set marked “Original”.
- 3) The NFO attachments and other documentation placed in the extra application sets may reflect photocopied signatures.

3. Application Content Requirements

This section specifies the order and content of each application. Assemble the materials in each application set in the following order:

a. Application Cover Page

A person authorized to bind the Applicant must sign the Application Cover Page (**Attachment 1**). If the Applicant is a corporation, a person authorized by the Board of Directors must sign the Application Cover Page. If the Applicant is a local government agency, a person authorized by the Board of Supervisors must sign the Application Cover Page.

b. Table of Contents

Properly identify each section and the contents therein. Paginate all items in each section with the exception of those items placed in the Forms Section and Appendix Section.

c. Narrative

The Narrative must not exceed ten (10) pages in length.

In preparing the Narrative, do not simply restate or paraphrase information in this NFO. Describe or demonstrate, in the Applicant’s own words, the following information as it relates to the capabilities of the applying organization.

- 1) Whether the proposed project will involve a single entity or a collaborative effort by more than one organization. If a collaborative effort is indicated, identify the collaborative organizations and the primary roles of each organization.
- 2) Applicants are expected to complete a current analysis for the state of EHR adoption and meaningful use and determine gaps within their target group(s). Target group(s) information should include:
 - a) Composition of the target group(s) (specify geographical area [please provide list of zip-three codes, or if smaller geographic units, zip-five], and/or eligible professional /specialty type, and/or other characteristics that will be targeted)
 - b) Percentage of total population targeted
 - c) Size of the target group(s)
 - d) Data sources used to select the target group(s) (i.e., use of historical health indicators or bench marks, demographic data, or statistical data and its source).
 - e) Does the target group(s) represent a population of eligible professionals in particular need of assistance with health information technology?

- f) Are there existing support organizations (such as IPAs or MSOs) serving the target group(s) of eligible professionals with which the applicant can partner?
 - g) Are there existing organization(s) to provide for the secure electronic exchange of health information?
- 3) The consequences that will result if the application is not funded or not fully funded.
 - 4) How this project will be effectively integrated into current obligations and existing workload.
 - 5) How other organizations in the community may/will contribute to the project.

Please note: Applicants may be required to modify their application if DHCS determines there is overlap of the target group(s) between Applicants. (See Section C. 2.)

d. Applicant Capability section

1) **Applicant Information**

Include the following information about the applying organization:

- a) The organization's mission and goals that are relevant, closely related, or will complement the services outlined in the SOW.
- b) Briefly describe the applying organization's accomplishments that are related and/or relevant to the services outlined in the SOW.
- c) Describe relationships, such as partnerships, collaborations, or arrangements with other service providers in the community that the applying organization is engaged in to ensure effective delivery of services.
- d) Describe how the organization will utilize, where locally available, the expertise and capabilities of health plans, IPAs, MSOs, provider associations, health professional societies, state/local/tribal public health agencies, health plans, hospital systems, community colleges, Medicare Quality Improvement Organization(s), and other relevant stakeholders.

2) **Experience**

Describe the experience that qualifies the applying organization to undertake the services outlined in the SOW. At a minimum, demonstrate the applying organization's possession of the experience types listed below. For each experience type possessed, briefly explain the nature of applying organization's experience and time period during which the experience occurred. Applicants should focus their descriptions on the following experience types:

- a) Assisting groups and eligible professionals with EHR implementation.
- b) Workflow redesign and clinical quality improvement.
- c) Outreach, education, and on-site direct technical assistance with EHR adoption, implementation, meaningful use.
- d) Any other relevant experience that aligns with the SOW.

3) Past Projects

Briefly, describe the projects (including contract and grant awards) begun or completed in the past five (5) years that involved services similar in nature or closely related to the SOW in this NFO.

For each project listed, include the following information:

- a) Name of agency, organization, or firm for whom services were performed
- b) Project length or duration
- c) Total cost or value of the project
- d) Indicate if the account or project is “active/open” or “closed/settled”
- e) Identify the type or nature of services the applicant performed

e. Work Plan section

1) Overview

- a) Complete Work Plan (**Attachment 12**) to ensure compliance with all Work Plan content requirements. When completing the Work Plan, Applicants may create like images or computerized reproductions of the cited attachment. Use as many pages as are necessary to fully articulate the Work Plan.
- b) DHCS is interested in proposals that provide well-organized, comprehensive, and technically sound business solutions. Vague explanations will undermine the proposing firm’s credibility and may result in DHCS finding an applicant non-responsive.
- c) The Work Plan must include an in-depth discussion and description of the methods, approaches and step-by-step actions that will be carried out to fulfill all SOW requirements and meet payment milestones listed in Exhibit B, Section D., 1., a-g.

If the nature of a task or function hinders specific delineation of in-depth methods and procedures (e.g., a task is dependent upon a future action or multiple approaches may be used), explain the probable methods, approaches or procedures that may be used to accomplish the task or function. Also, describe, in this instance, how the applying organization will introduce the ultimate strategies and detailed plans to DHCS for full consideration and approval before proceeding to carry out those aspects of the project.

- d) If, for any reason, the Work Plan does not wholly address each SOW requirement, fully explain each omission.

2) Rejection or alteration of activities, tasks, or functions

The Applicant may not reject any task, activity or function required by this NFO. Any language discovered during the evaluation by DHCS that states a task, activity or function is rejected may be grounds to deem an Applicant nonresponsive, at DHCS’ sole discretion. Upon execution of the contract the Applicant may not assert that any part, section or language of their application rejected a task, activity or function.

3) Work Plan content

Complete Work Plan (**Attachment 12**). Complete the following items, as indicated on the form:

a) **Goals**

- i. If the goals differ annually or in each budget period, include separate Work Plan sheets for each contract year or budget period.
- ii. If the goals will remain constant throughout the agreement term include only one set of Work Plan sheets.
- iii. Start a new page for each new goal.

b) **Objectives or outcomes** that will be employed to attain each goal.

- i. If the objectives differ each contract year or budget period, include separate Work Plan sheets for each budget period.
- ii. If the objectives will remain constant throughout the agreement term, include only one set of Work Plan sheets.

c) **Major tasks/activities and functions** that will be performed in the order they are likely to occur. Include the following information for each task/activity or function in the work plan:

- i. Indicate **who is responsible** for performing each major task/activity or function.

If the responsible party is known, identify a person's position or classification title including that of known key personnel. For subcontractors and/or consultants simply indicate "subcontractor" or "consultant" as applicable.

If the responsible party is not yet known, indicate "TBD" which is the abbreviation for "to be determined".

- ii. Identify all planned or anticipated deliverables and explain/describe how the applying organization intends to measure or prove successful completion of each major task, function or activity as noted in the SOW (Exhibit A).

If applicable, identify the key events or outcomes that will signify completion or identify tangible items (deliverables) that will result at the conclusion of the various tasks/activities or functions. Indicate the anticipated time frame for submission of each tangible deliverable e.g., final report to be submitted within thirty (30) days following the agreement end date.

f. Management Plan Section

- 1) Describe how the applicant plans to govern and manage the execution of its overall program. Include the applicant's governance structure, roles/responsibilities, operating procedures composition of committees, workgroups, teams, and associated leaders, and communications plans that will provide adequate planning, monitoring, and control to the overall project. The project management activities should provide details on how plans and decisions are developed and documented, issues/risks managed, and meetings facilitated. The applicant must demonstrate how it will effectively and efficiently provide prompt, responsive, individualized support to all eligible professionals in the target group(s).

- 2) Include financial statements, or a letter of credit to cover six (6) months of operation, or a letter of financial or in-kind support from parent entity or third party. Instructions are explained in the Appendix section. **Place the financial statements, letter of credit, or letter of financial or in-kind support in the Appendix section of the application.**

g. Budget section

The intention of this section is to inform DHCS regarding the applicant's understanding of the resource requirements and viability to undertake this effort. The information provided by the applicant in this section will be a factor in any resulting contract for the services.

1) Basic content

- a) Budget forms (**Attachments 13, 15 and 17**) for each budget period.
- b) Subcontractor Budgets (**Attachments 14, 16 and 18**) for each budget period.

2) General instructions

- a) All Budget forms must be typewritten or completed in ink. Errors, if any, should be crossed out and corrections should be printed in ink or typewritten adjacent to the error. The person authorized to take action on behalf of the Applicant should initial all corrections preferably in blue ink.
- b) When completing the Budget forms, project all estimated costs to perform the services for the entire term, including applicable annual rate adjustments attributable to merit increases or cost of living adjustments, etc.

3) Required Budget Detail

- a) On each Budget form, provide specific cost breakdowns for the budget line items identified in this section.
- b) All unit rates/costs, if any (i.e., square footage, salary rates/ranges, hourly rates, etc.), must be multiplied out and totaled for each budget period.
- c) Please report costs using whole dollars only. Round fractional dollar amounts or cents to the nearest whole dollar amount.
- d) When completing the Budget forms, like images or computerized reproductions of the Budget forms included in this NFO may be used or developed. Use as many pages as are necessary to display budgeted costs for the term specified. The Budget forms included in this NFO are intended to show the required format for reporting proposed budget expenses.
- e) Identify the projected detailed expenses for each line item or category identified below by following the instructions herein.

i. Personnel costs

- A. Identify each funded position title or classification.
- B. Indicate the number of personnel in each position/classification.
- C. Indicate the full time equivalent (FTE) or annual percentage of time/effort for each position (i.e., full time = 1.0, 1/2 time = .50, 3/4 time = .75, 1/4 time = .25, number of hours, if hourly, etc.).
- D. Identify the monthly salary rate or range for each position/classification.

- E. Project an annual total for each position/classification.
- F. Enter the grand total for salary/wage expenses.

ii. Operating Expenses (also referred to as General expenses)

Identify all direct program costs. These costs may include but are not limited to the following expense items:

- A. Facility rental (i.e., office space, storage facilities, etc.). Include the amount of square footage and the rate per square foot.
- B. Consumable office supplies.
- C. Miscellaneous equipment/property purchases (i.e., items with a unit cost of less than \$5,000 and a useful life of one year or more).
- D. Telecommunications (i.e., telephone or cellular telephones, fax, Internet service provider fees, etc.).
- E. Reproduction/printing/duplication.
- F. Postage or messenger/delivery service costs.
- G. Equipment/furniture rental/lease and maintenance.
- H. Information Technology infrastructure

iii. Equipment Expenses

- A. DHCS primarily classifies equipment as Major Equipment and defined as a tangible or intangible item with a base unit cost of \$5,000 or more and a life expectancy of one year or more that is purchased or rented, including maintenance costs.

List each major equipment item the applicant intends to purchase or rent. Include the number of units and anticipated unit cost. Extend each unit cost to display applicable subtotals and show a total equipment cost.

iv. Subcontract Expenses

- A. Specify a total cost for all subcontracted services (including those performed by independent consultants). Subcontractors include any persons/firms performing services that are not on the Applicant's payroll.
- B. If there is an intention to use subcontractors (including independent consultants), provide the information below depending on whether subcontractors are known/pre-identified or have yet to be determined.
- C. For **known/pre-identified** subcontractors or independent consultants, identify each subcontractor/consultant by name and include a separate expense breakdown for each of the subcontractor's costs for personnel expenses including operating/general expenses, travel, subcontracts and indirect costs.
- D. For **unknown/unidentified** subcontractors or independent consultants, list a title for each subcontracted activity/function and indicate a total projected cost for each activity/function to be out sourced.
- E. If applicable, enter \$0 if no subcontract expenses will be incurred.

v. Travel Expenses

- A. Indicate the total cost for travel and per diem.
- B. Include costs for expenses such as airfare, mileage reimbursement, parking, toll bridge fees, taxicab fares, overnight lodging and meal expenses, etc.
- C. If applicable, enter \$0 if no travel expenses will be incurred.

vi. Other Costs

- A. Indicate here those direct project expenses that do not clearly fit into the other budget line items. Such costs may include, but are not limited to training/conference registration fees, publication production costs, costs for educational material development or other items unique to performance.
- B. If any service, product or deliverable will be provided on a fixed price or lump sum basis, name the items and/or deliverable and indicate “fixed price” or “lump sum” next to the item along with the price or fee.
- C. If applicable, enter \$0.

vii. Indirect Costs

- A. Express the indirect costs as a percentage rate.

Applicants are to indicate their indirect cost percentage rate and the cost basis upon which it was determined (i.e., personnel costs excluding or including benefits or total direct costs, etc.).

- B. If applicable, enter \$0.

viii. Total Costs

- A. Enter a total annual cost the applicant is projecting for the contract.
- B. Ensure all itemized costs equal this figure when added together.

h. Appendix section

Place the following documentation in the Appendix section of the application in the order shown below.

1) Proof of Eligibility to do business in California

Any entity must submit a copy of the applying organization’s most current Certificate of Status issued by State or County of California, Office of the Secretary of State or submit a downloaded copy of your Applicant’s on-line status information from the California Business Portal website. Submit an explanation if this documentation cannot be submitted.

i. Financial Stability – Minimum Financial Criteria

In order to safeguard the interest of the State and in order to insure that a Applicant has the financial wherewithal to conduct this Contract, the Applicant shall supply the following information, as appropriate:

- 1) Applicants shall submit a Financial Stability Plan incorporating the following data discussed in items 1) through 5), below, for the past two corporate fiscal years of the Applicant and the interim period from the end of the last full fiscal year up to and including the date specified for submission of Applications.

If the Applicant is a subsidiary of any other legal entity and the financial resources of the Parent Corporation are required to qualify the subsidiary for competition under this

Procurement, the financial stability submission requirements for this section shall apply to the Parent Corporation.

Audited statements are preferred, but not required. DHCS will accept financial statements prepared by the Applicant's financial accounting department, accounting firm or an auditing firm. A statement signed by the Applicant's Chief Executive Officer, Chief Financial Officer or representative certifying that the financial statements are accurate and complete must accompany all financial statements. Un-audited financial statements may not be used to qualify under Section N.6.b. below.

- a) Applicant's annual financial statements for the last two fiscal years, accompanied by an independent certified public accountant's (CPA) report, certificate or Opinion Statement.
 - b) Applicant's public interim financial statements for the interim period from the end of the last full fiscal year up to and including the month prior to submission of Narrative Proposals. The State does not require submittal of interim statements for the last two fiscal years for which annual reports are submitted.
 - c) Applicant's projected pro forma financial statement and statement of changes in financial position for the next three years predicted upon operation without the award of this Contract.
 - d) Applicant's detailed financial plan and proposed cash flow budget demonstrating that the availability and source of sufficient funds to cover the Applicant's projected operation cost without risk of insolvency were the Applicant to provide the contractual services under the Contract period.
 - e) Applicant's organization history of claims of bankruptcy, receivership, questioned cost, repayment of funds, failure to fulfill contract and criminal and/or civil legal actions that name the organization or administrative/supervisory staff that have occurred within the past five years of the application submission date. If the Applicant supplies audited financial statements, all noted audit exceptions must be explained.
- 2) In lieu of the above Section N.6.a.1) through 5) Applicants may provide all of the following:
- a) Applicant's two most recent annual certified financial statements, accompanied by an independent certified public accountant's Unqualified Audit Report or Opinion Statement (Unqualified/Clean Opinion); and
 - b) An organization's history of claims of bankruptcy, receivership, questioned cost, repayment of funds, failure to fulfill contract and criminal or civil legal actions that name the organization or administrative/supervisory staff that have occurred within the past five years. Any noted audit exceptions of the audited financial statements must be explained; and, either
 - c) Evidence of capital contributions and retained earnings equal to an amount greater than five million dollars (\$5,000,000), as identified in the annual financial statements; or

Evidence of assets under control greater than ten million dollars (\$10,000,000), as identified in the annual financial statements.

2) Client References

Obtain and include three (3) Client References. DHCS reserves the right to require additional references upon request. Each Client Reference should be produced on agency letterhead, include an address, telephone number, fax number, contact person, name and title of letter’s author, and should address the following:

- a) Description of the capacity in which the supporting organization has worked with the Applicant.
- b) Describe the length and nature of previous collaborations with the Applicant.
- c) For new collaborations, if applicable, explain how the Applicant will establish and maintain an effective partner relationship.
- d) Brief description of past collaborative efforts between the Applicant and the supporting organization.

3) Conflict of Interest Compliance Certificate

Any organization that intends to submit an application is required to submit **Attachment 10**.

- a) If a conflict of interest is determined to exist that cannot be resolved to the satisfaction of DHCS, before the award of the agreement, the conflict will be grounds for deeming an application nonresponsive.
- b) Applicants must assess their own situation according to the Conflict of Interest Compliance Certification information in **Attachment 10**. Complete, sign and attach any required documentation according to the instructions on the attachment. **Place Attachment 10 and any accompanying documentation in the Appendix Section of the application.**

j. Forms section

Complete, sign and include the forms/attachments listed below. When completing the attachments, follow the instructions in this section and any instructions appearing on the cited attachment. After completing and signing the applicable attachments, assemble them in the order shown below. Remember to place all originals in the application package marked “Original” and photocopies in other required application sets.

Attachment and/or Documentation	Instructions
Application Cover Page (Attachment 1)	A person authorized to bind the Applicant must sign the Application Cover Page.

Attachment and/or Documentation	Instructions
Application Checklist (Attachment 2)	<p>1) Check each item with “Yes” or “N/A”, as applicable, and sign the form. If necessary, explain your responses.</p> <p>2) If an applicant marks “Yes” or “N/A” and makes any notation on the checklist and/or attaches an explanation to the checklist to clarify their choice, DHCS considers this a “qualified response”. Any “qualified response”, determined by DHCS to be unsatisfactory or insufficient to meet a requirement, may cause an application to be deemed nonresponsive or ineligible for funding.</p>
Client References (Attachment 3)	Identify three (3) clients serviced within the past five years that can confirm their satisfaction with the Applicant’s services and confirm that the Applicant provided timely and effective services or deliverables. If possible, identify clients whose needs were similar in scope and nature to the services sought in this NFO. List the most recent first.
NFO Clause Certification (Attachment 4)	Complete and sign this form indicating a willingness and ability to comply with the certification clauses appearing in the NFO section entitled, “Federal Certification Clauses”.
CCC 307 - Certification (Attachment 5)	<p>Complete and sign this form indicating a willingness and ability to comply with the Contractor Certification Clauses appearing in this Attachment. The attachment supplied in this bid represents only a portion of the contractor information in this document. Visit this web site to view the entire document:</p> <p>http://www.dgs.ca.gov/Default.aspx?alias=www.dgs.ca.gov/ols. Completion and return of this form does not apply to California state college campuses or University of California campuses.</p>
Payee Data Record (Attachment 6)	All non-government entities must complete and return this form, <u>only</u> if they have not previously entered into a contract with DHCS. If uncertain, complete and return the form.
Follow-on Consultant Contract Disclosure (Attachment 7)	Complete and sign this form. If applicable, attach to this form the appropriate disclosure information.
Darfur Contracting Act Certification (Attachment 8)	This NFO is exempt from the Darfur Contracting Act Certification (PCC 10475-10481) per the exemptions provided in WIC 14046.3. The Darfur Contracting Act Certification language has been retained as a placeholder to maintain cohesiveness of this NFO.
Iran Contracting Act Certification Attachment 9	Complete, sign and return this form and the required documentation. Detailed completion instructions appear on the cited attachment.

Attachment and/or Documentation	Instructions
Conflict of Interest Compliance Certificate (Attachment 10)	Applicants must assess their own situation according to the Conflict of Interest Compliance Certification information in this attachment. Complete, sign, and attach any required documentation according to the instructions in the attachment. In the event an Applicant has a suspected or potential conflict relationship, the Applicant must provide a written statement to DHCS that describes what relationship it has with the entity in question, and its plan for protecting DHCS from any potential conflict or negative impact.
Applicant Response Guide (Attachment 11)	See the instructions with the attachment.
Work Plan (Attachment 12)	Complete Work Plan to ensure compliance with all Work Plan content requirements.
Budget Detail Worksheet (Attachment 13)	Budget Detail Work Sheet (Year 1)
Subcontractor Budgets (Attachment 14)	Subcontractor Budgets (Year 1) (If Applicable)
Budget Detail Worksheet (Attachment 15)	Budget Detail Work Sheet (Year 2)
Subcontractor Budgets (Attachment 16)	Subcontractor Budgets (Year 2) (If Applicable)
Budget Detail Worksheet (Attachment 17)	Budget Detail Work Sheet (Year 3)
Subcontractor Budgets (Attachment 18)	Subcontractor Budgets (Year 3) (If Applicable)

L. Application Submission

1. Submission Instructions

- a. Assemble an original and five (5) copies of the Application together with one accompanying CD/DVD.
- b. Write “**Original**” on the original proposal set. Place the accompanying CD/DVD in a protective sleeve that bears the NFO number.
- c. Place all Application copies in a single envelope or package, if possible. Seal the envelope or package.
- d. If you submit more than one envelope or package, carefully label each one as instructed below and mark on the outside of each envelope or package “1 of X”, “2 of X”, etc.

- e. Mail or arrange for hand delivery of the application to the California Department of Health Care Services. Applications may not be transmitted electronically by fax or email.
- f. The DHCS must receive the application, regardless of postmark or method of delivery, by **4:00 p.m. (Pacific Time) on 06/12/15**. Late applications will not be reviewed.
- g. Label and submit the Application using one of the following methods.

Hand Delivery or Overnight Express:	U.S. Mail:
<p>Application - Notice of Funding Opportunity NFO 15-001 Office of Medi-Cal Procurement Attention: Jeff Ketelson – Brian Quacchia Mail Station Code 4200 1501 Capitol Ave , Suite 71.3041 P.O. Box Number 997413 Sacramento, CA 95899-7413</p>	<p>Application - Notice of Funding Opportunity NFO 15-001 Office of Medi-Cal Procurement Attention: Jeff Ketelson – Brian Quacchia Mail Station Code 4200 1501 Capitol Ave, Suite 71.3041 P.O. Box Number 997413 Sacramento, CA 95899-7413</p>

h. Applicant warning

- 1) DHCS’ internal processing of U.S. mail may add 48 hours or more to the delivery time. If mailing an application, consider using certified or registered mail and request a receipt upon delivery.
- 2) If choosing hand delivery, allow sufficient time to locate on street metered parking and to sign-in at the security desk. Be prepared to give security personnel this telephone number (916) 552-8006 and this DHCS personnel contact name Jeff Ketelson or Brian Quacchia if detained at the security desk.
- 3) Courier service personnel must sign-in at the security station and must obtain an access key card. Couriers will then be able to access pre-determined areas. If detained at the security desk, ask security personnel to call Jeff Ketelson or Brian Quacchia at this telephone number (916) 552-8006 if detained at the security desk.

2. Proof of timely receipt

- a) DHCS staff will log and attach a date/time stamped slip or receipt to each application package/envelope received. If an application envelope or package is hand delivered, DHCS staff will give a receipt to the hand carrier upon request.
- b) To be timely, DHCS’ personnel must physically receive each application at the stated delivery address no later than **4:00 p.m. (Pacific Time)** on the application submission due date. Neither delivery to the department’s mailroom or a U.S. postmark will serve as proof of timely delivery.
- c) DHCS will deem late applications nonresponsive.

3. Applicant costs

Applicants are responsible for all costs of developing and submitting an application. Such costs cannot be charged to DHCS or included in any cost element of an Applicant’s proposed budget.

M. Evaluation

A multiple stage evaluation process will be used to review applications. DHCS may reject any application found to be nonresponsive at any stage of evaluation.

1. Stage 1 – Application Checklist Evaluation

- a. Shortly after the application submission deadline, DHCS staff will convene to review each application for timeliness, completeness and initial responsiveness to the NFO requirements. This is a yes/no evaluation.
- b. In this review stage, DHCS will compare the contents of each Application to the claims made by the Applicant on the Application Checklist to determine if the Applicant's claims appear to be accurate.
- c. If deemed necessary, DHCS may at its sole discretion, collect additional documentation (i.e., missing forms, missing data from NFO attachments, missing signatures, etc.) from an Applicant to confirm the claims made on the Application Checklist and to ensure that the Application is initially responsive to the NFO requirements.
- d. If an Applicant's claims on the Application Checklist cannot be proven or substantiated, the Application may be deemed nonresponsive and rejected from further consideration.

2. Stage 2 – Application Evaluation

- a. Applications that are timely and appear to meet basic format requirements, initial eligibility requirements and contain the required documentation, as evidenced by passing the Stage 1 review, will be submitted to an evaluation committee.

Evaluators will individually and/or as a team review applications based on the Application's adequacy, thoroughness, the degree to which it complies with the NFO requirements, and meets DHCS' program needs.

- b. Reviewers may consider issues including, but not limited to, the extent to which an application response:
 - 1) Is lacking information, lacking depth or breadth, or lacking significant facts and/or details, and/or
 - 2) Is fully developed, comprehensive and has few if any weaknesses, defects or deficiencies, and/or
 - 3) Demonstrates that the Applicant understands DHCS' needs, the services sought, and/or the contractor's responsibilities, and/or
 - 4) Illustrates the Applicant's capability to perform all services and meet all SOW requirements, and/or
 - 5) If implemented, will contribute to the achievement of DHCS' goals and objectives, and/or
 - 6) Demonstrates the Applicant's capacity, capability and/or commitment to exceed regular service needs (i.e., enhanced features, approaches, or methods, creative or innovative business solutions).

N. Application Evaluation Factors

Evaluators will use the following criteria to evaluate each application on yes/no basis. Failure to meet the evaluation factor(s) with a “yes” response can be grounds for DHCS to deem an Applicant nonresponsive and/or ineligible for funding. Successful completion of this section does not guarantee that an Applicant will be awarded a contract.

Qualified Applicants will be evaluated based on their suitability to address their targeted group, including, but not limited to: relevant experience of organization, experience of employees, experience of contractors, location of organization relative to targeted group, size of targeted group as a function of the qualified Applicant’s apparent ability to address the group, overlap of the targeted group with other qualified Applicants’ targeted groups, and client references.

If multiple Applicants are deemed qualified, preference will be given to the Applicant(s) with the most relevant experience and/or greatest ability to serve the target group(s).

1. Narrative

#	Narrative Evaluation Factors	Yes	No
1	Did the Applicant describe a single or collaborative effort for this project and if a collaborative effort is indicated, did the Applicant clearly describe the primary roles of each collaborative organization? [K.3.c.1]		
2	Did the Applicant clearly describe the composition of the target group(s)? [K.3.c.2)a]		
3	Did the Applicant clearly identify the percentage of the population that is targeted and the size of the target group(s)? [K.3.c.2)b)&c)]		
4	Did the Applicant clearly identify the data sources used to select the target group(s) (i.e., use of historical health indicators or bench marks, demographic data, or statistical data and its source)? [K.3.c.2)d)]		
5	Did the Applicant clearly portray the consequences that will result if its application is not funded or not fully funded? [K.3.c.3)]		
6	Did the Applicant clearly demonstrate that it can effectively integrate this project into its current obligations and existing workload? [K.3.c.4)]		
7	Did the Applicant indicate how other organizations in the community may/will contribute to the project? [K.3.c.5)]		

2. Applicant Capability

#	Applicant Capability Evaluation Factors	Yes	No
8	Is the Applicant’s description of its mission and goals relevant, closely related, or complementary to the services outlined in the SOW? [K.3.d.1)a)]		
9	Is the Applicant’s description of its accomplishments related to and/or relevant to the services outlined in the SOW? [K.3.d.1)b)]		

#	Applicant Capability Evaluation Factors	Yes	No
10	Did the Applicant’s description of its relationships, such as partnerships, collaborations, or arrangements with other service providers in the community, describe relationships that ensure effective delivery of services? [K.3.d.1)c]		
11	Did the Applicant’s description of its accomplishments utilize, where locally available, their expertise and capabilities of working with health plans, IPAs, MSOs, provider associations, health professional societies, state/local/tribal public health agencies, hospital systems, community colleges, Medicare Quality Improvement Organization(s), and other relevant stakeholders? [K.3.d.1)d]		
12	Did the Applicant possess applicable experience with assisting groups and eligible professionals with EHR implementation? [K.3.d.2)a]		
13	Did the Applicant possess applicable experience with workflow redesign and clinical quality improvement? [K.3.d.2)b]		
14	Did the Applicant possess applicable experience with outreach, education, and on-site direct technical assistance with EHR adoption, implementation, and meaningful use? [K.3.d.2)c]		

3. Work Plan

#	Work Plan Evaluation Factors	Yes	No
15	Are the Applicant’s overall approaches and/or methods comprehensive and/or technically sound? [K.3.e.3, & Attachment 12]		
16	Are the Applicant’s procedures, methods and approaches appropriate and reasonable (i.e., if implemented are they likely to produce the desired results)? [K.3.e.3, & Attachment 12]		
17	Did the Applicant describe in detail the specific actions (i.e., tasks/activities and functions) that the Applicant will perform to fulfill the SOW requirements? [K.3.e.3, & Attachment 12]		
18	Will the Applicant perform the tasks/activities and functions in a logical order? [K.3.e.3, & Attachment 12]		
19	Did the Applicant adequately demonstrate how it will measure and/or prove the completion of major activities (i.e., identification of key events/outcomes or deliverables and delivery dates)? [K.3.e.3, & Attachment 12]		

4. Management Plan

#	Management Plan Evaluation Factors	Yes	No
20	Did the Applicant demonstrate its capability to effectively govern and manage the execution of its overall program, including effectively and efficiently providing prompt, responsive, individualized support to all eligible professionals in the target group(s)? [K.3.f.1]		
21	Did the Applicant’s financial statements, or letter of credit, or letter of financial or in-kind commitment in the Appendix Section, show that the Applicant is financially stable and sound? [K.3.h.2]; [K.3.f.2]		
22	Did the Applicant’s financial statements, or letter of credit, or letter of financial or in-kind commitment in the Appendix Section, show that the Applicant has access to appropriate fiscal resources to carry expenses for several months while awaiting reimbursement? [K.3.h.2]; [K.3.f.2]		

5. Budget

#	Budget Evaluation Factors	Yes	No
23	Did the Applicant’s Budget forms allocate sufficient funds to each budget line item in each budget period? [K.3.g.3]		
24	Did the Applicant’s Budget allocate sufficient funds to support the major program objectives or elements? [K.3.g.3)e]		
25	Did the Applicant’s salary/wage rates for the proposed personnel classifications and FTE equivalents appear reasonable based on the assigned level of responsibility and/or comparability to civil service classifications? [K.3.g.3)e)i.]		
26	Does it appear there is an appropriate balance between the costs allocated for in-house staff versus subcontracted personnel? [K.3.g.3)e)i.&iv.]		
27	Does it appear that the Applicant’s Total Operating costs are reasonable and kept to a minimum? [K.3.g.3)e)ii.]		
28	Are the Applicant’s “Equipment” expenses reasonable (i.e., only necessary items are scheduled, the unit rates are reasonable when compared to current market prices, and the number of units are reasonable for the number of staff that will use the equipment)? [K.3.g.3)e)iii.]		

O. Procurement Requirements and Information

1. Nonresponsive applications

In addition to any condition previously indicated in this NFO, the following occurrences **may** cause DHCS to deem an application nonresponsive and ineligible for funding.

- a. Failure of the Applicant to:
 - 1) Meet application format/content or submission requirements including, but not limited to, the labeling, packaging and/or timely and proper delivery of applications.
 - 2) Pass the Application Checklist review (i.e., by not marking “Yes” to applicable items or by insufficiently justifying, to DHCS’ satisfaction, all “N/A” designations).
 - 3) Submit a **mandatory** Conflict of Interest Compliance Certificate in the manner required, if applicable.
- b. If a submitted application is materially incomplete or contains material/significant defects, alterations or irregularities of any kind.
- c. If an Applicant supplies false, inaccurate or misleading information or falsely certifies compliance to any NFO requirement.
- d. If DHCS discovers, at any stage of the selection process or upon contract award, that the Applicant is unwilling or unable to comply with the contractual terms, conditions and exhibits cited in this NFO or those appearing in the resulting agreement.
- e. If other irregularities occur in an application response that is not specifically addressed herein.

2. Withdrawal and/or Resubmission of Applications

- a. Withdrawal deadlines

An Applicant may withdraw an application at any time before the submission deadline.

- b. Submitting a withdrawal request

- 1) Submit a written withdrawal request, signed by an authorized representative of the Applicant.
- 2) Label and submit the withdrawal request using one of the following methods.

U.S. Mail, Hand Delivery or Overnight Express:
<p>Withdrawal - NFO 15-001 Office of Medi-Cal Procurement Attention: Jeff Ketelson – Brian Quacchia Mail Station Code 4200 1501 Capitol Ave, Suite 71.3041 P.O. Box Number 997413 Sacramento, CA 95899-7413</p>
<p>Email: omcprfp4@dhcs.ca.gov</p>
<p>Insert “Withdrawal - NFO 15-001” in the subject line of the email message.</p>

- 3) An originally signed withdrawal request is generally required before DHCS will return an application to an Applicant. DHCS may grant an exception if the Applicant informs DHCS that a new or replacement application will immediately follow the withdrawal.

c. Resubmitting an application

After withdrawing an application, Applicants may resubmit a new application according to the application submission instructions. Replacement applications must be received at the stated place of delivery by the application due date and time.

3. Awards and appeals

a. Awards

- 1) Awards, if made, will be to the responsive Applicant(s) deemed qualified and eligible for funding by DHCS. DHCS expects to make up to ten (10) awards to eligible and qualified Applicants that pass the application evaluation process. If the number of eligible and qualified Applicants exceeds funding availability, DHCS reserves the right to determine the appropriate funding level and number of awards to be awarded to eligible and qualified Applicants.
- 2) DHCS shall issue award notices to all selected Applicants. DHCS expects to email or fax Award Notice(s) to all selected Applicants on or before the close of business on 06/25/15.
- 3) DHCS will confirm all awards with each selected Applicant after the appeal deadline. DHCS personnel may confirm the awards via email or fax. An appeal filed by any Applicant shall not delay awards to other Applicants.

b. Appeals

1) Who can appeal

Only non-funded Applicants that submit a timely application that complies with the NFO instructions may file an appeal.

2) Grounds for appeal

Appeals are limited to the grounds that DHCS failed to correctly apply the standards for reviewing applications in accordance with this NFO.

Applicants may not appeal solely on the basis of funding level. There is no appeal process for late or substantially incomplete/nonresponsive applications.

The receipt of an appeal by one Applicant shall not hinder or delay an award to another Applicant.

3) Appeal content

The written appeal must fully identify the issue(s) in dispute, the practice that the appellant believes DHCS has improperly applied in making its award decision(s), the legal authority or other basis for the appellant's position and the remedy sought.

4) Appeal Timelines

- a. If an eligible Applicant wishes to appeal the intended contract award, the Applicant must file a "Notice of Intent to Appeal" with DHCS within five (5) working days after DHCS posts the Notice of Intent to Award. The Notice of Intent to Appeal may be quite brief. Any Notice of Intent to Appeal filed more than five (5) working days after DHCS posts the Notice of Intent to Award shall be untimely.

- b. Within five (5) calendar days after filing a “Notice of Intent to Appeal”, the Applicant must file with DHCS a full and complete written appeal statement identifying the specific grounds for the appeal. The statement must contain, in detail, the reasons, law, rule, regulation or practice that the Applicant believes DHCS has improperly applied in awarding of the contracts.

5) Submitting an appeal

Written letters appealing DHCS’ final award selections must be received no later than **5:00 p.m. (Pacific Time) on 07/07/2015**

Hand deliver, mail, or fax an appeal to the address below. Label, address, and submit a letter of appeal using one of the methods described below.

U.S. Mail, Hand Delivery or Overnight Express:	Fax:
<p>Appeal to Notice of Funding Opportunity NFO 15-001 Office of Medi-Cal Procurement Attention: Kevin Morrill Mail Station Code 4200 1501 Capitol Ave, Suite 71.3041 P.O. Box Number 997413 Sacramento, CA 95899-7413</p>	<p>Appeal to Notice of Funding Opportunity NFO 15-001 Department of Health Care Services Office of Medi-Cal Procurement Attention: Kevin Morrill Fax: (916) 440-7369</p>

Confirmation of Receipt of faxed appeals

Dial the telephone number shown here to confirm receipt of the fax transmission:

Jeff Ketelson or Brian Quacchia (916) 552-8006

6) Appeal process

Only timely and complete appeals that comply with the instructions herein may be considered. An Applicant may submit a response to the appeal within five (5) calendar days following receipt of a copy of the appeal from Appellant. At its sole discretion, DHCS reserves the right to collect additional facts or information to aid in the resolution of any appeal. OMCP and OHIT reserves the right to submit briefs in response to any appeal brought by a bidder and to participate in any oral hearing called by a Hearing Officer.

A Hearing Officer appointed by the Director or his/her designee shall review each timely and complete appeal and may resolve the appeal either by considering the contents of the written appeal letters and any briefs or, at his/her sole discretion, by holding an oral appeal hearing. The Hearing Officer, at his/her sole discretion, may, within five (5) calendar days of appointment as Hearing Officer, request additional information or further clarification of an issue. If the Hearing Officer decides to hold an oral appeal hearing, the hearing shall take place within thirty (30) calendar days of his/her appointment as Hearing Officer. The oral appeal hearing will be an informal hearing in which the appellant makes an oral presentation describing the basis of its appeal, and the authority for the appeal, followed by questions if any, from the Hearing Officer. The Awardee OMCP and/or the OHIT may also make an oral presentation followed by questions, if any, from the Hearing Officer.

The decision of the Hearing Officer, which shall be made within sixty (60) calendar days of his/her appointment as Hearing Officer, shall be final and there will be no further administrative appeal. The Hearing Officer may, with the express written approval of the Director, have one extension to the sixty (60) calendar day period to issue a decision. The extension shall not exceed fifteen (15) calendar days.

Appellants will be notified of the decision of the Hearing Officer on the day that the decision is issued.

Appellants will be notified of the decisions regarding their appeal in writing within fifteen (15) working days of the hearing date

4. Disposition of Applications

- a. All materials submitted in response to this NFO will become the property of the California Department of Health Care Services and, as such, are subject to the Public Records Act (GC Section 6250, et seq.). DHCS will disregard any language purporting to render all or portions of any application confidential.
- b. Upon release of Award Notices, all documents submitted in response to this NFO and all documents used in the selection process (e.g., review checklists, evaluation sheets, letters of intent, etc.) will be regarded as public records under the California Public Records Act (Government Code Section 6250 et seq.) and subject to review by the public. However, application contents, Applicant correspondence, selection working papers, or any other medium shall be held in the strictest confidence until the Award Notices are released / issued.

5. Inspecting or obtaining copies of applications

- a. Who can inspect or copy application materials

Any person or member of the public can inspect or obtain copies of any application materials.

- b. What can be inspected and when

- 1) After DHCS releases the NFO, any existing Applicants List (i.e., list of firms to whom the NFO is sent) is considered a public record.
- 2) On or after the date DHCS releases/issues Award Notices, all applications, letters of intent, application review checklists and/or evaluation sheets become public records.

- c. Requesting Applicant Materials

Applicant's Packages can be viewed online at the OMCPs' website at:
http://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/OMCPHomePage.aspx.

Persons wishing to request materials via CD should identify the items they wish to obtain and submit a request by contacting Jeff Ketelson or Brian Quacchia by email at:
omcprfp4@dhcs.ca.gov.

Request for Copies - Notice of Funding Opportunity OHIT 15-001

Office of Medi-Cal Procurement
Attention: Jeff Ketelson - Brian Quacchia
Mail Station Code 4200
1501 Capitol Ave, Suite 71.3041
P.O. Box Number 997413
Sacramento, CA 95899-7413

6. Verification of Applicant information

By submitting an application, Applicants agree to authorize DHCS to verify any and all claims made by the Applicant including, but not limited to verification of prior experience and the possession of other eligibility requirements.

7. DHCS rights

In addition to the rights discussed elsewhere in this NFO, DHCS reserves the following rights.

a. NFO clarification / correction / alteration

- 1) DHCS reserves the right to do any of the following up to the application submission deadline:
 - a) Modify any date or deadline appearing in this NFO or the NFO Time Schedule.
 - b) Issue clarification notices, addenda, alternate NFO instructions, forms, etc.
 - c) Waive any NFO requirement or instruction for all Applicants if DHCS determines that a requirement or instruction was unnecessary, erroneous or unreasonable. If deemed necessary by DHCS, DHCS may also waive any NFO requirement or instruction after the application submission deadline.
 - d) Allow Applicants to submit questions about any NFO change, correction, or addenda. When DHCS allows such questions, specific instructions will appear in the cover letter accompanying the document.
- 2) If this NFO is clarified, corrected, or modified, DHCS intends to post all clarification notices and/or NFO addenda at the following web address:
http://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/OMCPHomePage.aspx .

If DHCS decides, just before or on the submission due date, to extend the submission deadline, DHCS may in its sole discretion, choose to notify potential Applicants of the extension by e-mail. DHCS will follow-up verbal notices in writing by e-mail

b. Insufficient responsive applications / additional awards / altered awards

If in DHCS' opinion the State's interests will be better served, DHCS reserves the right at its sole discretion to take any of the actions described below. These actions may be initiated at the onset of various events. These events include, but not are limited to: a determination that an insufficient number of applications are responsive, additional funding becomes available, anticipated funding decreases, geographic service coverage is insufficient, Applicant funding needs exceed available funding, etc.

- 1) Offer agreement modifications or amendments to funded organizations for increased or decreased services, term extensions, and/or increased/decreased funding following successful negotiations;
- 2) Open an additional or consecutive application acceptance period to invite additional interested organizations to submit applications for funding;

- 3) Extend the application acceptance period beyond the date indicated in the NFO to invite additional interested organizations to submit applications for funding;
- 4) Conduct a focused NFO process to solicit additional applications;
- 5) Negotiate changes to scopes of work or work plans and opt not to make an award if satisfactory agreement cannot be reached.

c. Collecting information from Applicants

- 1) If deemed necessary, DHCS may request an Applicant to submit additional documentation or clarifying information during or after the application review and evaluation process. DHCS will advise the Applicants orally, by fax, in writing, or other method of the required documentation/information and the timeline for submitting the documentation/information. DHCS will follow-up oral instructions in writing by fax, email, or regular mail. Failure to submit the required documentation/information by the date and time indicated may result in DHCS deeming an application nonresponsive.
- 2) DHCS, at its sole discretion, reserves the right to collect, by mail, fax, email, or other method; the following omitted documentation and/or additional information.
 - a) Signed copies of any form submitted without a signature.
 - b) Data or documentation omitted from any submitted NFO attachment/form.
 - c) Information/material needed to clarify or confirm certifications or claims made by an Applicant.
 - d) Information/material or form needed to correct or remedy an immaterial defect in an Application.
- 3) The collection/review of additional Applicant documentation may cause DHCS to extend the date for posting/issuing Award Notice(s). If DHCS changes the Award Notice posting/issuance date, DHCS will post or issue a notice as described in the DHCS Rights Section, O.,7.,a., 2).

d. Immaterial application defects

- 1) DHCS may waive any immaterial defect in any application and allow the Applicant to remedy those defects. DHCS reserves the right to use its best judgment to determine what constitutes an immaterial deviation or defect.
- 2) DHCS' waiver of an immaterial defect in an application shall in no way modify this NFO or excuse an Applicant from full compliance with all procurement requirements.

e. Correction of clerical or mathematical errors

- 1) DHCS reserves the right, at its sole discretion, to overlook, correct or require an Applicant to remedy any obvious clerical or mathematical errors occurring in the narrative portion of an application or on a Budget Attachment or other form.
- 2) If the correction of a mathematical error results in an increase or decrease in the total amount of funding sought, DHCS shall give the Applicant the option to accept the corrected amount or withdraw their application.
- 3) Applicants may be required to initial corrections to costs and dollar figures on any Budget Attachment or form if the correction of an error results in an alteration of the annual costs or total funds sought.

- 4) If a mathematical error occurs in a total or extended price and a unit price is present, DHCS will use the unit price to settle the discrepancy.

f. Right to remedy errors

DHCS reserves the right to remedy errors caused by:

- 1) DHCS office equipment malfunctions or negligence by agency staff,
- 2) Natural disasters (i.e., floods, fires, earthquakes, etc.).

g. No contract award or NFO cancellation

The issuance of this NFO does not constitute a commitment by DHCS to make one or more awards. DHCS reserves the right to reject all applications and to cancel this NFO if DHCS determines it is in the best interests of DHCS to do so.

h. Agreement amendments after award

DHCS reserves the right to amend any agreement resulting from this NFO. Amendments may include term extensions, SOW modifications, budget or funding alterations, etc.

i. Proposed use of subcontractors and/or independent consultants

Specific subcontract relationships proposed in response to this NFO (i.e., identification of pre-identified subcontractors and independent consultants) shall not be changed during the procurement process or prior to agreement execution. The pre-identification of a subcontractor or independent consultant does not affect DHCS' right to approve personnel or staffing selections or changes made after the agreement is awarded.

j. Staffing changes after award

DHCS reserves the right to approve or disapprove changes in key personnel that occur after awards are made.

k. Funding

- a) If the number of responsive and qualified applications prevents DHCS from providing funds in the full amount requested, DHCS reserves the right to enter into negotiations with responsive applicant(s) to perform alternate or reduced services at a reduced agreement amount. DHCS expects to make up to ten (10) awards to eligible and qualified applicants. If the number of eligible and qualified applicants exceeds funding availability, the funding program reserves the right to determine the appropriate funding level to be awarded to each eligible and qualified applicant.
- b) If full funding in the current or future years does not become available or is reduced, DHCS reserves the right to re-negotiate the agreement, cancel the agreement, or offer an amended agreement for reduced or alternate services.

If an Applicant's Work Plan contains proposed methods or approaches; functions, tasks, or activities known by DHCS to be ineffective or determined to be unacceptable, DHCS reserves the right to require the substitution of comparable or alternate items (e.g., methods or approaches, functions, tasks, or activities, etc.) that can be performed to accomplish the stated goals and objectives.

P. Federal Certification Clauses**1. Debarment and Suspension Certification**

- a. The Contractor certifies to the best of its knowledge and belief, that it and its principals:
 - 1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;
 - 2) Have not within a three (3) year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
 - 3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph a.2) of this certification; and
 - 4) Have not within a three (3) year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.
 - 5) It shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.
 - 6) It will include a clause entitled "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
 - 7) The Contractor certifies they will comply with the Additional Federal Terms and Conditions, Exhibit E, Section I.
- b. If the Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the program funding this contract.

2. Lobbying Restrictions and Disclosure

- a. The Contractor certifies, to the best of its knowledge and belief, that:
 - 1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
 - 2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative

agreement, the Contractor shall complete and submit federal Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

- 3) The Contractor shall require that the contents of this certification be collected from the recipients of all sub-awards, exceeding \$100,000, at all tiers (including sub-contracts, sub-grants, etc.) and shall be maintained for three (3) years following final payment/settlement of those agreements.
- b. This certification is a material representation of fact upon which reliance was placed when this contract was made and/or entered into. The making of the above certification is a prerequisite for making or entering into this contract pursuant to 31 U.S.C. 1352 (45 CFR 93). Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

The Standard Form-LLL may be obtained from various federal agencies, federally sponsored World Wide Web Internet sites, DHCS upon request, or may be copied from Exhibit D(f) entitled, Special Terms and Conditions.

Q. Contractual Terms and Conditions

Each funded Applicant must enter a written agreement that may contain portions of the Applicant's application (i.e., Budget, Work Plan), SOW, standard contractual provisions, a standard agreement, and the exhibits identified below. Other exhibits, not identified herein, may also appear in the resulting agreement.

The exhibits identified in this section contain contractual terms that require strict adherence to various laws and contracting policies. An Applicant's unwillingness or inability to agree to the proposed terms and conditions shown below or contained in any exhibit identified in this NFO may cause DHCS to deem an Applicant non-responsible and ineligible for an award. Note, California State Universities and/or colleges will be offered alternate agreement terms that represent DHCS' traditional contractual language, which differs slightly from the agreement terms contained or referenced herein. DHCS reserves the right to substitute the latest version of any form or exhibit listed below in the resulting agreement if a newer version is available.

The exhibits identified below illustrate many of the terms and conditions that may appear in the final agreement between DHCS and the funded applicants. Other terms and conditions, not specified in the exhibits identified below, may also appear in a resulting agreement. Some terms and conditions are conditional and may only appear in an agreement if certain conditions exist (i.e., agreement total exceeds a certain amount, federal funding is present, etc.).

In general, DHCS will not accept alterations to the General Terms and Conditions (GTC), DHCS' Special Terms and Conditions, the contents of other cited exhibits, or alternate language proposed or submitted by a prospective contractor. As indicated above, the awarding program will substitute DHCS' standard California State University or University of California agreement model in place of the terms and exhibits identified below.

1. Sample contract forms / exhibits

Exhibit Label	Exhibit Name
a. Exhibit A	Scope of Work
b. Exhibit B	Budget Detail and Payment Provisions

Exhibit Label	Exhibit Name
c. Exhibit C - View on-line.	General Terms and Conditions (GTC 610). View or download this document on the Internet at: http://www.dgs.ca.gov/ols/Resources/StandardContractLanguage.aspx
d. Exhibit D(f)	Special Terms and Conditions
e. Exhibit E	Additional Provisions
f. Exhibit F	Contractor's Release This exhibit is not applicable to agreements entered into with University of California campuses or California State University campuses.
g. Exhibit G	HIPAA Business Associate Addendum
h. Exhibit H	Information Confidentiality and Security Requirements
i. Exhibit I	American Recovery and Reinvestment Act (ARRA) Terms and Conditions
j. Exhibit J	Program Glossary

2. Resolution of language conflicts (NFO vs. final agreement)

If an inconsistency or conflict arises between the terms and conditions appearing in the final agreement and the proposed terms and conditions appearing in this NFO, any inconsistency or conflict will be resolved by giving precedence to the final agreement.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2015 Regular Meeting of the CalOptima Board of Directors

Consent Calendar

VII. E. Authorize Execution of Agreements with the California Department of Health Care Services Related to Medi-Cal Electronic Health Records Incentive Program

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400
Silver Ho, Compliance Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chief Executive Officer to execute the necessary Agreements with the California Department of Health Care Services (DHCS) for the Medi-Cal Electronic Health Records (EHR) Incentive Program.

Background

On February 17, 2009, the President signed the American Recovery and Reinvestment Act of 2009 (ARRA). Title XIII of Division A and Title IV of Division B of ARRA, together cited as the Health Information Technology for Economic and Clinical Health Act (HITECH Act), include provisions to promote Meaningful Use of health information technology to improve the quality and value of American health care. The HITECH Act authorizes incentive payments to eligible Medicare and Medicaid providers for Meaningful Use of certified EHR technology. In 2015, providers are expected to have adopted and be actively utilizing an EHR in compliance with the Meaningful Use definition or they will be subject to financial penalties under Medicare (per Sections 4101(b) and 4102 (b) of ARRA).

On May 28, 2015, DHCS announced a Notice of Funding Opportunity (NFO 15-001) to support physicians in reaching the next stage of Meaningful Use or to assist providers who did not qualify for assistance under the federal Regional Extension Center program.

Discussion

On June 4, 2015, the CalOptima Board of Directors authorized CalOptima to apply for the NFO to continue the type of technical assistance services previously provided by COREC (the CalOptima Regional Extension Center). On June 12, 2015, CalOptima submitted its application and on June 26, 2015, DHCS notified CalOptima that it was awarded a grant in the amount of \$4,325,000. DHCS further requested that CalOptima execute the necessary Agreements to receive the funds.

Fiscal Impact

The recommended action will result in \$4,325,000 in grant funds from DHCS to implement the Medi-Cal Electronic Health Records (EHR) Incentive Program over a three-year period. There is no requirement for CalOptima to provide a match of funds, in-kind or direct for this award. The administrative cost to support this grant is budget neutral. It is estimated at \$250,000 annually to cover staffing and support. Funding for projected administrative costs is from existing budgeted

CalOptima Board Action Agenda Referral
Authorize Execution of Agreements with the California DHCS
Related to Medi-Cal Electronic Health Records Incentive Program
Page 2

items under the Fiscal Year (FY) 2015-16 CalOptima Operating Budget approved by the Board on June 4, 2015.

Rationale for Recommendation

Execution of the necessary Agreements will allow CalOptima to assist 865 additional providers in Orange County with EHR implementation and meaningful use to better serve CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

07/31/2015
Date

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".

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.

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.1650A: 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.

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
Authorized Signature

8/29/2018
Date



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

1 **I. PURPOSE**

2
3 This policy defines the criteria by which CalOptima enrolls a Member in CalOptima Direct.

4
5 **II. POLICY**

6
7 A. CalOptima may enroll a Member in CalOptima Direct, in accordance with this ~~policy~~Policy.

8
9 B. CalOptima shall enroll the following Members in CalOptima Direct Administrative (COD-A)
10 subject to the provisions of this ~~policy~~Policy:

11
12 1. A Member who has Medicare coverage and is not enrolled in OneCare Connect:

13
14 a. For a Member who has both Medicare Parts A and B or Medicare Part B coverage and is
15 enrolled in CalOptima Direct pursuant to this policy, CalOptima shall not be required to
16 assign such Members who are eligible for services through Medicare to a Medi-Cal Primary
17 Care Provider (PCP) or require them to select a Medi-Cal PCP in accordance with the
18 policy of the Department of Health Care Services (DHCS).

19
20 b. For a Member who has Medicare Part A coverage, but does not have Medicare Part B
21 coverage, and is enrolled in CalOptima Direct, pursuant to this policy, CalOptima shall
22 assign such Member to a Medi-Cal PCP in accordance with ~~the DHCS~~ policy of ~~DHCS~~ ~~(s)~~.

23
24 2. A Member who becomes the responsibility of the Public Guardian or is in an Institute for
25 Mental Disease (IMD), or with Orange County Children and Family Services and is placed
26 outside of Orange County.

27
28 ~~2.3.~~ A Member with a Share of Cost (SOC) Aid Code.

29
30 ~~3. A Member residing outside Orange County~~

31
32 ~~a. A Member with a zip code outside of Orange County, as indicated by the State's Medi-Cal~~
33 ~~Eligibility file and for whom CalOptima is unable to verify a zip code within Orange~~
34 ~~County and has not selected a Health Network.~~

35
36 ~~b.4.~~ A Member who resides at the Fairview Developmental Center.

~~e.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.B₂ 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

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

3
4 ~~G. COD-A is responsible for all Covered Services provided during a month in which a Member has~~
5 ~~Retroactive Eligibility.~~

6
7 ~~H.G.~~ CalOptima Direct is not responsible for Covered Services provided to a Member outside the
8 United States, with the exception of Emergency Services requiring hospitalization in Canada or
9 Mexico, in accordance with Title 22, California Code of Regulations ~~section, Section~~ 51006.

10
11 **III. PROCEDURE**

12
13 A. ~~If At the time of initial enrollment in CalOptima, a Member has with a zip code outside of Orange~~
14 ~~County, as indicated by the eligibility file sent to CalOptima by the State, or, if CalOptima is unable~~
15 ~~to verify a zip code within Orange County; due to no address information provided by the State,~~
16 ~~such Member shall not be auto-assigned by CalOptima, and the Member shall remain in COD-A.~~

17
18 ~~1. The If a Member may select a Health Network or CCN. If the Member fails assigned to select a~~
19 ~~Health Network, CalOptima shall not auto assign the Member, and the Member shall remain in~~
20 ~~COD-A.~~

21
22 ~~2. If the Member enrolls in a Health Network or CCN, in accordance with the provisions of~~
23 ~~CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection~~
24 ~~Process, CCN or the Health Network, as applicable, shall be responsible for all Covered~~
25 ~~Services for the Member, in accordance with the Division of Financial Responsibility (DOFR).~~

26
27 ~~3. If the Member's due to having a zip code outside Orange County changes his or her zip code to~~
28 ~~an Orange County zip code and the Member is in COD-A, CalOptima shall:~~

29
30 ~~a.B. Request request~~ that the Member select a Health Network or CCN, in accordance with CalOptima
31 Policy DD.2008: Health Network and CalOptima Community Network Selection Process; ~~If the~~
32 ~~Member fails to choose a Health Network or CCN, then CalOptima shall auto-assign the Member,~~
33 ~~in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.~~

34
35 ~~b. Auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto~~
36 ~~Assignment Policy; or~~

37
38 ~~e. Enroll the Member in COD-A, subject to the provisions of this policy.~~

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

44
45 ~~B.D.~~ If a Health Network Eligible Member becomes the responsibility of the Public ~~Administrator or~~
46 ~~Public Guardian, or is in an Institute for Mental Disease, or is with Orange County Children and~~
47 ~~Family Services~~ and resides outside Orange County:

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.~~ 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.III.D.2~~ of this ~~policy~~Policy.

~~D.F.~~ 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:

- 1 1. The Member’s Health Network shall notify CalOptima, in writing, in accordance with
2 CalOptima Policy GG.1313: Coordination of Care for Transplant Members.
3
4 a. Except as set forth in Section III.D.1.b of this policy, CCN shall assume responsibility for
5 all Covered Services for the Member on the first (1st) calendar day of the month
6 immediately following the date CalOptima receives written notice from the Health
7 Network.
8
9 b. If the Member receives a Solid Organ Transplant or BMT after the date the Health Network
10 notifies CalOptima and before the first (1st) calendar day of the month immediately
11 following the date CalOptima receives notice, CCN shall assume responsibility for all
12 Covered Services for the Member on the first (1st) calendar day of the month of notice.
13
14 2. The Member’s Health Network shall be responsible for all Covered Services for the Member, in
15 accordance with the DOFR, until the Health Network notifies CalOptima, in writing, and
16 CalOptima transitions such Member to CalOptima Direct as set forth in Section III.D.1. of this
17 policy.
18
19 3. CCN shall be responsible for all Covered Services for the Member for three- hundred sixty-five
20 (365) calendar days after the Member receives a Solid Organ Transplant or BMT. After three-
21 hundred sixty-five (365) calendar days after the date the Member receives a Solid Organ
22 Transplant or BMT, CalOptima shall request the Member select a Health Network, in
23 accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community
24 Network Selection Process.
25
26 4. If CalOptima ~~or~~ the DHCS-approved Transplant Center or the CCS-paneled Transplant Special
27 Care Center, determines that the Member is ineligible for a Solid Organ Transplant or BMT:
28
29 a. If it has been less than three hundred sixty-five (365) calendar days after the Member
30 transitioned to CCN, CalOptima shall transition the Member to the Member’s previous
31 Health Network, effective the first (1st) calendar day of the month immediately following
32 the date CalOptima or the DHCS-approved Transplant Center determines that the Member
33 is ineligible for a Solid Organ Transplant or BMT; or
34
35 b. If it has been more than three hundred sixty-five (365) calendar days after the Member
36 transitioned to CCN, CalOptima shall request the Member select a Health Network, in
37 accordance with CalOptima Policy DD.2008: Health Network Selection Process, or
38 CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a:
39 CalOptima Auto-Assignment ~~Policy~~.40

41 E.G. If a Health Network Eligible Member received a Solid Organ Transplant or BMT within one
42 hundred twenty (120) calendar days prior to their effective date of enrollment in CalOptima:
43

- 44 1. The Member’s Health Network shall notify CalOptima by sending a Notification of Transplant
45 Member, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant
46 Members.
47
48 2. CCN shall assume responsibility for all Covered Services for the Member on the first (1st)
49 calendar day of the month immediately following the date CalOptima receives written notice

1 from the Health Network, for a period of not less than three hundred sixty-five (365) calendar
2 days after the date the Member received such Transplant.
3

- 4 3. CalOptima shall transition the Member to the Member's previous Health Network, effective no
5 later than the first (1st) calendar day of the month immediately following the three hundred sixty
6 fifth (365th) calendar day after the date the Member received a Solid Organ Transplant or BMT.
7
8 4. The Member's Health Network shall be responsible for all Covered Services for the Member
9 until the Health Network submits written notice and CalOptima transitions such Member to
10 CCN, as set forth in Section III.E.1 and III.E.2 of this ~~policy~~Policy.

11
12 ~~F.H.~~ If a Health Network Eligible Member, ~~who is at least twenty one (21) years of age,~~ is diagnosed
13 with ESRD ~~and is not already assigned to CCN:~~

- 14
15 1. The Member's Health Network shall notify CalOptima, in writing, of the Member by
16 submitting a copy of Form CMS-2728-U3 to CalOptima's ~~Health~~Network
17 ~~Management~~Relations Department.
18
19 a. If a Health Network submits a Form CMS-2728-U3 on or before the fifteenth (15th)
20 calendar day of a month, CCN shall assume responsibility for all Covered Services for the
21 Member effective no later than the first (1st) calendar day of the month after the immediate
22 following month. For example, if a Health Network submits Form CMS-2728-U3 on June
23 15, CCN shall assume responsibility for the Member effective August 1.
24
25 b. If a Health Network submits a Form CMS-2728-U3 after the fifteenth (15th) day of a month,
26 CCN shall assume responsibility for all Covered Services for the Member effective no later
27 than the first (1st) calendar day of the second (2nd) month after the immediately following
28 month. For example, if a Health Network submits Form CMS-2728-U3 on June 16, CCN
29 shall assume responsibility for the Member effective September 1.
30
31 c. CalOptima shall provide the Member with a thirty (30) calendar day notice of the transition,
32 pursuant to the CalOptima Contract with DHCS.
33

34 ~~G.I.~~ If CalOptima identifies a Member who meets the requirements specified in Sections II.B and II.C,
35 of this policy, CalOptima shall transition the Member to COD-A, ~~or CCN,~~ and notify the Member's
36 Health Network of such transition. CalOptima shall provide the Member, ~~excluding those residing~~
37 ~~in an LTC facility,~~ with a thirty (30) calendar day notice of the transition pursuant to CalOptima's
38 contract with DHCS.
39

- 40 1. The Member's Health Network shall be responsible for all Covered Services for the Member, in
41 accordance with the DOFR, until CalOptima enrolls the Member in COD-A ~~or CCN.~~
42

43 ~~H.J.~~ If CalOptima identifies a Member who meets the requirements specified in Section II.B.1.b of this
44 policy, CalOptima shall assign the Member a PCP as follows:
45

- 46 1. For an existing Member assigned to a Health Network, who gains Part A Dual status,
47 CalOptima shall transition the Member to COD-A in the month CalOptima is notified by the
48 State of the change to Medicare Part A eligibility.
49

Policy #: DD.2006

Title: Enrollment In/Eligibility with CalOptima Direct

Revised Date: ~~07/01/16~~09/06/18

- 1 a. CalOptima shall assign the Member a PCP in accordance with CalOptima Policy
2 DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.
3
- 4 2. For a newly enrolled Member who is also Medicare Part A Dual eligible, CalOptima shall
5 assign the Member to a PCP in accordance with the methodology described in CalOptima
6 Policy DD.2006b: CalOptima Community Network Primary Care Provider
7 Selection/Assignment.
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- 9 3. A Member may request to change his or her participating PCP every thirty (30) calendar days
10 by contacting CalOptima's Customer Service Department.
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12 IV. ATTACHMENTS

- 13 A. Notification of Transplant Member
- 14 B. Hemophilia Special Needs Screen Questionnaire
- 15 C. End Stage Renal Disease Medical Evidence Report – Medicare Entitlement and/or Patient
16 Registration (Form CMS-2728-U3)
17
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19 V. REFERENCES

- 20 A. CalOptima Contract with Department of Health Care Services (DHCS)
- 21 B. CalOptima Contract for Health Services
- 22 C. CalOptima Policy AA.1000: Glossary of Terms
- 23 D. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
- 24 E. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider
25 Selection/Assignment
26
- 27 F. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection
28 Process
- 29 G. CalOptima Policy FF.1001: Capitation Payment
- 30 H. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
- 31 I. CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members
- 32 J. California Health and Safety Code, §§ 104160 through 104163
- 33 K. Department of Health Care Services (DHCS) All Plan Letter (APL) 14-015: PCP Assignment in
34 Medi-Cal Managed Care for Dual-Eligible Beneficiaries
- 35 L. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services
36 Whole Child Model Program
- 37 M. Title 22, California Code of Regulations, §51006
- 38 N. Welfare and Institutions Code, §14182.17(d)(3)
39

40 VI. REGULATORY AGENCY APPROVALS

- 41 A. 10/07/15: Department of Health Care Services
- 42 B. 08/18/15: Department of Health Care Services
- 43 C. 04/01/15: Department of Health Care Services
- 44 D. 10/01/12: Department of Health Care Services
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47 VII. BOARD ACTIONS

- 48 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
- 49 A.B. 08/06/15: Regular Meeting of the CalOptima Board of Directors
50

Policy #: DD.2006

Title: Enrollment In/Eligibility with CalOptima Direct

Revised Date: ~~07/01/16~~09/06/18

- 1 ~~B.C.~~ 03/06/14: Regular Meeting of the CalOptima Board of Directors
- 2 ~~C.D.~~ 03/04/10: Regular Meeting of the CalOptima Board of Directors
- 3 ~~D.E.~~ 11/05/09: Regular Meeting of the CalOptima Board of Directors
- 4 ~~E.F.~~ 06/03/08: Regular Meeting of the CalOptima Board of Directors
- 5 ~~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
<u>Revised</u>	<u>09/06/2018</u>	<u>DD.2006</u>	<u>Enrollment In/Eligibility with CalOptima Direct</u>	<u>Medi-Cal</u>

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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.
<u>California Children’s Services Program</u>	<u>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.</u>
<u>California Children’s Services (CCS) Eligible Condition</u>	<u>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.</u>
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 notwithstanding 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.

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	<p>A Transplant for:</p> <ol style="list-style-type: none"> 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

1 **I. PURPOSE**

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

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5 **II. POLICY**

6
7 A. CalOptima may enroll a Member in CalOptima Direct, in accordance with this Policy.

8
9 B. CalOptima shall enroll the following Members in CalOptima Direct Administrative (COD-A)
10 subject to the provisions of this Policy:

11
12 1. A Member who has Medicare coverage and is not enrolled in OneCare Connect:

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

21
22 2. A Member who becomes the responsibility of the Public Guardian or is in an Institute for
23 Mental Disease (IMD), or with Orange County Children and Family Services and is placed
24 outside of Orange County.

25
26 3. A Member with a Share of Cost (SOC) Aid Code.

27
28 4. A Member who resides at the Fairview Developmental Center.

29
30 5. At the time of initial enrollment in CalOptima, a Member with a non-Orange County Zip Code,
31 or invalid address information from the State.

- 32 a. If the address and/or zip code changes to an Orange County address at a later date,
33 CalOptima shall request that the Member select a Health Network or CalOptima
34 Community Network (CCN), in accordance with CalOptima Policy DD.2008: Health
35 Network and CalOptima Community Network Selection Process. If the Member fails to
36 choose a Health Network or CCN, then CalOptima shall auto assign the Member, in
37 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.

1 **III. PROCEDURE**

- 2
- 3 A. At the time of initial enrollment in CalOptima, a Member with a zip code outside of Orange County,
- 4 as indicated by the eligibility file sent to CalOptima by the State, or, if CalOptima is unable to
- 5 verify a zip code within Orange County due to no address information provided by the State, such
- 6 Member shall not be auto-assigned by CalOptima, and the Member shall remain in COD-A.
- 7
- 8 B. If a Member assigned to COD-A due to having a zip code outside Orange County changes his or her
- 9 zip code to an Orange County zip code, CalOptima shall request that the Member select a Health
- 10 Network or CCN, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima
- 11 Community Network Selection Process. If the Member fails to choose a Health Network or CCN,
- 12 then CalOptima shall auto-assign the Member, in accordance with CalOptima Policy AA.1207a:
- 13 CalOptima Auto-Assignment.
- 14
- 15 C. If a current Member assigned to a Health Network has or receives a zip code outside of Orange
- 16 County as indicated by the eligibility file sent to CalOptima by the State, or CalOptima is unable to
- 17 verify a zip code within Orange County at a later date, the Member may remain with their assigned
- 18 Health Network unless Member makes a different Health Network choice or meets the criteria for
- 19 COD-A or CCN enrollment as stated in Section II.B or II.C.
- 20
- 21 D. If a Health Network Eligible Member becomes the responsibility of the Public Guardian, or is in an
- 22 Institute for Mental Disease, or is with Orange County Children and Family Services and resides
- 23 outside Orange County:
- 24
- 25 1. The Member's Public Guardian, or the Orange County Children and Family Services may
- 26 submit a written request to enroll the Member in COD-A.
- 27
- 28 a. If CalOptima receives such request to enroll the Member in COD-A by the tenth (10th)
- 29 calendar day of the month, CalOptima Direct shall assume responsibility for all Covered
- 30 Services for the Member effective the first (1st) calendar day of the immediately following
- 31 month.
- 32
- 33 b. If CalOptima receives such request after the tenth (10th) calendar day of the month, COD-A
- 34 shall assume responsibility for all Covered Services for the Member effective no later than
- 35 the first (1st) calendar day of the month after the immediately following month.
- 36
- 37 2. If the Member's Public Guardian, or Orange County Children and Family Services does not
- 38 submit a written request to enroll the Member in CalOptima Direct, the Member's Health
- 39 Network shall be responsible for all Covered Services for the Member, in accordance with the
- 40 Division of Financial Responsibility (DOFR).
- 41
- 42 3. If the Member returns to Orange County, the Public Guardian or Orange County Children and
- 43 Family Services may submit a written request to enroll the Member in a Health Network or
- 44 CCN.
- 45
- 46 E. If a Health Network Eligible Member is diagnosed with Hemophilia:
- 47
- 48 1. The Member's Health Network shall notify CalOptima of the Member's diagnosis, in writing,
- 49 using the Hemophilia Special Needs Screen Questionnaire, in accordance with CalOptima
- 50 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

1 Health Network, effective the first (1st) calendar day of the month immediately following
2 the date CalOptima or the DHCS-approved Transplant Center determines that the Member
3 is ineligible for a Solid Organ Transplant or BMT; or
4

- 5 b. If it has been more than three hundred sixty-five (365) calendar days after the Member
6 transitioned to CCN, CalOptima shall request the Member select a Health Network, in
7 accordance with CalOptima Policy DD.2008: Health Network Selection Process, or
8 CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a:
9 CalOptima Auto-Assignment.
10

11 G. If a Health Network Eligible Member received a Solid Organ Transplant or BMT within one
12 hundred twenty (120) calendar days prior to their effective date of enrollment in CalOptima:
13

- 14 1. The Member's Health Network shall notify CalOptima by sending a Notification of Transplant
15 Member, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant
16 Members.
17
18 2. CCN shall assume responsibility for all Covered Services for the Member on the first (1st)
19 calendar day of the month immediately following the date CalOptima receives written notice
20 from the Health Network, for a period of not less than three hundred sixty-five (365) calendar
21 days after the date the Member received such Transplant.
22
23 3. CalOptima shall transition the Member to the Member's previous Health Network, effective no
24 later than the first (1st) calendar day of the month immediately following the three hundred sixty
25 fifth (365th) calendar day after the date the Member received a Solid Organ Transplant or BMT.
26
27 4. The Member's Health Network shall be responsible for all Covered Services for the Member
28 until the Health Network submits written notice and CalOptima transitions such Member to
29 CCN, as set forth in Section III.E.1 and III.E.2 of this Policy.
30

31 H. If a Health Network Eligible Member is diagnosed with ESRD and is not already assigned to CCN:
32

- 33 1. The Member's Health Network shall notify CalOptima, in writing, of the Member by
34 submitting a copy of Form CMS-2728-U3 to CalOptima's Health Network Relations
35 Department.
36
37 a. If a Health Network submits a Form CMS-2728-U3 on or before the fifteenth (15th)
38 calendar day of a month, CCN shall assume responsibility for all Covered Services for the
39 Member effective no later than the first (1st) calendar day of the month after the immediate
40 following month. For example, if a Health Network submits Form CMS-2728-U3 on June
41 15, CCN shall assume responsibility for the Member effective August 1.
42
43 b. If a Health Network submits a Form CMS-2728-U3 after the fifteenth (15th) day of a month,
44 CCN shall assume responsibility for all Covered Services for the Member effective no later
45 than the first (1st) calendar day of the second (2nd) month after the immediately following
46 month. For example, if a Health Network submits Form CMS-2728-U3 on June 16, CCN
47 shall assume responsibility for the Member effective September 1.
48
49 c. CalOptima shall provide the Member with a thirty (30) calendar day notice of the transition,
50 pursuant to the CalOptima Contract with DHCS.

- 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

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

6 **VI. REGULATORY AGENCY APPROVALS**

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

13 **VII. BOARD ACTIONS**

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

23 **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

Policy #: DD.2006

Title: Enrollment In/Eligibility with CalOptima Direct

Revised Date: 09/06/18

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 notwithstanding 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.

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	<p>A Transplant for:</p> <ol style="list-style-type: none"> 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.



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:

TRANSPLANT TYPE

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

Provider NPI#: _____ TIN#: _____

Medi-Cal ID#: _____

Address: _____ Phone: _____

Fax: _____

Office Contact: _____

Physician's Signature: _____

Diagnosis: _____ ICD-9: _____

- 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

[Back to Agenda](#)

**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

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 Asian Native Hawaiian or Other Pacific Islander*
 *complete Item 9
 Print Name of Enrolled/Principal Tribe

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)

<p>Prior</p> <input type="checkbox"/> Unemployed <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired due to Age/Preference <input type="checkbox"/> Retired (Disability) <input type="checkbox"/> Medical Leave of Absence <input type="checkbox"/> Student	<p>Current</p> <input type="checkbox"/> Unemployed <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired due to Age/Preference <input type="checkbox"/> Retired (Disability) <input type="checkbox"/> Medical Leave of Absence <input type="checkbox"/> Student
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17. Co-Morbid Conditions (Check all that apply currently and/or during last 10 years) *See instructions

<p>a. <input type="checkbox"/> Congestive heart failure b. <input type="checkbox"/> Atherosclerotic heart disease ASHD c. <input type="checkbox"/> Other cardiac disease d. <input type="checkbox"/> Cerebrovascular disease, CVA, TIA* e. <input type="checkbox"/> Peripheral vascular disease* f. <input type="checkbox"/> History of hypertension g. <input type="checkbox"/> Amputation h. <input type="checkbox"/> Diabetes, currently on insulin i. <input type="checkbox"/> Diabetes, on oral medications j. <input type="checkbox"/> Diabetes, without medications k. <input type="checkbox"/> Diabetic retinopathy l. <input type="checkbox"/> Chronic obstructive pulmonary disease m. <input type="checkbox"/> Tobacco use (current smoker)</p>	<p>n. <input type="checkbox"/> Malignant neoplasm, Cancer o. <input type="checkbox"/> Toxic nephropathy p. <input type="checkbox"/> Alcohol dependence q. <input type="checkbox"/> Drug dependence* r. <input type="checkbox"/> Inability to ambulate s. <input type="checkbox"/> Inability to transfer t. <input type="checkbox"/> Needs assistance with daily activities u. <input type="checkbox"/> Institutionalized <input type="checkbox"/> 1. Assisted Living <input type="checkbox"/> 2. Nursing Home <input type="checkbox"/> 3. Other Institution v. <input type="checkbox"/> Non-renal congenital abnormality w. <input type="checkbox"/> None</p>
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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 months 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)	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	d. HbA1c	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/>
a.2. Serum Albumin Lower Limit	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	e. Lipid Profile TC	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>
a.3. Lab Method Used (BCG or BCP)	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	LDL	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>
b. Serum Creatinine (mg/dl)	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	HDL	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>
c. Hemoglobin (g/dl)	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	TG	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>

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 declines information Unsuitable due to age
 Patient has not been assessed Psychologically unfit 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
<input type="text"/>	<input type="text"/>	<input type="text"/>

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
<input type="text"/>	<input type="text"/>	<input type="text"/>

34. Current Status of Transplant (if functioning, skip items 36 and 37) <input type="checkbox"/> Functioning <input type="checkbox"/> Non-Functioning	35. Type of Donor: <input type="checkbox"/> Deceased <input type="checkbox"/> Living Related <input type="checkbox"/> Living Unrelated
36. If Non-Functioning, Date of Return to Regular Dialysis (mm/dd/yyyy)	37. Current Dialysis Treatment Site <input type="checkbox"/> Home <input type="checkbox"/> Dialysis Facility/Center <input type="checkbox"/> 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)
<input type="text"/>	<input type="text"/>

40. Date Training Began (mm/dd/yyyy)	41. Type of Training <input type="checkbox"/> Hemodialysis a. <input type="checkbox"/> Home b. <input type="checkbox"/> In Center <input type="checkbox"/> CAPD <input type="checkbox"/> CCPD <input type="checkbox"/> Other
<input type="text"/>	<input type="text"/>

42. This Patient is Expected to Complete (or has completed) Training and will Self-dialyze on a Regular Basis. <input type="checkbox"/> Yes <input type="checkbox"/> No	43. Date When Patient Completed, or is Expected to Complete, Training (mm/dd/yyyy)
<input type="text"/>	<input type="text"/>

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
<input type="text"/>	<input type="text"/>
c.) Date (mm/dd/yyyy)	<input type="text"/>

E. PHYSICIAN IDENTIFICATION

46. Attending Physician (Print)	47. Physician's Phone No. (include Area Code)	48. UPIN of Physician in Item 46
<input type="text"/>	<input type="text"/>	<input type="text"/>

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)
<input type="text"/>	<input type="text"/>
51. Physician Recertification Signature	52. Date (mm/dd/yyyy)
<input type="text"/>	<input type="text"/>
53. Remarks	
<input type="text"/>	

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)
<input type="text"/>	<input type="text"/>

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.

- | | |
|--|--|
| <ol style="list-style-type: none">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. | <ol style="list-style-type: none">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 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 time 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 or 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

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 Omnibus 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 Health 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.



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~~

1 **I. PURPOSE**

2
 3 This policy describes the criteria by which a CalOptima Community Network (CCN) Member shall
 4 select or be assigned a Primary Care Provider (PCP).
 5

6 **II. POLICY**

- 7
 8 A. CalOptima recognizes that it is in the best interest of a Member to establish a medical home and
 9 maintain continuity of care with a PCP.
 10
 11 B. As part of CalOptima’s commitment to these objectives, a CCN Member is encouraged to select a
 12 participating PCP in accordance with the terms and conditions of this policy. If a CCN Member
 13 does not select a participating PCP, CalOptima shall assign the Member to a participating PCP in
 14 accordance with this policy.
 15
 16 C. CalOptima shall only assign a Member to a participating PCP who has been credentialed as a PCP
 17 by CalOptima.
 18
 19 D. A Member shall have the right to select a participating Community Health Center, or Non-Physician
 20 Medical Practitioner, as his or her PCP. If a Member chooses a participating Non-Physician
 21 Medical Practitioner as his or her PCP, the Member shall be assigned directly to the supervising
 22 physician and not the Non-Physician Medical Practitioner.
 23
 24 E. A Member categorized as a senior or person with a disability (SPD) shall have the right to choose as
 25 a PCP a specialist physician who is a participating Provider, is willing to perform the role of the
 26 PCP, and has met CalOptima’s requirements for a specialist to act as a PCP.

27
 28 F. A Member eligible for the California Children’s Services (CCS) Program, or the Member’s
 29 parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall have
 30 the right to request a specialist as a PCP if the specialist agrees to serve in a PCP role and is a CCS-
 31 paneled provider qualified to treat the required range of CCS-Eligible Conditions of the CCS child
 32 or youth, in accordance with CCS program rules and regulations.

33
 34 ~~F.G.~~ CalOptima shall make reasonable efforts to ensure that a Member expressing a desire to
 35 continue his or her existing relationship with a participating CCN PCP is assigned to such PCP.
 36

37 ~~G.H.~~ A Member who selects or is assigned to a participating Federally Qualified Health Center
 38 (FQHC) or Rural Health Clinic (RHC) as his or her PCP:
 39

Selection/Assignment

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.

~~H.J.~~ A Member may change his or her CCN-participating PCP once every thirty (30) calendar days in accordance with this policy.

~~H.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.

Selection/Assignment

1 5. In the event III.A.3-4 do not apply, CalOptima shall assign the Member to a participating PCP
2 open for new assignment based on the following:

- 3
- 4 a. The geographic location of the participating PCP's office in relation to the Member's
5 residence, in accordance with CalOptima Policy GG.1600: Access and Availability
6 Standards;
- 7
- 8 b. The Member's language; then
- 9
- 10 c. The Member's age.
- 11
- 12 d. If more than one (1) PCP meets all assignment criteria, a PCP will be assigned based on a
13 rotation to allow balanced distribution.
- 14

15 B. If a Member selects a participating PCP that is not accepting new Members, CalOptima shall:

- 16
- 17 1. Inform the Member to choose a participating PCP to avoid Auto-Assignment.
- 18
- 19 2. Contact the PCP, if a Member contacts CalOptima and indicates an existing relationship with a
20 participating PCP not accepting new Members, and make all reasonable efforts to ensure that
21 the Member may continue an existing relationship with the participating PCP.
- 22
- 23 3. Assign the Member to a CCN-participating PCP, in accordance with Section III.A of this
24 policy, if CalOptima is unable to obtain a CCN-participating PCP from the Member.
- 25

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

- 28
- 29 1. If the Member requests a PCP change before seeing his or her assigned PCP prior to the
30 sixteenth (16th) of the current month, CalOptima shall make the change effective the first (1st)
31 calendar day of the current month.
- 32
- 33 2. If the Member requests a PCP change after seeing his or her assigned PCP after the sixteenth
34 (16th) of the current month, CalOptima shall make the change effective the first (1st) calendar
35 day of the immediately following month.
- 36

37 **IV. ATTACHMENTS**

38 Not Applicable

39

40

41 **V. REFERENCES**

- 42
- 43 A. CalOptima Community Network (CCN) Primary Care Provider (PCP) Selection Form and Guide
- 44 B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
- 45 C. CalOptima Contract for Health Care Services
- 46 D. CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct
- 47 E. CalOptima Policy GG.1600: Access and Availability Standards

Policy #: DD.2006b
Title: CalOptima Community Network Member Primary Care
Provider Selection/Assignment

Revised Date: 09/06/18 ~~09/01/17~~

Selection/Assignment

1 F. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services
2 Whole Child Model Program

3 ~~F.G.~~ Welfare and Institutions Code, ~~Section~~ §§ 14087.325 and 14094.14

4 ~~G.H.~~ Title 22, California Code of Regulations (CCR), §55170

5 ~~H.I.~~ Title 42, Code of Federal Regulations (CFR), §438.10(f)(5)

6

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VI. REGULATORY AGENCY APPROVALS

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9 A. 10/09/17: Department of Health Care Services

10 B. 04/07/15: Department of Health Care Services

11 C. 07/12/10: Department of Health Care Services

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VII. BOARD ACTIONS

14

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

16 ~~A.B.~~ 03/06/14: Regular Meeting of the CalOptima Board of Directors

17 ~~B.C.~~ 11/05/09: Regular Meeting of the CalOptima Board of Directors

18

Policy #: DD.2006b
 Title: CalOptima Community Network Member Primary Care
 Provider Selection/Assignment

Revised Date: 09/06/18 ~~09/01/17~~

Selection/Assignment

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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
<u>Revised</u>	<u>09/06/2018</u>	<u>DD.2006b</u>	<u>CalOptima Community Network Member Primary Care Provider Selection/Assignment</u>	<u>Medi-Cal</u>

4

Selection/Assignment

1 IX. GLOSSARY
 2

Term	Definition
<u>Authorized Representative</u>	<u>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.</u>
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.
<u>California Children’s Services (CCS) Program</u>	<u>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.</u>
<u>California Children’s Services (CCS) Eligible Condition</u>	<u>Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.</u>
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: <ol style="list-style-type: none"> 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

Policy #: DD.2006b
 Title: CalOptima Community Network Member Primary Care
 Provider Selection/Assignment

Revised Date: ~~09/06/18~~ 09/01/17

Selection/Assignment

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

1 **I. PURPOSE**

2
 3 This policy describes the criteria by which a CalOptima Community Network (CCN) Member shall
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6 **II. POLICY**

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- 8 A. CalOptima recognizes that it is in the best interest of a Member to establish a medical home and
- 9 maintain continuity of care with a PCP.
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- 11 B. As part of CalOptima’s commitment to these objectives, a CCN Member is encouraged to select a
- 12 participating PCP in accordance with the terms and conditions of this policy. If a CCN Member
- 13 does not select a participating PCP, CalOptima shall assign the Member to a participating PCP in
- 14 accordance with this policy.
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- 16 C. CalOptima shall only assign a Member to a participating PCP who has been credentialed as a PCP
- 17 by CalOptima.
- 18
- 19 D. A Member shall have the right to select a participating Community Health Center, or Non-Physician
- 20 Medical Practitioner, as his or her PCP. If a Member chooses a participating Non-Physician
- 21 Medical Practitioner as his or her PCP, the Member shall be assigned directly to the supervising
- 22 physician and not the Non-Physician Medical Practitioner.
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- 24 E. A Member categorized as a senior or person with a disability (SPD) shall have the right to choose as
- 25 a PCP a specialist physician who is a participating Provider, is willing to perform the role of the
- 26 PCP, and has met CalOptima’s requirements for a specialist to act as a PCP.
- 27
- 28 F. A Member eligible for the California Children’s Services (CCS) Program, or the Member’s
- 29 parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall have
- 30 the right to request a specialist as a PCP if the specialist agrees to serve in a PCP role and is a CCS-
- 31 paneled provider qualified to treat the required range of CCS-Eligible Conditions of the CCS child
- 32 or youth, in accordance with CCS program rules and regulations.
- 33
- 34 G. CalOptima shall make reasonable efforts to ensure that a Member expressing a desire to continue
- 35 his or her existing relationship with a participating CCN PCP is assigned to such PCP.
- 36
- 37 H. A Member who selects or is assigned to a participating Federally Qualified Health Center (FQHC)
- 38 or Rural Health Clinic (RHC) as his or her PCP:
- 39

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.

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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:

- 1 a. The geographic location of the participating PCP's office in relation to the Member's
- 2 residence, in accordance with CalOptima Policy GG.1600: Access and Availability
- 3 Standards;
- 4
- 5 b. The Member's language; then
- 6
- 7 c. The Member's age.
- 8
- 9 d. If more than one (1) PCP meets all assignment criteria, a PCP will be assigned based on a
- 10 rotation to allow balanced distribution.
- 11
- 12 B. If a Member selects a participating PCP that is not accepting new Members, CalOptima shall:
- 13
- 14 1. Inform the Member to choose a participating PCP to avoid Auto-Assignment.
- 15
- 16 2. Contact the PCP, if a Member contacts CalOptima and indicates an existing relationship with a
- 17 participating PCP not accepting new Members, and make all reasonable efforts to ensure that
- 18 the Member may continue an existing relationship with the participating PCP.
- 19
- 20 3. Assign the Member to a CCN-participating PCP, in accordance with Section III.A of this
- 21 policy, if CalOptima is unable to obtain a CCN-participating PCP from the Member.
- 22
- 23 C. A Member may request to change his or her participating PCP every thirty (30) calendar days by
- 24 contacting CalOptima's Customer Service Department.
- 25
- 26 1. If the Member requests a PCP change before seeing his or her assigned PCP prior to the
- 27 sixteenth (16th) of the current month, CalOptima shall make the change effective the first (1st)
- 28 calendar day of the current month.
- 29
- 30 2. If the Member requests a PCP change after seeing his or her assigned PCP after the sixteenth
- 31 (16th) of the current month, CalOptima shall make the change effective the first (1st) calendar
- 32 day of the immediately following month.
- 33

34 IV. ATTACHMENTS

35 Not Applicable

36 V. REFERENCES

- 37
- 38 A. CalOptima Community Network (CCN) Primary Care Provider (PCP) Selection Form and Guide
- 39 B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
- 40 C. CalOptima Contract for Health Care Services
- 41 D. CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct
- 42 E. CalOptima Policy GG.1600: Access and Availability Standards
- 43 F. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services
- 44 Whole Child Model Program
- 45 G. Welfare and Institutions Code, §§ 14087.325 and 14094.14
- 46 H. Title 22, California Code of Regulations (CCR), §55170
- 47 I. Title 42, Code of Federal Regulations (CFR), §438.10(f)(5)
- 48
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51 VI. REGULATORY AGENCY APPROVALS

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- 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

14

1 IX. GLOSSARY
 2

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 <i>in loco parentis</i> 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 (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.
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: <ol style="list-style-type: none"> 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.



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

1 **I. PURPOSE**

2
 3 This policy establishes the guidelines by which a Health Network shall assign and report a Health
 4 Network Member to a Primary Care Provider (PCP).
 5

6 **II. POLICY**

7
 8 A. A Health Network Eligible Member shall have a choice of PCP at the time the Member selects a
 9 Health Network for enrollment, and may change his or her PCP within the CalOptima network, on a
 10 monthly basis for any reason, in accordance with CalOptima Policy DD.2008: Health Network
 11 Selection Process.

12
 13 1. A Member eligible for the California Children’s Services (CCS) Program, or the Member’s
 14 parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall
 15 have the right to request a specialist or clinic as a PCP if the specialist or clinic agrees to serve
 16 in a PCP role and is a CCS-paneled provider qualified to treat the required range of CCS-
 17 Eligible Conditions of the CCS child or youth, in accordance with CCS program rules and
 18 regulations.

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 20 2. An SPD Member shall have the right to request a specialist or Community Health Center as a
 21 PCP if the specialist or Community Health Center agrees to serve in the PCP role.

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 23 B. If a Member does not select a PCP at the time of Health Network selection, a Health Network shall
 24 assign such Member to a PCP within seven (7) calendar days after receipt of the eligibility file, and
 25 no later than forty-five (45) calendar days after the Member’s enrollment with CalOptima.
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27 C. A Health Network shall only assign a Member to a PCP who has been credentialed in accordance
 28 with CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners; and
 29 registered with CalOptima as a PCP by the Health Network.
 30

31 D. Except for a Senior and Persons with Disabilities (SPD) Member, a Health Network shall assign a
 32 Member to a PCP, taking into consideration:

- 33
 34 1. The geographic location of the PCP’s office in relation to the Member’s residence, in
 35 accordance with CalOptima Policy GG.1600: Access and Availability Standards;
 36
 37 2. The Member’s language preference, if available; and
 38
 39 3. The Member’s age.

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2 E. For an SPD Member who does not select a PCP within thirty (30) calendar days of the effective date
3 of enrollment with CalOptima, a Health Network shall use Fee-For-Service (FFS) utilization data
4 provided by the Department of Health Care Services (DHCS) or other data sources, including
5 electronic data, to establish existing Provider relationships for the purpose of PCP assignment,
6 ~~including a Specialty Care Provider or clinic if a SPD Member indicates a preference for either, and~~
7 ~~the Specialty Care Provider or clinic agree to serve as a PCP,~~ and shall comply with all state and
8 federal privacy laws in the provision and use of data.
9
10 F. A Health Network shall make reasonable efforts to ensure that a Member expressing a desire to
11 continue his or her existing relationship with a contracted PCP in the CalOptima network is
12 assigned to such PCP.
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14 G. A Member who selects or is assigned to a Community Health Center, such as a Federally Qualified
15 Health Center (FQHC) or Rural Health Clinic (RHC), as his or her PCP:
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17 1. Shall be assigned directly to the Community Health Center; and
18
19 2. Shall not be assigned to individual PCP performing services on behalf of the Community Health
20 Center.
21
22 H. A Health Network shall notify the PCP that a Member has selected the PCP, or that the Health
23 Network assigned the Member to the PCP, within ten (10) calendar days after completion of the
24 selection or assignment.
25
26 I. A Health Network shall disclose to a Member the reason for which he or she could not select or be
27 assigned to a specific PCP.
28
29 J. A Health Network shall notify CalOptima via the PCP Upload of a Member's assignment to a PCP,
30 in accordance with Section III.C of this policy.
31
32 K. A Member may change his or her PCP monthly, for any reason, within his or her selected Health
33 Network. The Health Network shall process a Health Network Eligible Member's request to change
34 his or her PCP.
35
36 L. If a Health Network terminates a PCP, or a PCP terminates the contractual relationship with the
37 Health Network, the Health Network shall assign a new PCP to a Member affected by the
38 termination of his or her PCP within seven (7) calendar days after the effective date of the
39 termination. A Health Network shall notify the affected Members, in writing, of the change of
40 availability of Covered Services, in accordance with CalOptima Policy DD.2012: Member
41 Notification of Change in the Availability or Location of Covered Services.
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43 III. PROCEDURE

44 A. Primary Care Provider Selection

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47 1. A Health Network Eligible Member shall have the opportunity to select a PCP at the time of
48 Health Network selection during the first thirty (30) calendar days after enrollment/eligibility.
49

1 2. A Member shall have the right to select a Community Health Center or a Non-Physician
2 Medical Practitioner. If a Member chooses a Non-Physician Medical Practitioner as his or her
3 PCP, the Member shall be assigned directly to the supervising physician, and not the Non-
4 Physician Medical Practitioner.
5

6 3. An SPD Member shall have the right to request a specialist or Community Health Center as a
7 PCP if the specialist or Community Health Center agrees to serve in the PCP role.
8

9 4. A Member eligible for the California Children’s Services (CCS) Program, or the Member’s
10 parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall
11 have the right to request a specialist or clinic as a PCP if the specialist or clinic agrees to serve
12 in a PCP role and is a CCS-paneled provider qualified to treat the required range of CCS-
13 Eligible Conditions of the CCS child or youth.
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15 B. Member Assignment to Primary Care Provider
16

17 1. If a Member selects a Health Network, but does not select a PCP at the time of Health Network
18 Selection, the Health Network shall assign the Member to a PCP within seven (7) calendar days
19 after receipt of the eligibility file.
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21 2. If a Member selects neither a Health Network nor a PCP at the time of Health Network
22 selection, CalOptima shall:
23

24 a. Auto-assign the Member to a Health Network, in accordance with CalOptima Policy
25 AA.1207a: CalOptima Auto-Assignment; and
26

27 b. Defer the Member’s assignment to a PCP to the assigned Health Network, except for a
28 Member who is assigned directly to a Community Health Center.
29

30 c. The Health Network shall assign the Member to a PCP within seven (7) calendar days after
31 receipt of the eligibility file.
32

33 C. A Health Network shall report Member assignments and changes of a PCP in the PCP Upload File.
34

35 D. A Health Network shall correct PCP Upload File errors within ten (10) calendar days of receipt.
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37 **IV. ATTACHMENTS**

38 Not Applicable
39

40 **V. REFERENCES**

41 A. CalOptima Contract for Health Care Services
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43 B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
44

45 C. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
46

47 D. CalOptima Policy DD.2008: Health Network Selection Process
48

49 E. CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of
50 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

Policy #: EE.1112
Title: Health Network Eligible Member Assignment to Primary Care
Provider

Revised Date: ~~11/01/17~~
09/06/18

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
<u>Revised</u>	<u>09/06/2018</u>	<u>EE.1112</u>	<u>Health Network Eligible Member Assignment to Primary Care Provider</u>	<u>Medi-Cal</u>

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1 **IX. GLOSSARY**
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Term	Definition
<u>Authorized Representative</u>	<u>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 <i>in loco parentis</i> 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.</u>
<u>California Children’s Services Program</u>	<u>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.</u>
<u>California Children’s Services (CCS) Eligible Condition</u>	<u>Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.</u>
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: <ol style="list-style-type: none"> 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
<u>Health Network Eligible Member</u>	<u>A member who is eligible to choose a CalOptima Health Network or CalOptima Community Network (CCN).</u>
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.



CEO Approval: Michael Schrader _____

Effective Date: 10/01/95
 Last Review Date: 09/06/18
 Last Revised Date: 09/06/18

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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.

- 1
2 E. For an SPD Member who does not select a PCP within thirty (30) calendar days of the effective date
3 of enrollment with CalOptima, a Health Network shall use Fee-For-Service (FFS) utilization data
4 provided by the Department of Health Care Services (DHCS) or other data sources, including
5 electronic data, to establish existing Provider relationships for the purpose of PCP assignment, and
6 shall comply with all state and federal privacy laws in the provision and use of data.
7
8 F. A Health Network shall make reasonable efforts to ensure that a Member expressing a desire to
9 continue his or her existing relationship with a contracted PCP in the CalOptima network is
10 assigned to such PCP.
11
12 G. A Member who selects or is assigned to a Community Health Center, such as a Federally Qualified
13 Health Center (FQHC) or Rural Health Clinic (RHC), as his or her PCP:
14
15 1. Shall be assigned directly to the Community Health Center; and
16
17 2. Shall not be assigned to individual PCP performing services on behalf of the Community Health
18 Center.
19
20 H. A Health Network shall notify the PCP that a Member has selected the PCP, or that the Health
21 Network assigned the Member to the PCP, within ten (10) calendar days after completion of the
22 selection or assignment.
23
24 I. A Health Network shall disclose to a Member the reason for which he or she could not select or be
25 assigned to a specific PCP.
26
27 J. A Health Network shall notify CalOptima via the PCP Upload of a Member's assignment to a PCP,
28 in accordance with Section III.C of this policy.
29
30 K. A Member may change his or her PCP monthly, for any reason, within his or her selected Health
31 Network. The Health Network shall process a Health Network Eligible Member's request to change
32 his or her PCP.
33
34 L. If a Health Network terminates a PCP, or a PCP terminates the contractual relationship with the
35 Health Network, the Health Network shall assign a new PCP to a Member affected by the
36 termination of his or her PCP within seven (7) calendar days after the effective date of the
37 termination. A Health Network shall notify the affected Members, in writing, of the change of
38 availability of Covered Services, in accordance with CalOptima Policy DD.2012: Member
39 Notification of Change in the Availability or Location of Covered Services.
40

41 **III. PROCEDURE**

42
43 A. Primary Care Provider Selection

- 44
45 1. A Health Network Eligible Member shall have the opportunity to select a PCP at the time of
46 Health Network selection during the first thirty (30) calendar days after enrollment/eligibility.
47
48 2. A Member shall have the right to select a Community Health Center or a Non-Physician
49 Medical Practitioner. If a Member chooses a Non-Physician Medical Practitioner as his or her
50 PCP, the Member shall be assigned directly to the supervising physician, and not the Non-
51 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

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1 IX. GLOSSARY
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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 <i>in loco parentis</i> 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 (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.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: <ol style="list-style-type: none"> 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.



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: ~~11/01/1709/06/18~~
 Last Revised Date: ~~11/01/1709/06/18~~

1 **I. PURPOSE**

2
 3 This policy delineates criteria for a Health Network’s continued participation in the CalOptima Medi-
 4 Cal program as a Physician Hospital Consortium (PHC) after June 30, 2009.

5
 6 **II. POLICY**

- 7
 8 A. Physician Hospital Consortium (PHC) is a physician group contractually aligned with at least one
 9 (1) hospital, as described in CalOptima’s Health Network Service Agreement.
 10
 11 B. As of July 1, 2009, and unless otherwise approved by CalOptima Board Action, Health Networks
 12 participating as a PHC in the CalOptima Medi-Cal program shall be subject to this policy. Health
 13 Networks participating as a Pediatric PHC are excluded from the conditions of participation
 14 outlined in this policy.
 15
 16 C. To be considered for continued participation as a PHC in the CalOptima Medi-Cal program after
 17 June 30, 2009, a Health Network, except for a Pediatric PHC, shall demonstrate annually that it
 18 meets the following criteria:
 19
 20 1. The Health Network provides at least seventy percent (70%) of the hospital Bed Days for
 21 Covered Services provided to its Members at the Primary Hospital, an Affiliated Orange County
 22 System Hospital, or an Alternate Hospital, as described in Section III.B of this policy.
 23
 24 D. CalOptima’s Enterprise Analytics Department shall calculate Bed Day utilization for contracted
 25 PHCs. Health Network Relations Department shall ~~calculate and~~ review a PHC’s compliance with
 26 the seventy percent (70%) Bed Day threshold and shall provide an annual Bed Day summary report
 27 to each PHC.
 28
 29 E. The Primary Physician Group and Primary Hospital of a Health Network that meets the criteria set
 30 forth in Sections II.A and II.B of this policy may continue to participate in the CalOptima Medi-Cal
 31 program as a PHC.
 32
 33 F. CalOptima may terminate a Physician and Hospital contract in the event of non-compliance in
 34 accordance with Section III.C of this policy.

35
 36 **III. PROCEDURE**

- 37
 38 A. Calculation and Review of Bed Day Utilization for Compliance with the Seventy Percent (70%)
 39 Threshold:
 40
 41 1. CalOptima shall calculate and review a PHC’s Bed Day utilization on an annual basis.
 42

- 1 2. CalOptima shall limit the Bed Day threshold calculation to the following criteria:
 - 2
 - 3 a. CalOptima shall only consider utilization in hospitals located in Orange County. CalOptima
 - 4 shall not consider utilization in a hospital that is located outside of Orange County for any
 - 5 part of the calculation.
 - 6
 - 7 b. CalOptima shall only consider emergency room Bed Days, including emergency room Bed
 - 8 Days attributed to a California Children's Services (CCS)-Eligible Condition of a CCS-
 - 9 eligible Member at ~~primary hospitals~~Primary Hospitals and exclude emergency room Bed
 - 10 Days at ~~non-primary~~Non-Primary hospitals.
 - 11
 - 12 c. CalOptima shall only consider Bed Days attributed to a CCS-Eligible Condition for CCS-
 - 13 eligible Members at Primary Hospitals and exclude CCS Bed Days at Non-Primary
 - 14 Hospitals.
 - 15
 - 16 e.d. CalOptima shall base utilization on paid emergency, urgent, elective, and other admission
 - 17 Encounters for the Medi-Cal Program only.
 - 18
- 19 3. CalOptima shall calculate the Bed Day utilization using the previous year's data.
- 20
- 21 4. CalOptima shall only count acute Bed Days at the Primary Hospital, Affiliated Orange County
- 22 System Hospital, or Alternate Hospital, as described in Section III.B of this policy, toward the
- 23 seventy percent (70%) threshold.
- 24
- 25 B. CalOptima shall make the exception to allow the use of an Alternate Hospital under the following
- 26 conditions:
 - 27
 - 28 1. The PHC shall select one (1) Alternate Hospital partner;
 - 29
 - 30 2. The PHC may divert less than ten percent (10%) of admissions to the Alternate Hospital
 - 31 partner; and
 - 32
 - 33 3. The PHC Hospital shall hold a contract directly with the Alternate Hospital. The Alternate
 - 34 Hospital shall meet payment and other contractual requirements and shall release CalOptima of
 - 35 all liability.
 - 36
- 37 C. Annual Bed Day Summary Report
 - 38
 - 39 1. CalOptima shall provide an annual written notice to the Primary Physician Group and Primary
 - 40 Hospital of their continued PHC participating status no later than June of each calendar year.
 - 41
 - 42 2. A PHC not meeting the seventy percent (70%) Bed Day threshold shall have thirty (30)
 - 43 calendar days to comment or appeal the finding if the PHC disagrees with CalOptima's
 - 44 summary results.
 - 45
 - 46 a. CalOptima shall review the PHC's submission and notify the PHC of its final determination
 - 47 within ten (10) calendar days after receipt of the submitted documentation.
 - 48
 - 49 b. If, upon final review, CalOptima determines that a PHC Hospital does not meet the seventy
 - 50 percent (70%) Bed Day threshold, CalOptima shall terminate Physician and Hospital

1 contracts no sooner than one hundred twenty (120) calendar days after notification of non-
2 compliance.

3
4 D. In the event of contract termination as a result of non-compliance, and if the Primary Physician
5 Group wishes to continue to participate in the CalOptima Medi-Cal program, such Primary
6 Physician Group may participate as a Shared Risk Group, subject to all applicable financial and
7 operational criteria outlined in CalOptima policy. The Primary Physician Group shall transmit a
8 signed CalOptima Medi-Cal Shared Risk Group agreement to CalOptima.
9

10 **IV. ATTACHMENTS**

11 Not Applicable

12
13
14 **V. REFERENCES**

15 A. CalOptima Health Network Service Agreement
16
17

18 **VI. REGULATORY AGENCY APPROVALS**

19
20 A. ~~May 2010~~ 05/28/10: Department of Health Care Services
21

22 **VII. BOARD ACTIONS**

23
24 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors

25 ~~A.B.~~ 02/04/10: —Regular Meeting of the CalOptima Board of Directors

26 ~~B.C.~~ 04/02/09: —Regular ~~M~~meeting of the CalOptima Board of Directors

27 ~~C.D.~~ 06/05/07: —Regular Meeting of the CalOptima Board of Directors
28

29 **VIII. REVIEW/REVISION HISTORY**

30

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
<u>Revised</u>	<u>09/06/2018</u>	<u>EE.1132</u>	<u>Bed Day Utilization Criteria for Physician Hospital Consortia</u>	<u>Medi-Cal</u>

31

1 IX. GLOSSARY
 2

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.
<u>California Children’s Services (CCS) Program</u>	<u>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 (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.</u>
<u>California Children’s Services (CCS) Eligible Condition</u>	<u>Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.</u>
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 notwithstanding 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.
<u>Non-Primary Hospital</u>	<u>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.</u>
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

1 **I. PURPOSE**

2
3 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.

4
5
6 **II. POLICY**

- 7
8 A. Physician Hospital Consortium (PHC) is a physician group contractually aligned with at least one
9 (1) hospital, as described in CalOptima’s Health Network Service Agreement.
10
11 B. As of July 1, 2009, and unless otherwise approved by CalOptima Board Action, Health Networks
12 participating as a PHC in the CalOptima Medi-Cal program shall be subject to this policy. Health
13 Networks participating as a Pediatric PHC are excluded from the conditions of participation
14 outlined in this policy.
15
16 C. To be considered for continued participation as a PHC in the CalOptima Medi-Cal program after
17 June 30, 2009, a Health Network, except for a Pediatric PHC, shall demonstrate annually that it
18 meets the following criteria:
19
20 1. The Health Network provides at least seventy percent (70%) of the hospital Bed Days for
21 Covered Services provided to its Members at the Primary Hospital, an Affiliated Orange County
22 System Hospital, or an Alternate Hospital, as described in Section III.B of this policy.
23
24 D. CalOptima’s Enterprise Analytics Department shall calculate Bed Day utilization for contracted
25 PHCs. Health Network Relations Department shall review a PHC’s compliance with the seventy
26 percent (70%) Bed Day threshold and shall provide an annual Bed Day summary report to each
27 PHC.
28
29 E. The Primary Physician Group and Primary Hospital of a Health Network that meets the criteria set
30 forth in Sections II.A and II.B of this policy may continue to participate in the CalOptima Medi-Cal
31 program as a PHC.
32
33 F. CalOptima may terminate a Physician and Hospital contract in the event of non-compliance in
34 accordance with Section III.C of this policy.

35
36 **III. PROCEDURE**

- 37
38 A. Calculation and Review of Bed Day Utilization for Compliance with the Seventy Percent (70%)
39 Threshold:
40
41 1. CalOptima shall calculate and review a PHC’s Bed Day utilization on an annual basis.
42

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 - 3 a. CalOptima shall only consider utilization in hospitals located in Orange County. CalOptima
 - 4 shall not consider utilization in a hospital that is located outside of Orange County for any
 - 5 part of the calculation.
 - 6
 - 7 b. CalOptima shall only consider emergency room Bed Days, including emergency room Bed
 - 8 Days attributed to a California Children’s Services (CCS)-Eligible Condition of a CCS-
 - 9 eligible Member at Primary Hospitals and exclude emergency room Bed Days at Non-
 - 10 Primary hospitals.
 - 11
 - 12 c. CalOptima shall only consider Bed Days attributed to a CCS-Eligible Condition for CCS-
 - 13 eligible Members at Primary Hospitals and exclude CCS Bed Days at Non-Primary
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 - 16 d. CalOptima shall base utilization on paid emergency, urgent, elective, and other admission
 - 17 Encounters for the Medi-Cal Program only.
 - 18
- 19 3. CalOptima shall calculate the Bed Day utilization using the previous year’s data.
- 20
- 21 4. CalOptima shall only count acute Bed Days at the Primary Hospital, Affiliated Orange County
- 22 System Hospital, or Alternate Hospital, as described in Section III.B of this policy, toward the
- 23 seventy percent (70%) threshold.
- 24
- 25 B. CalOptima shall make the exception to allow the use of an Alternate Hospital under the following
- 26 conditions:
 - 27
 - 28 1. The PHC shall select one (1) Alternate Hospital partner;
 - 29
 - 30 2. The PHC may divert less than ten percent (10%) of admissions to the Alternate Hospital
 - 31 partner; and
 - 32
 - 33 3. The PHC Hospital shall hold a contract directly with the Alternate Hospital. The Alternate
 - 34 Hospital shall meet payment and other contractual requirements and shall release CalOptima of
 - 35 all liability.
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 - 40 Hospital of their continued PHC participating status no later than June of each calendar year.
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 - 43 calendar days to comment or appeal the finding if the PHC disagrees with CalOptima’s
 - 44 summary results.
 - 45
 - 46 a. CalOptima shall review the PHC’s submission and notify the PHC of its final determination
 - 47 within ten (10) calendar days after receipt of the submitted documentation.
 - 48
 - 49 b. If, upon final review, CalOptima determines that a PHC Hospital does not meet the seventy
 - 50 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

1 IX. GLOSSARY
2

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Health Network Service Agreement	The written agreement between CalOptima and a Health Network to provide Covered Services to Members.
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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



CEO Approval: Michael Schrader _____

Effective Date: 01/01/96
 Last Review Date: 07/01/01/181709/06/18
 Last Revised Date: 07/01/01/181709/06/18

1 **I. PURPOSE**

2
 3 This policy defines CalOptima’s Pharmacy ~~Prior Authorization~~prior authorization process.

4
 5 **II. POLICY**

6
 7 A. CalOptima shall require ~~Prior Authorization~~prior authorization (PA) for medications and supplies
 8 that:

- 9
 10 1. Are not listed on the closed Formulary, also known as the approved drug list;
 11
 12 2. Are on the formulary but exceed Formulary limitations for quantity, refill frequency, or duration
 13 of therapy;
 14
 15 3. Do not meet on-line contingent therapy or Step-Therapy restrictions, as described on the
 16 Formulary; and/or
 17
 18 4. Are prescribed for clinical indications outside specified utilization management restrictions, as
 19 described on the Formulary.

20
 21 B. CalOptima and its Pharmacy Benefit Manager (PBM) shall process requests for PA using the PA
 22 ~~definitions~~categorization, turn-around time, and notification standards as specified in Pharmacy
 23 Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals
 24 under the Pharmacy benefit.

25
 26 C. Requests marked as urgent that do not meet the definition for expedited review shall be reclassified
 27 as routine requests as outlined in the Pharmacy Prior Authorization and Appeals: Timeframes for
 28 Decisions and Notifications for Pharmaceuticals under the Pharmacy benefit.

29
 30 D. CalOptima and its PBM shall maintain appropriate communication with the Prescribing Practitioner
 31 and/or Member or the Member’s Authorized Representative throughout the PA process to facilitate
 32 delivery of appropriate services.

33
 34 E. The PBM or CalOptima shall provide a written response ~~by facsimile to a PA request within~~
 35 ~~twenty four (24) hours after receipt of a PA request. A response may include:~~ of approve,
 36 ~~defer~~modify, delay for Medical Necessity ~~information~~Information from the Prescribing Practitioner,
 37 ~~modify,~~ or deny to an authorization within twenty-four (24) hours after receipt of an expedited
 38 (preservice or concurrent) and standard request and thirty (30) calendar days for a retrospective
 39 request to the request. However, only Prescribing Practitioner and Member. A decision to modify or
 40 deny shall be limited to a CalOptima pharmacist or Medical Director ~~may modify or deny a PA.~~

1
2 F. In the event that all information reasonably necessary to make a determination was not received,
3 CalOptima may extend the timeframe of an authorization request if the following are met:

4
5 E.1. For an expedited preservice request, once, for forty-eight (48) hours, if CalOptima asks the
6 Member, the Member's representative, or the Prescribing Provider for the specific information
7 necessary to make the decision within twenty-four (24) hours of the receipt of the request;

8
9
10 2. For a standard preservice request once, for an additional fourteen (14) calendar days, if the
11 Member or the Prescribing Practitioner requested for an extension, or CalOptima can provide
12 justification upon request by the Department of Health Care Services (DHCS) the need for
13 additional information and how it is in the Member's interest. If the extension was not requested
14 by the Member, CalOptima shall make reasonable efforts to give the Member and Prescribing
15 Provider oral notice of the delay. The Prescribing Provider shall be provided with an electronic
16 Notice of Action (NOA) within twenty-four (24) hours of the decision and the member shall be
17 given a written NOA within two (2) business days of the decision. The NOA shall include the
18 reason for the extension, the additional information needed to render the decision, the type of
19 expert needed to review, and/or the additional examinations or tests required and the anticipated
20 date on which a decision will be rendered. CalOptima shall send the NOA pursuant to Section
21 III.G. of this Policy.

22 3. Upon receipt of all of the information reasonably necessary and requested by CalOptima,
23 CalOptima shall approve, modify, or deny the request for Authorization within five (5) business
24 days or seventy-two (72) hours for standard and expedited requests, respectively of the decision

25
26 F.G. Participating Pharmacies may dispense up to a ten (10) calendar day supply of the requested
27 medication pending final decision of the PA, in accordance with CalOptima Policy GG.1403:
28 Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement,
29 and Vacation Medication Supplies and CalOptima Policy GG.1639: Post-Hospital Discharge
30 Medication Supply.

31
32 G.H. ~~Appropriately~~ For ~~appropriately~~ prescribed pain management medications for terminally ill
33 patients when Medically Necessary ~~shall be approved or denied~~ CalOptima shall approve, modify,
34 ~~delay for information reasonably necessary to make a determination, or deny a PA~~ in a timely
35 fashion, appropriate for the nature of the Member's condition, and not to exceed seventy-two (72)
36 hours of the CalOptima's receipt of the information requested by the plan to make the decision.

37
38 1. If the request is modified, denied, or ~~if additional delay due to lack of~~ information reasonably
39 necessary to make a determination is required, CalOptima shall contact the provider within ~~one~~
40 ~~(1) working day~~ twenty-four (24) hours of the determination, with an explanation of the reason
41 for the modification, denial or the need for additional information.

42
43 2. Only licensed physicians or health care professionals (competent to evaluate the clinical issues)
44 make decisions to modify, deny, or delay (due to lack of information reasonably necessary to
45 make a determination) a PA for pain management for terminally ill patients.

46
47 3. The requested treatment shall be deemed authorized as of the expiration of the applicable
48 timeframe.

1 H.I. Newly enrolled Members may continue use of a covered benefit single-source drug which is part of
2 a prescribed therapy in effect for the Member immediately prior to the date of enrollment, whether
3 or not the drug is included on the Formulary, until the prescribed therapy is no longer prescribed by
4 the Practitioner. PA may be required if the single-source drug is not on the Formulary.
5

6 J. Members determined eligible with the California Children’s Services (CCS) program prior to
7 January 1, 2019 and transitioned into the Whole Child Model program shall be permitted to
8 continue use of any currently prescribed medication that is part of a prescribed therapy for the
9 Member's CCS-eligible condition or conditions immediately prior to the date of transition of
10 responsibility for the Member’s CCS services to CalOptima, whether or not the drug is included on
11 the Formulary, without PA until the Member's prescribing CCS provider has completed an
12 assessment of the child or youth, created a treatment plan, and decides that the particular medication
13 is no longer Medically Necessary, or the medication is no longer prescribed by the Member's CCS
14 provider.
15

16 H.K. CalOptima shall require the use of a U.S. Food and Drug Administration (FDA)-approved and
17 nationally-marketed drugs, unless Medical Necessity can be established requiring the use of a
18 compounded alternative. Compounded products may be dispensed only when an FDA-approved
19 therapeutic equivalent does not exist in the marketplace or when the FDA-approved product does
20 not meet the medical needs of the Member and a compound alternative is Medically Necessary.
21

22 H.L. CalOptima Pharmacy Management shall require generic substitution when an equivalent
23 generic product is available for Members not meeting the following criteria as listed in Section
24 H.J.3. of this policy.:
25

- 26 1. CalOptima Pharmacy Management adheres to Title 22, Ssection 51003 of the California Code
27 of Regulations: Authorization may be granted only for the lowest cost item or service covered
28 by the program that meets the Member’s medical needs.
29
- 30 2. CalOptima Pharmacy Management shall utilize the FDA bioequivalent ratings when requiring
31 generic substitution. -The FDA has rated all generic drugs “A” or “B.”- Only “A” rated products
32 are considered bioequivalent and interchangeable to the brand-name equivalents by the FDA.
33
 - 34 a. The FDA ensures that generic drugs deliver the same amount of active ingredients in the
35 same amount of time as the brand-name counterpart. -For reformulations of a brand-name
36 drug or generic versions of a drug, it reviews data showing the drug is bioequivalent to the
37 one used in the original safety and efficacy testing. -It requires generics to have the same
38 quality, strength, purity, and stability as the brand name drugs. -For these reasons, requests
39 for brand versions should not be approved based on assumptions that there will be better
40 efficacy or safety.
41
- 42 3. Prior authorization requests for use of a brand name product when a generic equivalent is
43 available shall be considered for review when the following information is provided:
44
 - 45 a. Documentation from the Member’s prescription profile or from the Prescribing
46 Practitioner’s progress notes that the Member has had a previous adequate trial of at least
47 two (2) available generic equivalents within one hundred eighty (180) calendar days of the
48 request.
49

- 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 guidelinesGuidelines 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

1 Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy
2 Benefit.
3

4 D. CalOptima shall notify the Member, the Member's Authorized Representative, if applicable, and
5 Prescribing Practitioner, ~~in writing~~, of any denial, delay, modification, termination, suspension, or
6 reduction of the level of treatment or services currently underway, or medication carve out,
7 ~~through~~ in a written NOA, in accordance with CalOptima Policy GG.1507: Notification
8 Requirements for Covered Services Requiring Prior Authorization. The NOA shall be provided
9 within the PA time frame as specified in the Pharmacy Prior Authorization and Appeals:- Time
10 frames for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.
11

12 E. The written NOA shall contain information as required by applicable ~~State~~ state and ~~Federal~~ federal
13 regulations, and outlined in the CalOptima Policy GG.1507: -Notification Requirements for
14 Covered Service Requiring Prior Authorization. -It shall also:
15

16 1. Describe the statement of action CalOptima is taking on the request;
17

18 2. ~~Describe~~ Clearly and concisely describe the specific reason(s) for the deny, modify, delay,
19 termination, suspension, reduction of the level of treatment or services currently underway, or
20 medication carve out decision in easy to understand language and provide a reference to the
21 CalOptima ~~PA guidelines~~ Pharmacy Prior Authorization Guidelines on which the decision was
22 based;
23

24 3. Contain all of the following for decisions based in whole or in part on Medical Necessity:
25

26 ~~3.a.~~ Provide a description of the criteria or guidelines used ~~including~~ to include a reference to the
27 specific regulation or authorization procedures that support the decision, as well as an
28 explanation of the criteria or guidelines;
29

30 ~~4.b.~~ Describe the clinical reasons for the decision and ~~explain~~ explicitly state how the Member's
31 condition does not meet the criteria or guidelines;
32

33 ~~5.4.~~ Describe how the Member or Prescribing Practitioner can obtain the medication for PA requests
34 that exceed the formulary quantity limit. CalOptima shall advise the Member or Prescribing
35 Practitioner how to fill a prescription for a lesser quantity when a denial is made on the basis of
36 quantity limit;
37

38 ~~6.5.~~ Describe how the Member or Prescribing Practitioner can obtain a formulary alternative on the
39 CalOptima Approved Drug List without a PA;
40

41 ~~7.6.~~ Define how the Member and Prescribing Practitioner may request, free of charge, copies of all
42 documents and records relevant to the NOA, including the actual benefit provision, guideline,
43 protocol, or other criteria on which the decision was based;
44

45 ~~8.7.~~ Inform the Prescribing Practitioner of the availability of an appropriate Practitioner to discuss
46 the denial and provide contact instructions;
47

48 ~~9.8.~~ Include the Member and Prescriber's appeal rights, an explanation of the appeal process, and
49 instructions on how to submit an appeal;
50

1 ~~10.9.~~ Explain that the Member or Prescribing Practitioner can provide written comments,
2 documents, or other information to appeal the denial;

3
4 ~~11.10.~~ Include the name and direct telephone number of the decision maker on the Prescribing
5 Practitioner notification; and

6
7 ~~12.11.~~ Include a "Your Rights" attachment, along with the nondiscrimination notice and
8 language assistance taglines, as set forth in CalOptima Policy GG.1507: Notification
9 Requirements for Covered Service Requiring Prior Authorization.

10
11 ~~D.F.~~ CalOptima shall communicate the ~~PA~~ decision to the Member, in writing, which shall be
12 dated and postmarked within two (2) business days of the decision.

13
14 G. CalOptima shall notify the Prescribing Practitioner initially by facsimile, then in writing, except for
15 decisions rendered retrospectively. The written notification shall be dated within ~~two (2) business~~
16 ~~days~~twenty-four (24) hours of the decision.

17
18 H. In accordance with CalOptima Policy GG.1410: Appeals Process for Pharmacy Authorizations, a
19 Prescribing Practitioner, Member, or Member's Authorized Representative may appeal any
20 ~~request~~decision that involves the delay, modification, or denial of services based on Medical
21 Necessity, termination, suspension, or reduction of the level of treatment or services currently under
22 way, or a determination that the requested service was not a covered benefit within sixty (60)
23 calendar days from the date on the NOA.

24
25 I. For ~~services that are terminated, suspended terminations, suspensions,~~ or ~~are~~ reductions of
26 previously authorized services, CalOptima shall notify Members at least ten (10) calendar days
27 before the date of the action, with the exception of circumstances permitted under Title 42 of the
28 Code of Federal Regulations (CFR), ~~Sections~~sections 431.213 and 431.214.

29
30 **IV. ATTACHMENTS**

- 31
32 A. Prior Authorization (PA) Form
33 B. Pharmacy Prior Authorization and Appeals:- Timeframes for Decisions and Notifications for
34 Pharmaceuticals under the Pharmacy Benefit
35 C. MedWatch ~~F~~form

36
37 **V. REFERENCES**

- 38
39 A. 2017 NCQA Health Plan Accreditation-UM Standards
40 B. California Business and Professions Code, Section 4039
41 C. California Health and Safety Code section 1367.215(a)
42 D. California Welfare and Institutions Code, Sections 14185 and 14094.13 (d).
43 E. CalOptima Approved Drug List
44 F. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
45 ~~A. 2017 NCQA Health Plan Accreditation-UM Standards~~
46 ~~B. California Business and Professions Code, Section 4039~~
47 ~~C. California Health and Safety Code section 1367.215(a)~~
48 ~~D. California Welfare and Institutions Code, Section~~Sections ~~14185 and 14094.13 (d).~~
49 ~~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

Policy #: GG.1401

Title: Pharmacy Authorization Process

Revised Date: 07/01/01/181709/06/18

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
<u>Revised</u>	<u>09/06/2018</u>	<u>GG.1401</u>	<u>Pharmacy Authorization Process</u>	<u>Medi-Cal</u>
<u>Revised</u>	<u>01/01/2018</u>	<u>GG.1401</u>	<u>Pharmacy Authorization Process</u>	<u>Medi-Cal</u>

1 IX. GLOSSARY
 2

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 <i>in loco parentis</i> 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 <u>Authorized Personal Representative</u> .
<u>Appeal</u>	<u>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.</u>
<u>California Children's Services Program</u>	<u>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.</u>
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.
<u>Grievance</u>	<u>An oral or written expression of dissatisfaction with any aspect of the CalOptima program, other than an Adverse Benefit Determination.</u>
<u>Health Risk Assessment</u>	<u>A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.</u>
<u>Individual Care Plan</u>	<u>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.</u>
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.
<u>Whole Child Model</u>	<u>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.</u>

1



CEO Approval: Michael Schrader _____

Effective Date: 01/01/96
Last Review Date: 09/06/18
Last Revised Date: 09/06/18

1 **I. PURPOSE**

2
3 This policy defines CalOptima's Pharmacy prior authorization process.

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5 **II. POLICY**

6
7 A. CalOptima shall require a prior authorization (PA) for medications and supplies that:

- 8
9 1. Are not listed on the closed Formulary, also known as the approved drug list;
- 10
11 2. Are on the formulary but exceed Formulary limitations for quantity, refill frequency, or duration
12 of therapy;
- 13
14 3. Do not meet on-line contingent therapy or Step-Therapy restrictions, as described on the
15 Formulary; and/or
- 16
17 4. Are prescribed for clinical indications outside specified utilization management restrictions, as
18 described on the Formulary.

19
20 B. CalOptima and its Pharmacy Benefit Manager (PBM) shall process requests for PA using the PA
21 categorization, turn-around time, and notification standards as specified in Pharmacy Prior
22 Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under
23 the Pharmacy benefit.

24
25 C. Requests marked as urgent that do not meet the definition for expedited review shall be reclassified
26 as routine requests as outlined in the Pharmacy Prior Authorization and Appeals: Timeframes for
27 Decisions and Notifications for Pharmaceuticals under the Pharmacy benefit.

28
29 D. CalOptima and its PBM shall maintain appropriate communication with the Prescribing Practitioner
30 and/or Member or the Member's Authorized Representative throughout the PA process to facilitate
31 delivery of appropriate services.

32
33 E. The PBM or CalOptima shall provide a written response of approve, modify, delay for Medical
34 Necessity Information from the Prescribing Practitioner, or deny to an authorization within twenty-
35 four (24) hours after receipt of an expedited (preservice or concurrent) and standard request and
36 thirty (30) calendar days for a retrospective request to the Prescribing Practitioner and Member. A
37 decision to modify or deny shall be limited to a CalOptima pharmacist or Medical Director.

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39 F. In the event that all information reasonably necessary to make a determination was not received,
40 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.

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2 J. Members determined eligible with the California Children’s Services (CCS) program prior to
3 January 1, 2019 and transitioned into the Whole Child Model program shall be permitted to
4 continue use of any currently prescribed medication that is part of a prescribed therapy for the
5 Member's CCS-eligible condition or conditions immediately prior to the date of transition of
6 responsibility for the Member’s CCS services to CalOptima, whether or not the drug is included on
7 the Formulary, without PA until the Member's prescribing CCS provider has completed an
8 assessment of the child or youth, created a treatment plan, and decides that the particular medication
9 is no longer Medically Necessary, or the medication is no longer prescribed by the Member's CCS
10 provider.
11
- 12 K. CalOptima shall require the use of a U.S. Food and Drug Administration (FDA)-approved and
13 nationally-marketed drugs, unless Medical Necessity can be established requiring the use of a
14 compounded alternative. Compounded products may be dispensed only when an FDA-approved
15 therapeutic equivalent does not exist in the marketplace or when the FDA-approved product does
16 not meet the medical needs of the Member and a compound alternative is Medically Necessary.
17
- 18 L. CalOptima Pharmacy Management shall require generic substitution when an equivalent
19 generic product is available for Members not meeting the following criteria:
20
- 21 1. CalOptima Pharmacy Management adheres to Title 22, Section 51003 of the California Code of
22 Regulations: Authorization may be granted only for the lowest cost item or service covered by
23 the program that meets the Member’s medical needs.
24
 - 25 2. CalOptima Pharmacy Management shall utilize the FDA bioequivalent ratings when requiring
26 generic substitution. The FDA has rated all generic drugs “A” or “B.” Only “A” rated products
27 are considered bioequivalent and interchangeable to the brand-name equivalents by the FDA.
28
 - 29 a. The FDA ensures that generic drugs deliver the same amount of active ingredients in the
30 same amount of time as the brand-name counterpart. For reformulations of a brand-name
31 drug or generic versions of a drug, it reviews data showing the drug is bioequivalent to the
32 one used in the original safety and efficacy testing. It requires generics to have the same
33 quality, strength, purity, and stability as the brand name drugs. For these reasons, requests
34 for brand versions should not be approved based on assumptions that there will be better
35 efficacy or safety.
36
 - 37 3. Prior authorization requests for use of a brand name product when a generic equivalent is
38 available shall be considered for review when the following information is provided:
39
 - 40 a. Documentation from the Member’s prescription profile or from the Prescribing
41 Practitioner’s progress notes that the Member has had a previous adequate trial of available
42 generic equivalents within one hundred eighty (180) calendar days of the request.
43
 - 44 b. Documentation from the Member’s prescription profile or from the Prescribing
45 Practitioner’s progress notes that the Member has had a previous adequate trial of
46 therapeutic alternatives within one hundred eighty (180) calendar days of the request.
47
 - 48 c. Medical justification of why the Member is unable to use the generic equivalent and cannot
49 use an alternative therapeutic equivalent.
50

- 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

1 CalOptima PA Guidelines shall be reviewed by a CalOptima Clinical Pharmacist and/or Medical
2 Director.

- 3
4 1. The PBM pharmacy technician, PBM pharmacist, a CalOptima pharmacy technician, or a
5 CalOptima clinical pharmacist shall review all PA requests, except Post-service Requests, and
6 render a response within twenty-four (24) hours after receipt of the PA. Concurrent urgent and
7 Post-service Requests shall be reviewed by the PBM and CalOptima based on the timelines
8 specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and
9 Notifications for Pharmaceuticals under the Pharmacy Benefit.
10
11 2. If the PA request has sufficient clinical information to meet the CalOptima PA guidelines, the
12 PBM shall approve the PA and notify the Prescribing Practitioner and Participating Pharmacy
13 representative by facsimile.
14
15 3. If the PA request has insufficient information to meet the CalOptima PA guidelines, the PBM
16 shall defer the PA for additional Medical Necessity information and notify the Prescribing
17 Practitioner and/or the Member's Participating Pharmacy by facsimile.
18
19 a. The Prescribing Practitioner and/or the Member's Participating Pharmacy shall be notified
20 of the deferral for requests with insufficient information. The notice shall include a reason
21 for the deferral and date of when a response is needed to render a decision.
22
23 b. If additional information is not received in the timeframe requested, the request shall be
24 forwarded to CalOptima to modify the PA request to a Formulary alternative, delay due to
25 missing information necessary to make a determination, or deny based on the timelines
26 specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and
27 Notifications for Pharmaceuticals under the Pharmacy Benefit.
28
29 4. If all information reasonably necessary is received and the information provided by the
30 Prescribing Practitioner or Participating Pharmacy is insufficient for approval, the PBM's
31 Pharmacist shall make recommendation to deny or modify to a Formulary alternative the PA
32 request and shall forward the PA request to a CalOptima Pharmacist for review. CalOptima
33 shall render a decision pursuant to timelines specified in the Pharmacy Prior Authorization and
34 Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy
35 Benefit.
36
37 D. CalOptima shall notify the Member, the Member's Authorized Representative, if applicable, and
38 Prescribing Practitioner, of any denial, delay, modification, termination, suspension, or reduction of
39 the level of treatment or services currently underway, or medication carve out, in a written NOA, in
40 accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services
41 Requiring Prior Authorization. The NOA shall be provided within the PA time frame as specified
42 in the Pharmacy Prior Authorization and Appeals: Time frames for Decisions and Notifications for
43 Pharmaceuticals under the Pharmacy Benefit.
44
45 E. The written NOA shall contain information as required by applicable state and federal regulations
46 and outlined in the CalOptima Policy GG.1507: Notification Requirements for Covered Service
47 Requiring Prior Authorization. It shall also:
48
49 1. Describe the statement of action CalOptima is taking on the request;
50

- 1 2. Clearly and concisely describe the specific reason(s) for the deny, modify, delay, termination,
2 suspension, reduction of the level of treatment or services currently underway, or medication
3 carve out decision in easy to understand language and provide a reference to the CalOptima
4 Pharmacy Prior Authorization Guidelines on which the decision was based;
5
- 6 3. Contain all of the following for decisions based in whole or in part on Medical Necessity:
7
 - 8 a. Provide a description of the criteria or guidelines used to include a reference to the specific
9 regulation or authorization procedures that support the decision, as well as an explanation of
10 the criteria or guidelines;
 - 11
 - 12 b. Describe the clinical reasons for the decision and explicitly state how the Member's
13 condition does not meet the criteria or guidelines;
 - 14
- 15 4. Describe how the Member or Prescribing Practitioner can obtain the medication for PA requests
16 that exceed the formulary quantity limit. CalOptima shall advise the Member or Prescribing
17 Practitioner how to fill a prescription for a lesser quantity when a denial is made on the basis of
18 quantity limit;
- 19
- 20 5. Describe how the Member or Prescribing Practitioner can obtain a formulary alternative on the
21 CalOptima Approved Drug List without a PA;
- 22
- 23 6. Define how the Member and Prescribing Practitioner may request, free of charge, copies of all
24 documents and records relevant to the NOA, including the actual benefit provision, guideline,
25 protocol, or other criteria on which the decision was based;
- 26
- 27 7. Inform the Prescribing Practitioner of the availability of an appropriate Practitioner to discuss
28 the denial and provide contact instructions;
- 29
- 30 8. Include the Member and Prescriber's appeal rights, an explanation of the appeal process, and
31 instructions on how to submit an appeal;
- 32
- 33 9. Explain that the Member or Prescribing Practitioner can provide written comments, documents,
34 or other information to appeal the denial;
- 35
- 36 10. Include the name and direct telephone number of the decision maker on the Prescribing
37 Practitioner notification; and
- 38
- 39 11. Include a "Your Rights" attachment, along with the nondiscrimination notice and language
40 assistance taglines, as set forth in CalOptima Policy GG.1507: Notification Requirements for
41 Covered Service Requiring Prior Authorization.
42
- 43 F. CalOptima shall communicate the decision to the Member, in writing, which shall be dated and
44 postmarked within two (2) business days of the decision.
45
- 46 G. CalOptima shall notify the Prescribing Practitioner initially by facsimile, then in writing, except for
47 decisions rendered retrospectively. The written notification shall be dated within twenty-four (24)
48 hours of the decision.
49

- 1 H. In accordance with CalOptima Policy GG.1410: Appeals Process for Pharmacy Authorizations, a
2 Prescribing Practitioner, Member, or Member's Authorized Representative may appeal any decision
3 that involves the delay, modification, or denial of services based on Medical Necessity, termination,
4 suspension, or reduction of the level of treatment or services currently under way, or a
5 determination that the requested service was not a covered benefit within sixty (60) calendar days
6 from the date on the NOA.
7
- 8 I. For terminations, suspensions, or reductions of previously authorized services, CalOptima shall
9 notify Members at least ten (10) calendar days before the date of the action, with the exception of
10 circumstances permitted under Title 42 of the Code of Federal Regulations (CFR), sections 431.213
11 and 431.214.
12

13 **IV. ATTACHMENTS**

- 14 A. Prior Authorization (PA) Form
15 B. Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for
16 Pharmaceuticals under the Pharmacy Benefit
17 C. MedWatch Form
18

19 **V. REFERENCES**

- 20 A. 2017 NCQA Health Plan Accreditation-UM Standards
21 B. California Business and Professions Code, Section 4039
22 C. California Health and Safety Code section 1367.215(a)
23 D. California Welfare and Institutions Code, Sections 14185 and 14094.13 (d).
24 E. CalOptima Approved Drug List
25 F. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
26 G. CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of
27 Emergency, Disaster, Replacement, and Vacation Medication Supplies
28 H. CalOptima Policy GG.1410: Appeals Process for Pharmacy Authorizations
29 I. CalOptima Policy GG.1507: Notification Requirements for Covered Service Requiring Prior
30 Authorization
31 J. CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply
32 K. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal
33 Requirements and Revised Notice Templates and "Your Rights" Attachments
34 L. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services
35 Whole Child Model Program
36 M. Department of Health Care Services (DHCS) Policy Letter (PL) 14-002: Requirement to Use
37 Food and Drug Administration Approved Drugs, Rather Than Compounded Alternatives.
38 N. Title 22, California Code of Regulations, §§ 51003 and 51303
39 O. Title 42, California Code of Regulations, §§ 431.213-214 and 438.910(b).
40
41
42

43 **VI. REGULATORY AGENCY APPROVALS**

- 44 A. 08/09/16: Department of Health Care Services
45 B. 04/19/16: Department of Health Care Services
46 C. 11/10/15: Department of Health Care Services
47 D. 07/23/14: Department of Health Care Services
48

49 **VII. BOARD ACTIONS**

1
2 A. 08/06/18: Regular Meeting of the CalOptima Board of Directors

3
4 **VIII. REVIEW/REVISION HISTORY**

5

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

Policy #: GG.1401

Title: Pharmacy Authorization Process

Revised Date: 09/06/18

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

1

1 IX. GLOSSARY
 2

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 <i>in loco parentis</i> 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 (21) 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: <ol style="list-style-type: none">1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or2. 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.

1



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

<p>Request Type</p> <p><input type="checkbox"/> New <input type="checkbox"/> Renewal <input type="checkbox"/> Retroactive <input type="checkbox"/> Appeal</p>	<p>Call 888-807-5705 for an override if the request is for:</p> <ul style="list-style-type: none"> ▪ 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: <input type="checkbox"/> Male <input type="checkbox"/> Female DOB: _____ Other Primary Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Home <input type="checkbox"/> B&C <input type="checkbox"/> Sub-Acute <input type="checkbox"/> SNF <input type="checkbox"/> 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 eligibility. 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 [Back to Agenda](#) distribute this information. Thank You.

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*
<p>Standard (Non-urgent) Preservice</p> <ul style="list-style-type: none"> - All necessary information received at time of initial request 	<p>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}.</p>	<ul style="list-style-type: none"> - Practitioner: Within <u>24 hours -business days</u> of making the decision² (electronic and written notification) - Member: -Within 2 business days of making the decision² (written notification)
<p>Standard (Non-urgent) Preservice - Extension Needed</p> <ul style="list-style-type: none"> - Additional clinical information required - Requires consultation by an Expert Reviewer - Additional examination or tests to be performed - [AKA: Deferral or Request for Information (RFI)] 	<ul style="list-style-type: none"> - 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. - <u>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:</u> <ul style="list-style-type: none"> - <u>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}.</u> - <u>Notice of deferral-The Delay notice should shall</u> 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 such². 	<ul style="list-style-type: none"> - Practitioner: -Within <u>24 hours of 2-business days</u> of making the decision², not to exceed 14 calendar days from the receipt of the request for service³ (electronic and written notification) - Member: -Within 2 business days of making the decision², not to exceed 14 calendar days from the receipt of the request for service³ (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

<p>Expedited (Urgent) Pre-Service</p> <ul style="list-style-type: none">- 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	<ul style="list-style-type: none">- 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:<ul style="list-style-type: none">▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations:<ul style="list-style-type: none">• 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 request⁴.	<ul style="list-style-type: none">- Practitioner: <u>Within 24 hours of the decision²</u> Within 2 business days of making the decision^{2,3} (electronic and written notification)- Member: <u>Within 24 hours of the decision²</u> Within 2 business days of making the decision^{2,4} (written notification)
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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
<p>Expedited (Urgent) Pre-Service - Extension Needed</p> <ul style="list-style-type: none"> - 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)] 	<ul style="list-style-type: none"> - 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}. - <u>The Plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions:</u> <ul style="list-style-type: none"> ▪ <u>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.</u> ▪ <u>The Plan gives the member or member's authorized representative at least 48 hours to provide the information.</u> ▪ <u>The extension period, within which a decision must be made by the Plan, begins:</u> <ul style="list-style-type: none"> • <u>On the date when the Plan receives the member's response (even if not all of the information is provided), or</u> • <u>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.</u>³ - Expedited (Urgent) Pre-Service request may be reclassified as Standard (Non-urgent) Preservice if the following definition for urgent request is not met: <ul style="list-style-type: none"> ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: <ul style="list-style-type: none"> • 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 such². 	<ul style="list-style-type: none"> - Practitioner and Member: Within <u>24 hours of the decision² 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 request³</u> (electronic and written notification) - Member: Within 2 business days of making <u>making the decision² 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</u> (written notification) - Note: CalOptima shall make <u>reasonable efforts to give the Member and Prescribing Provider oral notice of the delay.</u>

Attachment B (for GG.1401 and GG.1410):

Pharmacy Prior Authorization and Appeals: -Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

<p>Concurrent review of treatment regimen already in place</p> <ul style="list-style-type: none"> - 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. 	<ul style="list-style-type: none"> - 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 <u>NCQA UM 5: Timeliness of UM decision, Element E: Timeliness of Pharmacy UM Decisions, 2016 HP Accreditation UM Standards</u>^{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 hours². - 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 deny². 	<ul style="list-style-type: none"> - 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)
<p>Post-Services / Retrospective Review</p>	<ul style="list-style-type: none"> ▪ A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request^{2,4}. 	<ul style="list-style-type: none"> - Practitioner: Within <u>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 request^{2,3}</u> (written notification) - Member: Within <u>30-2 business days of making the decision² but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination-² 30 days from the receipt of the request³the receipt of the request^{2,3}</u> (written notification)

<p style="text-align: center;">Appeals</p> <p style="text-align: center;">Time period to file an appeal: within 60 days of the initial denial decision^{5,6}</p>		<p style="text-align: center;"><u>Notice of Appeal Resolution (NAR)</u> Notification Timeframe</p>
<p>Type of Request</p>	<p>Decision</p>	<p>Practitioner and Member</p>
<p>Routine (Standard) Preservice Appeal</p>	<p>A decision to approve, modify, or deny is required within 30 <u>calendar</u> days of the initial receipt of the request⁵.</p>	<ul style="list-style-type: none"> - Practitioner: Within 30 <u>calendar</u> days of making the <u>from the receipt of the request decision</u>⁵ (electronic & written notification) - Member: Within 30 <u>of receipt of the request</u> <u>days of making the decision</u>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

<p>Expedited (Urgent) Pre-Service Appeal</p> <p>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}.</p>	<p>- A decision to approve, modify, or deny is required within 72 hours <u>of receiving the additional information</u>, or as soon as a Member's health condition requires, after receipt of the request⁵.</p> <p><u>The Plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions:</u></p> <ul style="list-style-type: none"> ▪ <u>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.</u> ▪ <u>The Plan gives the member or member's authorized representative at least 48 hours to provide the information.</u> ▪ <u>The extension period, within which a decision must be made by the Plan, begins:</u> <ul style="list-style-type: none"> • <u>On the date when the Plan receives the member's response (even if not all of the information is provided), or</u> • <u>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 representative⁵.</u> <p>- Expedited (Urgent) Pre-Service request may be reclassified as Standard (Non-urgent) Preservice if the following definition for urgent request is not met:</p> <ul style="list-style-type: none"> ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: <ul style="list-style-type: none"> • 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}. 	<ul style="list-style-type: none"> - Practitioner: Within 72 hours <u>from the receipt of the request of making the decision⁵ of the decision</u> (electronic & written notification)⁵ - Member: Within 72 hours <u>from the receipt of the request of making the decision⁵ of the decision</u> (oral and written notification)⁵
<p>Postservice Appeal</p>	<p>A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request⁵.</p>	<ul style="list-style-type: none"> - Practitioner: Within 30 <u>calendar days of the receipt of information that is reasonably necessary to make this determination² days from the receipt of the request of making the decision⁵</u> (electronic & written notification) - Member: Within 30 <u>calendar days of the receipt of information that is reasonably necessary to make this determination² from the receipt of the request of making the decision⁵</u> (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 FE: Notification of Pharmacy Decisions, 2016~~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 89: -~~Polices for Appeals~~Timeliness of Appeal Process, Element AE: 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*
<p>Standard (Non-urgent) Preservice</p> <ul style="list-style-type: none"> - All necessary information received at time of initial request 	<p>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}.</p>	<ul style="list-style-type: none"> - Practitioner: Within 24 hours of the decision² (electronic and written notification) - Member: Within 2 business days of the decision² (written notification)
<p>Standard (Non-urgent) Preservice - Extension Needed</p> <ul style="list-style-type: none"> - Additional clinical information required - Requires consultation by an Expert Reviewer - Additional examination or tests to be performed - [AKA: Deferral or Request for Information (RFI)] 	<ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> ▪ 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 such². 	<ul style="list-style-type: none"> - Practitioner: Within 24 hours of the decision², not to exceed 14 calendar days from the receipt of the request³ (electronic and written notification) - Member: Within 2 business days of making the decision², not to exceed 14 calendar days from the receipt of the request³ (written notification) - Note: CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay.
<p>Expedited (Urgent) Pre-Service</p> <ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: <ul style="list-style-type: none"> • 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 request⁴. 	<ul style="list-style-type: none"> - Practitioner: Within 24 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
<p>Expedited (Urgent) Pre-Service - Extension Needed</p> <ul style="list-style-type: none"> - 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)] 	<ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: <ul style="list-style-type: none"> • 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 such². 	<ul style="list-style-type: none"> - Practitioner and Member: Within 24 hours of the decision² but no later than 72 hours from receipt of information that is reasonably necessary to make a determination³ (electronic and written notification) - Member: Within 2 business days of the decision² but no later than 72 hours from receipt of information that is reasonably necessary to make a determination³ (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**

<p>Concurrent review of treatment regimen already in place</p> <ul style="list-style-type: none"> - 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. 	<ul style="list-style-type: none"> - 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 hours². - 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 deny². 	<ul style="list-style-type: none"> - 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)
<p>Post-Services / Retrospective Review</p>	<ul style="list-style-type: none"> ▪ A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request^{2,4}. 	<ul style="list-style-type: none"> - 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 determination²³ (written notification) - Member: Within 2 business days of the decision² but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination²³(written notification)

<p align="center">Appeals</p> <p align="center">Time period to file an appeal: within 60 days of the initial denial decision^{5,6}</p>		<p align="center">Notice of Appeal Resolution (NAR) Notification Timeframe</p>
<p>Type of Request</p>	<p>Decision</p>	<p>Practitioner and Member</p>
<p>Routine (Standard) Preservice Appeal</p>	<p>A decision to approve, modify, or deny is required within 30 calendar days of the initial receipt of the request⁵.</p>	<ul style="list-style-type: none"> - Practitioner: Within 30 calendar days from the receipt of the request ⁵ (electronic & written notification) - Member: Within 30 of receipt of the request⁵ (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**

<p>Expedited (Urgent) Pre-Service Appeal</p> <ul style="list-style-type: none"> - 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}. 	<ul style="list-style-type: none"> - 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 request⁵. The Plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions: <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> • 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 representative⁵. - Expedited (Urgent) Pre-Service request may be reclassified as Standard (Non-urgent) Preservice if the following definition for urgent request is not met: <ul style="list-style-type: none"> ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: <ul style="list-style-type: none"> • 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}. 	<ul style="list-style-type: none"> - Practitioner: Within 72 hours of the decision (electronic & written notification)⁵ - Member: Within 72 hours of the decision (oral and written notification)⁵
<p>Postservice Appeal</p>	<p>A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request⁵.</p>	<ul style="list-style-type: none"> - 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.

**Attachment B (for GG.1401 and GG.1410):
Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for
Pharmaceuticals Under the Pharmacy Benefit**

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.](#)

MEDWATCH

The FDA Safety Information and Adverse Event Reporting Program

For VOLUNTARY reporting of adverse events, product problems and product use errors

FDA USE ONLY	
Triage unit sequence #	
FDA Rec Date	

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	2 Age <input type="checkbox"/> Year(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Days(s) or Date of Birth (e.g., 08 Feb 1925)	3 Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	4 Weight <input type="checkbox"/> lb <input type="checkbox"/> kg

5 a Ethnicity (Check single best answer) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	5 b Race (Check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
--	---

B. ADVERSE EVENT, PRODUCT PROBLEM	
1 Check all that apply <input type="checkbox"/> Adverse Event <input type="checkbox"/> Product Problem (e.g., defects/malfunctions) <input type="checkbox"/> Product Use Error <input type="checkbox"/> Problem with Different Manufacturer of Same Medicine	
2 Outcome Attributed to Adverse Event (Check all that apply) <input type="checkbox"/> Death Include date (dd-mmm-yyyy) _____ <input type="checkbox"/> Life-threatening <input type="checkbox"/> Disability or Permanent Damage <input type="checkbox"/> Hospitalization - initial or prolonged <input type="checkbox"/> Congenital Anomaly/Birth Defects <input type="checkbox"/> Other Serious (Important Medical Events) <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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)		9 Event Abated After Use Stopped or Dose Reduced?
#1		#1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply
#2		#2 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply
5 Diagnosis or Reason for Use (indication)		10 Event Reappeared After Reintroduction?
#1		#1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply
#2		#2 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply
6 Is the Product Compounded?	7 Is the Product Over-the-Counter?	
#1 <input type="checkbox"/> Yes <input type="checkbox"/> No	#1 <input type="checkbox"/> Yes <input type="checkbox"/> No	
#2 <input type="checkbox"/> Yes <input type="checkbox"/> No	#2 <input type="checkbox"/> Yes <input type="checkbox"/> No	
8 Expiration Date (dd-mmm-yyyy)		
#1	#2	

E. SUSPECT MEDICAL DEVICE		
1 Brand Name		
2 Common Device Name		2b Procode
3 Manufacturer Name, City and State		
4 Model #	Lot #	5 Operator of Device
Catalog #	Expiration Date (dd-mmm-yyyy)	<input type="checkbox"/> Health Professional <input type="checkbox"/> Lay User/Patient <input type="checkbox"/> Other
Serial #	Unique Identifier (UDI) #	
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	3 Occupation	4 Also Reported to: <input type="checkbox"/> Manufacturer/Compounder <input type="checkbox"/> User Facility <input type="checkbox"/> Distributor/Importer	
5 If you do NOT want your identity disclosed to the manufacturer, please mark this box: <input type="checkbox"/>			

PLEASE TYPE OR USE BLACK INK

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

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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:

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Food and Drug Administration
Office of Chief Information Officer
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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

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Food and Drug Administration
Rockville, MD 20857

Official Business
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MEDWATCH

The FDA Safety Information and Adverse Event Reporting Program
Food and Drug Administration
5600 Fishers Lane
Rockville, MD 20852-9787

[Back to Agenda](#)



MEDWATCH

The FDA Safety Information and
Adverse Event Reporting Program

FORM FDA 3500 (10/15) *(continued)*

(CONTINUATION PAGE)

For VOLUNTARY reporting of
adverse events and product problems

Page 3 of 3

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)*



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

1 **I. PURPOSE**

2
3 This policy defines the process by which CalOptima shall develop and manage the drug Formulary.
4

5 **II. POLICY**

- 6
7 A. The Formulary development and management process shall ensure Member access to clinically
8 appropriate and cost-effective pharmaceuticals, in accordance with the decisions of the CalOptima
9 Pharmacy and Therapeutics (P&T) Committee, and consistent with the scope of benefits for
10 pharmaceutical services, as established by the California Department of Health Care Services
11 (DHCS) and Title 22 of the California Code of Regulations.
12
13 B. CalOptima's Pharmacy Management Department shall delegate daily formulary administrative
14 functions to the Pharmacy Benefit Manager (PBM), and shall ensure that these activities are
15 conducted pursuant to CalOptima policy through oversight and monitoring of the PBM's
16 ~~Formulary~~formulary administrative process.
17
18 C. ~~Nothing~~CalOptima's Approved Drug List (Formulary) shall be comparable to the Medi-Cal Fee-
19 For-Service (FFS) contract drug list. ~~Nothing~~ herein shall require CalOptima's Approved Drug List
20 (Formulary) to duplicate the medications, or parameters as contained on the DHCS Contract Drug
21 List.
22
23 D. ~~CalOptima's Approved Drug List (CalOptima's Formulary)~~ shall be posted on the CalOptima
24 website in a machine-readable file and format and a printed version shall be made available to the
25 Members upon request, pursuant to Title 42 Code of Federal Regulations (CFR) Ssection 438.10(i).
26
27 E. CalOptima shall meet DHCS Formulary requirements.
28
29 F. On an annual basis, CalOptima Pharmacy Management, with the participation of physicians and
30 pharmacists, shall review and update the Formulary and ~~Pharmaceutical Management~~
31 ~~pharmaceutical management~~ procedures.
32
33 G. CalOptima shall post a summary of the changes to the Formulary on the CalOptima website
34 following the quarterly P&T Committee meetings.
35
36 H. CalOptima shall communicate changes and updates relating to the Formulary and pharmaceutical
37 management procedures to Members and Prescribing Practitioners annually, and as needed after
38 Formulary updates: to notify them:
39

- 1 1. Where to find the Formulary, including restrictions and preferences such as Step Therapy
- 2 protocols, on the CalOptima website;
- 3
- 4 2. How to use the Pharmaceutical Management procedures;
- 5
- 6 3. An explanation of Formulary limits and restrictions and the process for Step Therapy protocols;
- 7
- 8 4. How Prescribing Practitioners must provide information to support a Prior Authorization
- 9 request; and
- 10
- 11 5. Where changes to the Formulary are posted on the CalOptima website.
- 12

13 **III. PROCEDURE**

14 **A. Formulary Development**

- 15
- 16
- 17 1. The CalOptima P&T Committee shall make reasonable effort to review a new chemical entity,
- 18 new U.S. Food and Drug Administration (FDA) approved drug product, or new FDA approved
- 19 indication within ninety (90) calendar days after release into the market, and shall make a
- 20 decision on the formulary status of the drug within one hundred eighty (180) calendar days after
- 21 its release into the market, or provide a clinical justification if the timeframe is not met.
- 22
- 23 2. The P&T Committee shall also:
- 24
- 25 a. Approve all changes and updates to the Formulary;
- 26
- 27 b. Approve the inclusion, or exclusion, of classes of drugs in the Formulary;
- 28
- 29 c. On an annual basis, review the therapeutic classes in the Formulary;
- 30
- 31 d. Consider whether or not the inclusion of a particular drug on the Formulary has any
- 32 therapeutic advantages in safety and efficacy compared to other drugs in the same class, and
- 33 the therapeutic advantages of a particular drug in relation to the interaction of a drug
- 34 therapy regimen and the use of other health care services;
- 35
- 36 e. Review the Prior Authorization guidelines for drugs;
- 37
- 38 f. Base clinical decisions on the strength of scientific evidence, standards of practice, and
- 39 safety and efficacy considerations;
- 40
- 41 g. Consider use of the following resources to assist in decision-making:
- 42
- 43 i. Peer-reviewed medical literature;
- 44
- 45 ii. Randomized clinical trials;
- 46
- 47 iii. Well-established Clinical Practice Guidelines (CPG);
- 48
- 49 iv. Pharmacoeconomic studies;
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- 1 v. Outcomes research data;
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3 vi. Centers for Medicare & Medicaid Services (CMS) policies and guidelines;
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5 vii. Centers for Disease Control and Prevention (CDC) policies and guidelines;
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7 viii. Medi-Cal Manual;
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9 ix. FDA policies and guidelines; and
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11 x. Other information, as appropriate;
12
13 h. Meet on a regular basis, but not less than quarterly; and
14
15 i. Include a majority of members that are practicing physicians or practicing pharmacists,
16 with:
17
18 i. At least one (1) practicing physician and at least one (1) practicing pharmacist that do
19 not have a conflict of interest with respect to CalOptima and pharmaceutical
20 manufacturers;
21
22 ii. At least one (1) practicing physician and at least one (1) practicing pharmacist that are
23 independent experts in the care of the elderly, or disabled, persons, and represent:
24
25 1) Various clinical specialties that represent the needs of Members; and
26
27 2) Are practicing physicians and pharmacists who do not work for CalOptima.
28
29 j. Request external review by a Prescribing Practitioner with a specialty, or subspecialty, of
30 medical practice when that specialty is not represented on the P&T Committee when
31 additional expertise is needed.
32
33 3. As part of the Formulary decision process, the P&T Committee may elect to set specific drug
34 usage criteria, such as:
35
36 a. Preferred drug status;
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38 b. Contingent therapy;
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40 c. Step Therapy protocols;
41
42 d. Duration-of-therapy limits;
43
44 e. Age or gender limits;
45
46 f. Strength-related quantity limits; and
47
48 g. Therapeutic substitution.
49

- 1 4. Decisions and recommendations of the P&T Committee shall be reported to CalOptima's
2 ~~Quality Improvement~~Utilization Management Committee.
- 3
- 4 5. CalOptima's Pharmacy Management Department shall be responsible for:
 - 5
 - 6 a. Presenting therapeutic drug selection and usage recommendations to the P&T Committee;
 - 7
 - 8 b. Presenting Prior Authorization guidelines for the drugs under review;
 - 9
 - 10 c. Presenting the annual review of therapeutic classes in the Formulary;
 - 11
 - 12 d. Tracking and reporting the resulting pharmacy utilization trends to the P&T Committee for
13 follow-up assessment of the effectiveness and outcomes of the P&T Committee's decisions;
 - 14
 - 15 e. Ensuring that the P&T drug evaluations and P&T minutes contain the criteria used when
16 making a Formulary, or preferred status decision for a drug, or drug class, and how the P&T
17 Committee makes decisions on:
 - 18
 - 19 i. Drug class reviews;
 - 20
 - 21 ii. Drug classes that are preferred or covered at any level;
 - 22
 - 23 iii. The Prior Authorization guidelines for drugs which are not preferred or non-Formulary;
 - 24
 - 25 iv. Limiting access to drugs within certain classes; and
 - 26
 - 27 v. Evidence that preferred-status drugs may produce similar, or better, results for the
28 majority of the population compared to other drugs within the same class.
 - 29
 - 30 f. Accepting Member, pharmacist, or Prescribing Provider, requests to add to, or remove,
31 drugs from the Formulary, and reviewing the request at the next P&T meeting; and
 - 32
 - 33 g. Providing at least sixty (60) calendar ~~days~~days' notice to Participating Pharmacies, via
34 facsimile, prior to removing a medication from the Formulary, or making any changes to
35 the preferred status of a drug.
 - 36

37 B. Formulary Management

- 38
- 39 1. The CalOptima Pharmacy Management Department shall be responsible for the overall
40 administration of the Formulary management process. The Pharmacy Management Department
41 shall coordinate activities with other internal departments, as needed, to carry out its
42 administrative responsibilities. Specific responsibilities include, but are not limited to, the
43 following:
 - 44
 - 45 a. Ensuring compliance with DHCS Formulary requirements, which include:
 - 46
 - 47 i. Submitting a complete CalOptima ~~Approved Drug List~~Formulary to DHCS annually for
48 review and approval and any changes to DHCS as File and Use;
 - 49

- 1 ii. Using the Formulary as published, unless DHCS notifies CalOptima of changes that
2 must be made;
- 3
- 4 iii. Reviewing the CalOptima ~~Approved Drug List~~ Formulary to ensure that it is
5 comparable to the Medi-Cal Fee-For-Service (FFS) contract drugs list, except for drugs
6 carved out of the State Contract. For this purpose, “comparable” means:
7
- 8 ~~iv.a)~~ Ensuring that the ~~The~~ CalOptima ~~Approved Drug List~~ Formulary shall
9 ~~contain~~ include at least one (1) drug in every therapeutic category or class listed on
10 the Medi-Cal FFS contract drug list ~~without a Prior Authorization requirement,~~
11 within 6 months of its inclusion on the Medi-Cal FFS contract drug list ~~except for~~
12 ~~drugs carved out of the State Contract.~~
- 13
- 14 ~~v.b)~~ If CalOptima chooses to subject all drugs within the same therapeutic category to
15 ~~prior authorization~~ Prior Authorization requirements and one (1) such drug is
16 available on the Medi-Cal FFS contract drug list without treatment authorization
17 request requirements, CalOptima shall ~~allow the drug to be available by Prior~~
18 ~~Authorization if deemed Medically Necessary and shall also~~ submit the following
19 for all drugs of that same mechanism of action:
20
- 21 ~~a)1)~~ Clinical rationale for ~~subjecting the prior authorization utilization control on all~~
22 ~~drugs within the individual therapeutic category with a specific mechanism of~~
23 ~~actions~~ such an action; and
- 24
- 25 ~~b)2)~~ Criteria used to adjudicate the ~~prior authorization~~ Prior Authorization
26 ~~request of the formulary option~~ and/or how the approval criteria for the
27 formulary option(s) differ from the non-formulary options.
- 28
- 29 ~~c)~~ A drug not listed on the formulary must be available by Prior Authorization if
30 deemed Medically Necessary.
31
- 32 ~~vi.iv.)~~ Implementing and maintaining a process to ensure that the Formulary is reviewed and
33 updated, no less than quarterly, by the P&T Committee, which will include
34 CalOptima’s pharmacists as voting members on the Committee;
35
- 36 ~~vii.v.)~~ Ensuring that the review and update considers all drugs approved by the FDA and/or
37 added to the Medi-Cal FFS contract drugs list;
38
- 39 ~~viii.vi.)~~ Documenting deletions to the Formulary, and justifying deletions to DHCS; and
40
- 41 ~~ix.vii.)~~ Ensuring drug utilization reviews are appropriately conducted by the P&T Committee
42 and pursuant to DHCS guidelines.
43
- 44 b. Pharmacy utilization management tracking and reporting;
- 45
- 46 c. Assessing and reporting Formulary compliance;
- 47
- 48 d. Oversight of the PBM in the performance of the online administration of the Formulary;
- 49
- 50 e. Communication to the PBM regarding Formulary changes;

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- 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

1 does not exist in the marketplace or when the FDA-approved product does not meet the medical
2 needs of the member and a compound alternative is medically necessary.
3

- 4 3. All FDA-approved tobacco cessation medications including bupropion SR, Varenicline,
5 nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, and the nicotine patch, are
6 available without a Prior Authorization for all adults.
7
- 8 4. Daily operations to implement, maintain, and report compliance with the Formulary shall be
9 delegated to the PBM, and shall be carried out according to CalOptima standards. Delegated
10 activities shall be described in the PBM Services Agreement, and shall include, but not be
11 limited to, the following activities:
12
- 13 a. Entry and maintenance of the Formulary into the Prior Authorization and claims
14 adjudication systems, as directed by CalOptima and approved by the P&T Committee,
15 including the accompanying preferred drugs, Step Therapy Protocols, Contingent Therapy
16 Protocols, Therapeutic Substitution Protocols, Quantity Limits, and Duration-of-Therapy
17 Limits;
18
 - 19 b. Supervision of online functions to administer the CalOptima approved Step Therapy
20 Protocols, Contingent Therapy Protocols, Duration-of-Therapy Limits, and Quantity Limits,
21 as listed on the Formulary; and
22
 - 23 c. Supervision of online functions to administer CalOptima approved online drug utilization
24 review program and drug-to-drug interaction alerts for drugs not listed on the Formulary.
25
 - 26 i. Drug utilization review edits consist of alerts on duplication of therapy for the same
27 medication, which generate a rejection at the point of dispensing, and notification to the
28 Participating Pharmacy that duplication of therapy is present and Prior Authorization is
29 required in order to dispense the medication.
30
 - 31 ii. Drug-to-drug interactions, such as Severity Level 1 drug interactions, which generate a
32 rejection at the point of dispensing, and notification to the Participating Pharmacy that a
33 drug-to-drug interaction is present and shall require a Prior Authorization in order to
34 dispense the medication.
35 - 36 d. Administration of the Prior Authorization process for non-Formulary medications, in
37 accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process;
38
 - 39 e. Claims control processes, e.g., to prevent payment for a non-Formulary medication without
40 entry of a Prior Authorization specific to the medication and the Member to which it has
41 been prescribed.
42

43 **IV. ATTACHMENTS**

- 44 A. Pharmacy & Therapeutic Committee Roster
- 45 B. MedWatch form

46 **V. REFERENCES**

- 47 A. CalOptima Approved Drug List

- 1 B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- 2 C. CalOptima Pharmacy & Therapeutics Committee Roster
- 3 D. CalOptima Policy AA.1000: Glossary of Terms
- 4 E. CalOptima Policy GG.1401: Pharmacy Authorization Process
- 5 F. Department of Health Care Services (DHCS) Policy Letter (PL) 14-002: Requirement to Use
- 6 Food and Drug Administration Approved Drugs, Rather Than Compounded Alternatives.
- 7 G. Department of Health Care Services (DHCS) Policy Letter (PL) 14-006: Comprehensive Tobacco
- 8 Services for Medi-Cal Members; Preventing Tobacco Use in Children and Adolescent
- 9 H. Department of Health Care Services (DHCS) All-Plan Letter (APL) 16-010: Medi-Cal Managed
- 10 Health Plan Pharmaceutical Formulary Comparability Requirement
- 11 I. Health and Safety Code, §1363.01
- 12 J. Title 22, California Code of Regulations (CCR), §51003
- 13 K. Title 42, Code of Federal Regulations (CFR), §438.10(d)(6) and (i)
- 14

15 **VI. REGULATORY AGENCY APPROVALS**

- 16
- 17 ~~A. 08/03/17: Department of Health Care Services~~
- 18 ~~B.A. 04/19/16: Department of Health Care Services~~
- 19 ~~C.B. 03/16/15: Department of Health Care Services~~
- 20

21 **VII. BOARD ACTIONS**

- 22
- 23 ~~None to Date~~ A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
- 24

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
<u>Revised</u>	<u>09/06/2018</u>	<u>GG.1409</u>	<u>Drug Formulary Development and Management</u>	<u>Medi-Cal</u>

1 **IX. GLOSSARY**
2

Term	Definition
<u>File and Use</u>	<u>A submission to DHCS that does not need review and approval prior to use or implementation, but which DHCS can require edits as determined</u>
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

1 **I. PURPOSE**

2
3 This policy defines the process by which CalOptima shall develop and manage the drug Formulary.
4

5 **II. POLICY**

- 6
7 A. The Formulary development and management process shall ensure Member access to clinically
8 appropriate and cost-effective pharmaceuticals, in accordance with the decisions of the CalOptima
9 Pharmacy and Therapeutics (P&T) Committee, and consistent with the scope of benefits for
10 pharmaceutical services, as established by the California Department of Health Care Services
11 (DHCS) and Title 22 of the California Code of Regulations.
12
13 B. CalOptima's Pharmacy Management Department shall delegate daily formulary administrative
14 functions to the Pharmacy Benefit Manager (PBM) and shall ensure that these activities are
15 conducted pursuant to CalOptima policy through oversight and monitoring of the PBM's formulary
16 administrative process.
17
18 C. CalOptima's Approved Drug List (Formulary) shall be comparable to the Medi-Cal Fee-For-Service
19 (FFS) contract drug list. Nothing herein shall require CalOptima's Approved Drug List (Formulary)
20 to duplicate the medications, or parameters as contained on the DHCS Contract Drug List.
21
22 D. CalOptima's Formulary shall be posted on the CalOptima website in a machine-readable file and
23 format and a printed version shall be made available to the Members upon request, pursuant to Title
24 42 Code of Federal Regulations (CFR) Section 438.10(i).
25
26 E. CalOptima shall meet DHCS Formulary requirements.
27
28 F. On an annual basis, CalOptima Pharmacy Management, with the participation of physicians and
29 pharmacists, shall review and update the Formulary and pharmaceutical management procedures.
30
31 G. CalOptima shall post a summary of the changes to the Formulary on the CalOptima website
32 following the quarterly P&T Committee meetings.
33
34 H. CalOptima shall communicate changes and updates relating to the Formulary and pharmaceutical
35 management procedures to Members and Prescribing Practitioners annually, and as needed after
36 Formulary updates to notify them:
37
38 1. Where to find the Formulary, including restrictions and preferences such as Step Therapy
39 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;

- 1 vi. Centers for Medicare & Medicaid Services (CMS) policies and guidelines;
- 2
- 3 vii. Centers for Disease Control and Prevention (CDC) policies and guidelines;
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- 5 viii. Medi-Cal Manual;
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- 7 ix. FDA policies and guidelines; and
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- 9 x. Other information, as appropriate;
- 10
- 11 h. Meet on a regular basis, but not less than quarterly; and
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- 13 i. Include a majority of members that are practicing physicians or practicing pharmacists,
- 14 with:
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- 16 i. At least one (1) practicing physician and at least one (1) practicing pharmacist that do
- 17 not have a conflict of interest with respect to CalOptima and pharmaceutical
- 18 manufacturers;
- 19
- 20 ii. At least one (1) practicing physician and at least one (1) practicing pharmacist that are
- 21 independent experts in the care of the elderly, or disabled, persons, and represent:
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- 23 1) Various clinical specialties that represent the needs of Members; and
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- 25 2) Are practicing physicians and pharmacists who do not work for CalOptima.
- 26
- 27 j. Request external review by a Prescribing Practitioner with a specialty, or subspecialty, of
- 28 medical practice when that specialty is not represented on the P&T Committee when
- 29 additional expertise is needed.
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- 31 3. As part of the Formulary decision process, the P&T Committee may elect to set specific drug
- 32 usage criteria, such as:
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- 34 a. Preferred drug status;
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 - 7 c. Presenting the annual review of therapeutic classes in the Formulary;
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 - 9 d. Tracking and reporting the resulting pharmacy utilization trends to the P&T Committee for
 - 10 follow-up assessment of the effectiveness and outcomes of the P&T Committee’s decisions;
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 - 12 e. Ensuring that the P&T drug evaluations and P&T minutes contain the criteria used when
 - 13 making a Formulary, or preferred status decision for a drug, or drug class, and how the P&T
 - 14 Committee makes decisions on:
 - 15 i. Drug class reviews;
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 - 17 ii. Drug classes that are preferred or covered at any level;
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 - 20 iii. The Prior Authorization guidelines for drugs which are not preferred or non-Formulary;
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 - 22 iv. Limiting access to drugs within certain classes; and
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 - 24 v. Evidence that preferred-status drugs may produce similar, or better, results for the
 - 25 majority of the population compared to other drugs within the same class.
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 - 27 f. Accepting Member, pharmacist, or Prescribing Provider, requests to add to, or remove,
 - 28 drugs from the Formulary, and reviewing the request at the next P&T meeting; and
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 - 30 g. Providing at least sixty (60) calendar days’ notice to Participating Pharmacies, via
 - 31 facsimile, prior to removing a medication from the Formulary, or making any changes to
 - 32 the preferred status of a drug.
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34 B. Formulary Management

- 35
- 36 1. The CalOptima Pharmacy Management Department shall be responsible for the overall
- 37 administration of the Formulary management process. The Pharmacy Management Department
- 38 shall coordinate activities with other internal departments, as needed, to carry out its
- 39 administrative responsibilities. Specific responsibilities include, but are not limited to, the
- 40 following:
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 - 42 a. Ensuring compliance with DHCS Formulary requirements, which include:
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 - 44 i. Submitting a complete CalOptima Formulary to DHCS annually for review and
 - 45 approval and any changes to DHCS as File and Use;
 - 46
 - 47 ii. Using the Formulary as published, unless DHCS notifies CalOptima of changes that
 - 48 must be made;
 - 49

- 1 iii. Reviewing the CalOptima Formulary to ensure that it is comparable to the Medi-Cal
2 Fee-For-Service (FFS) contract drugs list, except for drugs carved out of the State
3 Contract. For this purpose, “comparable” means:
4
5 a) The CalOptima Formulary shall include at least one (1) drug in every therapeutic
6 category or class listed on the Medi-Cal FFS contract drug list within 6 months of
7 its inclusion on the Medi-Cal FFS contract drug list.
8
9 b) If CalOptima chooses to subject all drugs within the same therapeutic category to
10 Prior Authorization requirements and one (1) such drug is available on the Medi-
11 Cal FFS contract drug list without treatment authorization request requirements,
12 CalOptima shall submit the following for all drugs of that same mechanism of
13 action:
14
15 1) Clinical rationale for such an action; and
16
17 2) Criteria used to adjudicate the Prior Authorization request and/or how the
18 approval criteria for the formulary option(s) differ from the non-formulary
19 options.
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21 c) A drug not listed on the formulary must be available by Prior Authorization if
22 deemed Medically Necessary.
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24 iv. Implementing and maintaining a process to ensure that the Formulary is reviewed and
25 updated, no less than quarterly, by the P&T Committee, which will include
26 CalOptima’s pharmacists as voting members on the Committee;
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28 v. Ensuring that the review and update considers all drugs approved by the FDA and/or
29 added to the Medi-Cal FFS contract drugs list;
30
31 vi. Documenting deletions to the Formulary, and justifying deletions to DHCS; and
32
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35
36 b. Pharmacy utilization management tracking and reporting;
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40 d. Oversight of the PBM in the performance of the online administration of the Formulary;
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42 e. Communication to the PBM regarding Formulary changes;
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44 f. Publication of the Formulary and quarterly updates to the Formulary following the P&T
45 Committee meeting on the CalOptima website: www.caloptima.org, as well as in a print
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49 i. An explanation of what a formulary is, which medications are covered, both generic
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- 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.

- 1 4. Daily operations to implement, maintain, and report compliance with the Formulary shall be
2 delegated to the PBM, and shall be carried out according to CalOptima standards. Delegated
3 activities shall be described in the PBM Services Agreement, and shall include, but not be
4 limited to, the following activities:
5
6 a. Entry and maintenance of the Formulary into the Prior Authorization and claims
7 adjudication systems, as directed by CalOptima and approved by the P&T Committee,
8 including the accompanying preferred drugs, Step Therapy Protocols, Contingent Therapy
9 Protocols, Therapeutic Substitution Protocols, Quantity Limits, and Duration-of-Therapy
10 Limits;
11
12 b. Supervision of online functions to administer the CalOptima approved Step Therapy
13 Protocols, Contingent Therapy Protocols, Duration-of-Therapy Limits, and Quantity Limits,
14 as listed on the Formulary; and
15
16 c. Supervision of online functions to administer CalOptima approved online drug utilization
17 review program and drug-to-drug interaction alerts for drugs not listed on the Formulary.
18
19 i. Drug utilization review edits consist of alerts on duplication of therapy for the same
20 medication, which generate a rejection at the point of dispensing, and notification to the
21 Participating Pharmacy that duplication of therapy is present and Prior Authorization is
22 required in order to dispense the medication.
23
24 ii. Drug-to-drug interactions, such as Severity Level 1 drug interactions, which generate a
25 rejection at the point of dispensing, and notification to the Participating Pharmacy that a
26 drug-to-drug interaction is present and shall require a Prior Authorization in order to
27 dispense the medication.
28
29 d. Administration of the Prior Authorization process for non-Formulary medications, in
30 accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process;
31
32 e. Claims control processes, e.g., to prevent payment for a non-Formulary medication without
33 entry of a Prior Authorization specific to the medication and the Member to which it has
34 been prescribed.
35

36 **IV. ATTACHMENTS**

- 37
38 A. Pharmacy & Therapeutic Committee Roster
39 B. MedWatch form
40

41 **V. REFERENCES**

- 42
43 A. CalOptima Approved Drug List
44 B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
45 C. CalOptima Pharmacy & Therapeutics Committee Roster
46 D. CalOptima Policy AA.1000: Glossary of Terms
47 E. CalOptima Policy GG.1401: Pharmacy Authorization Process
48 F. Department of Health Care Services (DHCS) Policy Letter (PL) 14-002: Requirement to Use
49 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 AGENCY APPROVALS

- 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

1 IX. GLOSSARY
2

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.

3
4

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
Himmat 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

MEDWATCH

The FDA Safety Information and Adverse Event Reporting Program

FDA USE ONLY	
Triage unit sequence #	
FDA Rec. Date	

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	2 Age <input type="checkbox"/> Year(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Days(s) or Date of Birth (e.g., 08 Feb 1925)	3 Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	4 Weight <input type="checkbox"/> lb <input type="checkbox"/> kg

5 a. Ethnicity (Check single best answer) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	5 b. Race (Check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
---	--

B. ADVERSE EVENT, PRODUCT PROBLEM	
1 Check all that apply <input type="checkbox"/> Adverse Event <input type="checkbox"/> Product Problem (e.g., defects/malfunctions) <input type="checkbox"/> Product Use Error <input type="checkbox"/> Problem with Different Manufacturer of Same Medicine	
2 Outcome Attributed to Adverse Event (Check all that apply) <input type="checkbox"/> Death Include date (dd-mmm-yyyy): - - - - <input type="checkbox"/> Life-threatening <input type="checkbox"/> Disability or Permanent Damage <input type="checkbox"/> Hospitalization - initial or prolonged <input type="checkbox"/> Congenital Anomaly/Birth Defects <input type="checkbox"/> Other Serious (Important Medical Events) <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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)		9 Event Abated After Use Stopped or Dose Reduced?
#1		#1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply
#2		#2 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply
5 Diagnosis or Reason for Use (indication)		10. Event Reappeared After Reintroduction?
#1		#1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply
#2		#2 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply
6 Is the Product Compounded?	7 Is the Product Over-the-Counter?	
#1 <input type="checkbox"/> Yes <input type="checkbox"/> No	#1 <input type="checkbox"/> Yes <input type="checkbox"/> No	
#2 <input type="checkbox"/> Yes <input type="checkbox"/> No	#2 <input type="checkbox"/> Yes <input type="checkbox"/> No	
8 Expiration Date (dd-mmm-yyyy)		
#1 - - - - #2 - - - -		

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 <input type="checkbox"/> Health Professional <input type="checkbox"/> Lay User/Patient <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	3 Occupation	4 Also Reported to: <input type="checkbox"/> Manufacturer/Compounder <input type="checkbox"/> User Facility <input type="checkbox"/> Distributor/Importer	
5 If you do NOT want your identity disclosed to the manufacturer, please mark this box: <input type="checkbox"/>			

PLEASE TYPE OR USE BLACK INK

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
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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

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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MEDWATCH

The FDA Safety Information and
Adverse Event Reporting Program
FORM FDA 3500 (10/15) (continued)

(CONTINUATION PAGE)

For VOLUNTARY reporting of
adverse events and product problems

Page 3 of 3

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)



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: ~~07/01/1709/06/18~~
Last Revised Date: ~~07/01/1709/06/18~~

1 **I. PURPOSE**

2
3 This policy defines the process by which CalOptima addresses and resolves a Pre-service, Post-service,
4 or expedited Appeal for Pharmaceutical Services, in accordance with applicable statutory, regulatory,
5 and contractual requirements.

6
7 **II. POLICY**

- 8
9 A. CalOptima shall process requests for Appeals using the definition, turn-around time, and
10 notification standards as specified in the Pharmacy Prior Authorization and Appeals: Timeframes
11 for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit. A request marked
12 as an Urgent Request that does not meet the definition for expedited review shall be reclassified as a
13 routine request as outlined in this attachment. CalOptima shall maintain appropriate communication
14 with the Prescribing Practitioner and/or Member or the Member’s Authorized Representative
15 throughout the Appeal process to facilitate delivery of appropriate services.
- 16
17 B. Upon receipt of a Notice of Action (NOA) notifying a Prescribing Practitioner or a Member of a
18 CalOptima pharmacy decision that a Pharmaceutical Service request has been modified; denied;
19 carved out of a treatment; or terminated, reduced, or suspended, a Prescribing Practitioner, a
20 Member, or an Authorized Representative, including an attorney, shall have the right to Appeal the
21 decision.
- 22
23 C. A pharmacy Appeal shall be a separate process from the Provider Complaint, Member Complaint,
24 or Member State Fair Hearing, as specified in CalOptima Policies GG.1510: Appeals Process for
25 Decisions Regarding Care and Services, HH.1101: CalOptima Provider Complaint, HH.1102:
26 CalOptima Member Complaint, and HH.1108: State Hearings Process and Procedures.
- 27
28 D. ~~A~~If the Member wishes to have an Authorized Representative, act on the Member’s behalf in the
29 appeals process, a Member must authorize the appointment, in writing, of an Authorized
30 Representative to represent the Member in the Appeal process, or the Authorized Representative
31 shall submit a copy of a Durable Power of Attorney for health care, or similar legal appointment or
32 representative document, or must otherwise be recognized under California law as a legal
33 representative of the Member.
- 34
35 E. A Prescribing Practitioner on behalf of the Member, the Member, or the Member’s Authorized
36 Representative may request a pharmacy Appeal by submitting a written or verbal Appeal request
37 within sixty (60) calendar days from the date written on the NOA received from CalOptima, in
38 accordance with the provisions of this policy. Appeals filed by the Prescribing Practitioner on
39 behalf of the Member shall require written consent from the Member.
- 40

1
2
3 F. CalOptima shall document the reason for the Appeal, who requested the Appeal, how the Appeal
4 was received, and any actions taken on the appeal.

5
6 G. CalOptima shall ensure prompt review and full investigation of the substance for an Appeal,
7 including any aspects of clinical care involved.

8
9 H. CalOptima shall give a Member, Authorized Representative or Provider a reasonable opportunity to
10 present, in writing or in person, before the individual(s) resolving the Appeal, evidence, facts, and
11 law in support of the Appeal. In the case of an Appeal subject to an expedited review, CalOptima
12 shall inform the Member, Authorized Representative or Provider of the limited time available to
13 present evidence.

14
15 I. The person making the final decision for the proposed resolution of an Appeal has neither
16 participated in any prior decisions related to the Appeal, nor is a subordinate of someone who has
17 participated in a prior decision and has clinical expertise in treating the Member's condition or
18 disease if deciding on any of the following:

19
20 1. An Appeal of a denial based on lack of Medical Necessity; and

21
22 2. Any Appeal involving clinical issues.

23
24 M. CalOptima shall ensure that at least one person reviewing the Appeal who is a practitioner in the
25 same or similar specialty.

26
27 N. Members shall exhaust CalOptima's Appeal process prior to requesting a State Hearing, in
28 accordance with CalOptima Policy HH.1108: State Hearing Process.

29
30 O. A Member may receive continuation of benefits while the pharmacy Appeal is pending resolution
31 if:

32
33 1. The Member files the pharmacy Appeal request within ten (10) calendar days of the mailing
34 date of the NOA;

35
36 2. The authorized Prescribing Practitioner orders the medication;

37
38 3. The pharmacy Appeal involves the termination, suspension, or reduction of a previously
39 authorized course of treatment;

40
41 4. The period covered by the original authorization has not expired; and

42
43 5. The Member verbally requests an extension of the benefits by calling the CalOptima Customer
44 Service Department.

45
46 P. CalOptima may extend the timeframe to resolve the Appeal by up to fourteen (14) calendar days at
47 the request of the Member or if there is a need for additional information and how the delay is in the
48 Member's best interest.

49
50 Q. For any extensions not requested by the Member, CalOptima must provide the Member with written
51 notice of the reason for the delay and the right to file a Grievance within two (2) calendar days from
52 the oral notification of the extension.

1
2 R. For Appeals resolved in favor of the Member, CalOptima shall authorize the request no later than
3 seventy-two (72)-hours from the date reversing the determination.

4
5 S. CalOptima shall make reasonable efforts to provide oral notification to the Member of the
6 resolution of an expedited Appeal.

7
8 T. CalOptima shall provide culturally and linguistically appropriate notices of the Appeals process to
9 Members, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

10
11 U. Effective no sooner than January 1, 2019, Members eligible with the California Children’s Services
12 (CCS) Program and transitioned into the Whole Child Model program shall be permitted to continue
13 use of any currently prescribed medication that is part of a prescribed therapy in accordance with
14 CalOptima Policy GG.1401: Pharmacy Authorization Process.

15
16 **III. PROCEDURE**

17
18 **A. Request for a Pharmacy Appeal**

19
20 1. A Member, or their Authorized Representative, may request a pharmacy Appeal, verbally or in
21 writing, within sixty (60) calendar days from the date on the NOA from CalOptima by:

22
23 a. Telephone or in-person to CalOptima’s Customer Service Department; or

24
25 b. Facsimile, or in writing, to CalOptima’s Grievance and Appeals Resolution Services
26 (GARS).

27
28 F.2. Telephone Appeals from Members, excluding expedited Appeals, shall be followed by a
29 written, signed Appeal. The date of the oral Appeal shall establish the filing date for the
30 Appeal. CalOptima shall provide the Member with an Appeal form along with the Member's
31 written acknowledgement notification. In the event that CalOptima does not receive a written,
32 signed Appeal from the Member, CalOptima shall neither dismiss ~~nor~~ delay the resolution of
33 the Appeal.

34
35 3. A Prescribing Practitioner may request a Pharmacy Appeal within sixty (60) calendar days from
36 the date on the NOA received from CalOptima regarding Pharmaceutical Services for a
37 Member. The request shall include all relevant material, such as clinical documentation or other
38 documentation supporting the request, and the Prescribing Practitioner shall clearly label the
39 request with “Appeal” or “Expedited Appeal.” A Prescribing Practitioner may request a
40 pharmacy Appeal by:

41
42 a. Facsimile or telephone to CalOptima’s Pharmacy Benefits Manager (PBM); or

43
44 b. Telephone, or in writing, via mail or facsimile, to CalOptima’s GARS, Customer Service,
45 or Pharmacy Management Departments.

46
47 4. Oral Appeal requests, excluding expedited Appeals, from a Member, or their Authorized
48 Representative, or a Prescribing Practitioner shall be followed by a written and signed Appeal
49 request. The date of the oral Appeal shall establish the filing date for the Appeal. CalOptima
50 shall provide the Appeal Form to the Member along with the acknowledgement notice. In the
51 event that CalOptima does not receive a written and signed Appeal from the Member,
52 CalOptima shall neither dismiss nor delay resolution of the Appeal.

1
2 5. CalOptima shall ensure that the Member or Authorized Representative, is given a reasonable
3 opportunity to present, in writing or verbally, comments, documents or other information
4 relating to the pharmacy Appeal, including evidence, facts, and law in support of the pharmacy
5 Appeal. A Prescribing Practitioner may also contact a CalOptima physician, or a health care
6 professional reviewer, to discuss the NOA for modification, denial, termination, or carve out of
7 a service, or to obtain a copy of the criteria used to make the decision. In the case of a pharmacy
8 Appeal subject to expedited review, the CalOptima Customer Service Department or the
9 CalOptima Pharmacy Management Department shall inform the Member or Authorized
10 Representative of the limited time available to present evidence.

11
12 ~~G.6.~~ Upon request by the Member ~~or~~, Authorized Representative, ~~or Prescribing Practitioner~~,
13 CalOptima shall provide the opportunity, before and during the Appeals process, to examine or
14 obtain a copy of the Member's case file, including medical records, and any other relevant
15 documents and records considered during the Appeals process, free of charge and sufficiently in
16 advance of the resolution timeframe for Appeal.

17
18 ~~H.7.~~ CalOptima shall provide written acknowledgement to the Member, dated and
19 postmarked within five (5) calendar days of the receipt of a standard Appeal request.

20
21 ~~8. CalOptima shall ensure that the Member or Authorized Representative is given a reasonable~~
22 ~~opportunity to present, in writing or verbally, comments, documents or other information~~
23 ~~relating to the pharmacy Appeal, including evidence, facts, and law in support of the pharmacy~~
24 ~~Appeal. CalOptima shall process appeals based on the following timeframes:~~

25 ~~I.1. In the case of a pharmacy Appeal subject to expedited review, the CalOptima Customer Service~~
26 ~~Department or the CalOptima Pharmacy Management Department shall inform the Member or~~
27 ~~Authorized Representative of the limited time available to present evidence.~~

28
29 ~~J. A Prescribing Practitioner may contact a CalOptima physician, or a health care professional~~
30 ~~reviewer, to discuss the NOA for modification, denial, termination, or carve out of a service, or to~~
31 ~~obtain a copy of the criteria used to make the decision.~~

32
33 ~~K.A. CalOptima shall make reasonable efforts to provide oral notification to the Member of the~~
34 ~~resolution of an expedited Appeal.~~

35
36 ~~L. CalOptima shall ensure the individual reviewing the pharmacy Appeal was not involved in the~~
37 ~~initial decision and the reviewer is not a subordinate of the initial reviewer.~~

38
39 ~~M. Members shall exhaust CalOptima's Appeal process prior to requesting a State Hearing, in~~
40 ~~accordance with CalOptima Policy III.1108: State Hearing Process.~~

41
42 ~~N.M. A Member may receive continuation of benefits while the pharmacy Appeal is pending~~
43 ~~resolution if:~~

44
45 ~~1. The Member files the pharmacy Appeal request within ten (10) calendar days of the mailing~~
46 ~~date of the NOA;~~

47
48 ~~2.1. The authorized Prescribing Practitioner orders the medication;~~

49
50 ~~3.1. The pharmacy Appeal involves the termination, suspension, or reduction of a previously~~
51 ~~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.

~~b.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.

~~e.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.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 expedited 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

- 1 ~~3) "Your Rights" Attachment.~~
2 ~~3) The Member's right to request and receive continuation of benefits within 10 days~~
3 ~~calendar days of when the NOA was sent.~~
4

5 **IV. ATTACHMENTS**

- 6
7 A. Notice of Appeal Resolution (NAR) - Decision Uphold (MCAL MM-17-35)
8 B. Notice of Appeal Resolution (NAR) - Decision Overturn (MCAL MM-17-33)
9 C. Centers for Medicare and Medicaid Appointment of Representative Form
10 D. Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for
11 Pharmaceuticals Under the Pharmacy Benefit
12

13 **V. REFERENCES**

- 14
15 A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
16 B. CalOptima Contract for Health Care Services
17 C. CalOptima Policy AA.1000: Glossary of Terms
18 ~~C.D.~~ CalOptima Policy DD.2002: Cultural and Linguistic Services
19 ~~D.E.~~ CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior
20 Authorization
21 F. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
22 ~~E.G.~~ CalOptima Policy HH.1101: CalOptima Provider Complaint
23 ~~F.H.~~ CalOptima Policy HH.1102: CalOptima Member Complaint
24 ~~G.I.~~ CalOptima Policy HH.1108: State Hearings Process and Procedures
25 ~~H.J.~~ Title 22, California Code of Regulations, §§51003 and 51303
26 ~~I.K.~~ Title 28, California Code of Regulations, §1300.68
27 ~~J.L.~~ Title 42, Code of Federal Regulations, §§438.402(b)(2), 438.406, 438.420(a) – (c)
28 ~~K.M.~~ All plan letter, 17-006: Grievance and Appeal Requirements and Revised Notice Templates and
29 "Your Rights" Attachments.
30 N. Welfare & Institutions Code, § 14094.13 (d).
31 O. All plan letter, 18-011: California Children's Services Whole Child Model Program
32

33 **VI. REGULATORY AGENCY APPROVALS**

- 34
35 A. 08/09/16: Department of Health Care Services
36 B. 04/26/16: Department of Health Care Services
37 C. 08/11/14: Department of Health Care Services
38

39 **VII. BOARD ACTIONS**

- 40
41 ~~A. None to Da~~09/06/18: Regular Meeting of the CalOptima Board of Directorste
42

43 **VIII. REVIEW/REVISION HISTORY**

44

Version	Date	Policy Number	Policy Title	Line(s) of Business
<u>Effective</u>	<u>07/01/2008</u>	<u>GG.1410</u>	<u>Appeal Process for Pharmacy Authorization</u>	<u>Medi-Cal</u>
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

Policy #: GG.1410

Title: Appeal Process for Pharmacy Authorization

Revised Date: ~~07/01/17~~09/06/18

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
<u>Revised</u>	<u>09/06/2018</u>	<u>GG.1410</u>	<u>Appeal Process for Pharmacy Authorization</u>	<u>Medi-Cal</u>

1

1 IX. GLOSSARY
 2

Term	Definition
<u>Acknowledgement Letter</u>	<u>A written statement acknowledging receipt of an appeal.</u>
<u>Adverse Benefit Determination</u>	<u>Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.</u>
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.
<u>Appeal Resolution</u>	<u>An outcome for appeal request as a result of an adverse benefit determination.</u>
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 <i>in loco parentis</i> 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: Acess by <u>Access</u> by 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.
<u>Delay Determination</u>	<u>The failure to act within the required timeframes for standard resolution of a prior authorization request.</u>
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.
<u>Modification Determination</u>	<u>A limited authorization or in denial in part, of a payment or requested service.</u>
<u>Notice of Action (NOA)</u>	<u>A NOA is a formal letter informing the Member and Prescriber of an Adverse Benefit Determination.</u>
<u>Notice of Appeal Resolution (NAR)</u>	<u>A NAR is a formal letter informing the Member that an Adverse Benefit Determination has been overturned or upheld.</u>
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: <ol style="list-style-type: none">1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member’s psychological state, or2. 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.

1



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

1 **I. PURPOSE**

2
 3 This policy defines the process by which CalOptima addresses and resolves a Pre-service, Post-service,
 4 or expedited Appeal for Pharmaceutical Services, in accordance with applicable statutory, regulatory,
 5 and contractual requirements.

6
 7 **II. POLICY**

- 8
 9 A. CalOptima shall process requests for Appeals using the definition, turn-around time, and
 10 notification standards as specified in the Pharmacy Prior Authorization and Appeals: Timeframes
 11 for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit. A request marked
 12 as an Urgent Request that does not meet the definition for expedited review shall be reclassified as a
 13 routine request as outlined in this attachment. CalOptima shall maintain appropriate communication
 14 with the Prescribing Practitioner and/or Member or the Member’s Authorized Representative
 15 throughout the Appeal process to facilitate delivery of appropriate services.
 16
 17 B. Upon receipt of a Notice of Action (NOA) notifying a Prescribing Practitioner or a Member of a
 18 CalOptima pharmacy decision that a Pharmaceutical Service request has been modified; denied;
 19 carved out of a treatment; or terminated, reduced, or suspended, a Prescribing Practitioner, a
 20 Member, or an Authorized Representative, including an attorney, shall have the right to Appeal the
 21 decision.
 22
 23 C. A pharmacy Appeal shall be a separate process from the Provider Complaint, Member Complaint,
 24 or Member State Fair Hearing, as specified in CalOptima Policies GG.1510: Appeals Process for
 25 Decisions Regarding Care and Services, HH.1101: CalOptima Provider Complaint, HH.1102:
 26 CalOptima Member Complaint, and HH.1108: State Hearings Process and Procedures.
 27
 28 D. If the Member wishes to have an Authorized Representative, act on the Member’s behalf in the
 29 appeals process, a Member must authorize the appointment, in writing, of an Authorized
 30 Representative to represent the Member in the Appeal process, or the Authorized Representative
 31 shall submit a copy of a Durable Power of Attorney for health care, or similar legal appointment or
 32 representative document, or must otherwise be recognized under California law as a legal
 33 representative of the Member.
 34
 35 E. A Prescribing Practitioner on behalf of the Member, the Member, or the Member’s Authorized
 36 Representative may request a pharmacy Appeal by submitting a written or verbal Appeal request
 37 within sixty (60) calendar days from the date written on the NOA received from CalOptima, in
 38 accordance with the provisions of this policy. Appeals filed by the Prescribing Practitioner on
 39 behalf of the Member shall require written consent from the Member.
 40
 41

- 1
2 F. CalOptima shall document the reason for the Appeal, who requested the Appeal, how the Appeal
3 was received, and any actions taken on the appeal.
4
5 G. CalOptima shall ensure prompt review and full investigation of the substance for an Appeal,
6 including any aspects of clinical care involved.
7
8 H. CalOptima shall give a Member, Authorized Representative or Provider a reasonable opportunity to
9 present, in writing or in person, before the individual(s) resolving the Appeal, evidence, facts, and
10 law in support of the Appeal. In the case of an Appeal subject to an expedited review, CalOptima
11 shall inform the Member, Authorized Representative or Provider of the limited time available to
12 present evidence.
13
14 I. The person making the final decision for the proposed resolution of an Appeal has neither
15 participated in any prior decisions related to the Appeal, nor is a subordinate of someone who has
16 participated in a prior decision and has clinical expertise in treating the Member's condition or
17 disease if deciding on any of the following:
18
19 1. An Appeal of a denial based on lack of Medical Necessity; and
20
21 2. Any Appeal involving clinical issues.
22
23 M. CalOptima shall ensure that at least one person reviewing the Appeal who is a practitioner in the
24 same or similar specialty.
25
26 N. Members shall exhaust CalOptima's Appeal process prior to requesting a State Hearing, in
27 accordance with CalOptima Policy HH.1108: State Hearing Process.
28
29 O. A Member may receive continuation of benefits while the pharmacy Appeal is pending resolution
30 if:
31
32 1. The Member files the pharmacy Appeal request within ten (10) calendar days of the mailing
33 date of the NOA;
34
35 2. The authorized Prescribing Practitioner orders the medication;
36
37 3. The pharmacy Appeal involves the termination, suspension, or reduction of a previously
38 authorized course of treatment;
39
40 4. The period covered by the original authorization has not expired; and
41
42 5. The Member verbally requests an extension of the benefits by calling the CalOptima Customer
43 Service Department.
44
45 P. CalOptima may extend the timeframe to resolve the Appeal by up to fourteen (14) calendar days at
46 the request of the Member or if there is a need for additional information and how the delay is in the
47 Member's best interest.
48
49 Q. For any extensions not requested by the Member, CalOptima must provide the Member with written
50 notice of the reason for the delay and the right to file a Grievance within two (2) calendar days from
51 the oral notification of the extension.
52

- 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. Telephone 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.

- 1 5. CalOptima shall ensure that the Member or Authorized Representative, is given a reasonable
2 opportunity to present, in writing or verbally, comments, documents or other information
3 relating to the pharmacy Appeal, including evidence, facts, and law in support of the pharmacy
4 Appeal. A Prescribing Practitioner may also contact a CalOptima physician, or a health care
5 professional reviewer, to discuss the NOA for modification, denial, termination, or carve out of
6 a service, or to obtain a copy of the criteria used to make the decision. In the case of a pharmacy
7 Appeal subject to expedited review, the CalOptima Customer Service Department or the
8 CalOptima Pharmacy Management Department shall inform the Member or Authorized
9 Representative of the limited time available to present evidence.
10
- 11 6. Upon request by the Member, Authorized Representative, or Prescribing Practitioner,
12 CalOptima shall provide the opportunity, before and during the Appeals process, to examine or
13 obtain a copy of the Member's case file, including medical records, and any other relevant
14 documents and records considered during the Appeals process, free of charge and sufficiently in
15 advance of the resolution timeframe for Appeal.
16
- 17 7. CalOptima shall provide written acknowledgement to the Member, dated and postmarked
18 within five (5) calendar days of the receipt of a standard Appeal request.
19
- 20 8. CalOptima shall process appeals based on the following timeframes:
21
 - 22 a. The decision for a pre-service Appeal and notification to the Prescribing Practitioner and
23 Member shall be made within thirty (30) calendar days of the initial receipt of the request.
24
 - 25 b. The decision for a post-service Appeal and notification to the Prescribing Practitioner and
26 Member shall be made within thirty (30) calendar days of the initial receipt of the request.
27
 - 28 c. The decision for an expedited appeal and notification to the Prescribing Practitioner and
29 Member shall be made within seventy-two (72) hours, or as soon as a Member's health
30 condition requires, after the receipt of the request.
31
 - 32 d. The plan may extend the Appeal timeframe for either standard or expedited Appeals by up
33 to fourteen (14) calendar days if either of these two (2) conditions apply:
34
 - 35 i. The Member requests the extension.
36
 - 37 ii. CalOptima demonstrates to the satisfaction of DHCS, upon request, that there is a need
38 for additional information and the delay is in the Member's best interest.
39
 - 40 e. For any extension not requested by the Member, CalOptima shall provide the Member with
41 written notice of the reason for the delay within two (2) calendar days and notify the
42 Member of the right to file a Grievance if the Member disagrees with the extension.
43
 - 44 f. CalOptima shall make reasonable efforts to provide the Member with oral notice of the
45 extension.
46
 - 47 g. CalOptima shall resolve the Appeal as expeditiously as the Member's health condition
48 requires, but in no event may extend resolution beyond the initial fourteen (14) calendar day
49 extension.
50

1 h. In the event that CalOptima fails to adhere to the notice and timing requirements of an
2 Appeal, the Member is deemed to have exhausted the CalOptima internal Appeal process
3 and may initiate a State Hearing request.
4

5 9. Members shall be notified of the Appeal decision by mail, unless the request is an expedited
6 Appeal, then CalOptima shall make reasonable efforts to provide oral notification to the
7 Member of the resolution. Prescribing Practitioners shall be notified of the Appeal decision by
8 fax and mail based on the notification standards as specified in the Pharmacy Prior
9 Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals
10 under the Pharmacy Benefit.
11

12 B. Pharmacy Appeal Processing
13

14 1. Upon receipt of a Pharmacy Appeal from a Member, the Member's Authorized Representative,
15 or Prescribing Practitioner, CalOptima's Pharmacy Management Department shall:
16

17 a. Acknowledge the receipt of a standard Appeal request to the Member, dated and
18 postmarked within five (5) calendar days of the receipt of the Appeal. The
19 Acknowledgement notice shall advise the Member that the Appeal has been received,
20 include the date of receipt, and provide the name, telephone number, and address of the
21 representative who may be contacted about the Appeal. The acknowledgement letter shall
22 include the nondiscrimination notice and the language assistance taglines.
23

24 b. Oral Appeals from Members, excluding expedited Appeals, shall be followed by a written,
25 signed Appeal. The date of the oral Appeal shall establish the filing date for the Appeal.
26 CalOptima shall provide the Member with an Appeal form along with the Member's written
27 acknowledgement notification. In the event that CalOptima does not receive a written,
28 signed Appeal from the member, CalOptima shall neither dismiss or delay the resolution of
29 the Appeal.
30

31 c. Review the initial Pharmacy decision and all documents related to the determination of
32 Medical Necessity of the service requested, including any additional information supplied
33 by the Member, the Member's Authorized Representative, or the Prescribing Practitioner.
34

35 d. Prepare the case file for review by a new health care professional reviewer who was not
36 involved in the initial decision, except if the decision is found fully in favor of the Member,
37 in which case the person making the initial decision may reverse the prior decision.
38

39 e. A CalOptima Clinical Pharmacist shall:
40

41 i. Fully investigate the content of the Appeal without giving deference to the previous
42 denial decision;
43

44 ii. Document the substance of the Appeal, including any aspects of clinical care involved;
45

46 iii. Document the findings of their Appeal review; and
47

48 iv. Document the reasons for the Appeal decision if upheld or overturned.
49

50 f. A CalOptima Clinical Pharmacist, or Medical Director, may reverse a denial decision and
51 overturn an Appeal. For Appeal requests that do not meet the CalOptima Clinical

1 Guidelines, the CalOptima Clinical Pharmacist shall send a recommendation to a Medical
2 Director to review for a potential appeal upheld decision.

3
4 g. CalOptima may utilize a specialist health care professional consultant in the same or similar
5 specialty that typically treats the Medical Condition, as appropriate.
6

7 2. CalOptima Pharmacy Management Department shall process an expedited Appeal as standard
8 Appeal timeframe, if the Appeal request does not meet the criteria for expedited review.
9

10 a. An expedited Appeal may be granted, if a standard Appeal timeframe:

11
12 i. Could seriously jeopardize the life, health or safety of the Member or others, due to the
13 Member's psychological state, or
14

15 ii. In the opinion of a practitioner with knowledge of the Member's medical or behavioral
16 condition, would subject the Member to adverse health consequences without the care
17 or treatment that is the subject of the request.
18

19 b. CalOptima's Pharmacy Management Department shall document and notify the Prescribing
20 Practitioner of the appeal status change to standard appeal.
21

22 3. Pharmacy Notice of Appeal Resolution (NAR)

23
24 a. The CalOptima Pharmacy Management Department shall mail the Member and the
25 Prescribing Practitioner a Notice of Appeal Resolution (NAR) for all Pharmaceutical
26 Services Appeal requests.
27

28 b. The NAR shall include information as described in this Section.
29

30 c. If CalOptima upholds a pharmacy decision for a Pharmaceutical Service based in whole or
31 in part on findings that the Pharmaceutical Service is not Medically Necessary or not a
32 Covered Service, the NAR shall clearly specify the applicable reference that excludes that
33 service along with the member's right to request for a State Hearing within one hundred
34 twenty (120) calendar days from the date of on the NAR.
35

36 d. The NAR shall include the following information:

37
38 i. The results of the resolution and the date it was completed.
39

40 ii. For denial determination based in whole or in part on medical necessity, CalOptima
41 shall include clear and concise reason reasons for the determination and clearly
42 reference the criteria, clinical guidelines, or medical policies on which the Appeal
43 decision is based.
44

45 iii. For determination in which the requested service is not a covered benefit, CalOptima
46 shall include the provision in the DHCS contract or Member Handbook that excludes
47 the service with the page where the provision is found and direct the Member to the
48 applicable section of the contract containing the provision, or provide a copy of the
49 provision and explain in clear and concise language how the exclusion applied to the
50 requested services.
51

- 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

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
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

14

IX. GLOSSARY

Term	Definition
Acknowledgement 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 <i>in loco parentis</i> 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: 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 requested service.
Notice of Action (NOA)	A NOA is a formal letter informing the Member and Prescriber 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: <ol style="list-style-type: none">1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member’s psychological state, or2. 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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DRAFT

[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]

MCAL MM-17-35_DHCS Approved 05.30.17_NAR Uphold (Pharmacy)

[Back to Agenda](#)

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]

APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier Number (provider as party)
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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

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
<p>Standard (Non-urgent) Preservice</p> <ul style="list-style-type: none"> - All necessary information received at time of initial request 	<p>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.</p>	<ul style="list-style-type: none"> - Practitioner: Within 2 business days of making the decision² (electronic and written notification) - Member: Within 2 business days of making the decision² (written notification)
<p>Standard (Non-urgent) Preservice - Extension Needed</p> <ul style="list-style-type: none"> - Additional clinical information required - Requires consultation by an Expert Reviewer - Additional examination or tests to be performed - [AKA: Deferral or Request for Information (RFI)] 	<ul style="list-style-type: none"> - 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 such². 	<ul style="list-style-type: none"> - Practitioner: Within 2 business days of making the decision², not to exceed 14 calendar days from the receipt of the request for service³ (electronic and written notification) - Member: Within 2 business days of making the decision², not to exceed 14 calendar days from the receipt of the request for service³ (written notification)
<p>Expedited (Urgent) Pre-Service</p> <ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: <ul style="list-style-type: none"> • 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 request⁴. 	<ul style="list-style-type: none"> - Practitioner: Within 2 business days of making the decision² (electronic and written notification) - Member: Within 2 business days of making the decision² (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
<p>Expedited (Urgent) Pre-Service - Extension Needed</p> <ul style="list-style-type: none"> - 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)] 	<ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: <ul style="list-style-type: none"> • 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 such². 	<ul style="list-style-type: none"> - Practitioner and Member: Within 2 business days of making the decision² (electronic and written notification) - Member: Within 2 business days of making the decision² (written notification)
<p>Concurrent review of treatment regimen already in place</p> <ul style="list-style-type: none"> - 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. 	<ul style="list-style-type: none"> - 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 hours². - 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 deny². 	<ul style="list-style-type: none"> - Practitioner: Within 24 hours of making the decision² (electronic and written notification) - Member: Within 24 hours of making the decision² (written notification)
<p>Post-Services / Retrospective Review</p>	<p>A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request^{2,4}.</p>	<ul style="list-style-type: none"> - 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 .	<ul style="list-style-type: none"> - Practitioner: Within 30 days of making the decision⁵ (electronic & written notification) - Member: Within 30 days of making the decision⁵ (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} .	<ul style="list-style-type: none"> - 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 request⁵. - Expedited (Urgent) Pre-Service request may be reclassified as Standard (Non-urgent) Preservice if the following definition for urgent request is not met: <ul style="list-style-type: none"> ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: <ul style="list-style-type: none"> • 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}. 	<ul style="list-style-type: none"> - Practitioner: Within 72 hours of making the decision⁵ (electronic & written notification) - Member: Within 72 hours of making the decision⁵ (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 .	<ul style="list-style-type: none"> - Practitioner: Within 30 days of making the decision⁵ (electronic & written notification) - Member: Within 30 days of making the decision⁵ (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: Policies 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~~

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I. PURPOSE

This policy establishes required access and availability standards for Members-
 to obtain

~~H. 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.~~

~~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.

~~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.~~
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		
<u>Description</u>	<u>Standard</u>	<u>Minimum Performance Level</u>
<u>Urgent appointments for services that DO require Prior Authorization</u>	<u>Available within ninety-six (96) hours of the request for appointment</u>	<u>90%</u>
<u>Non-Urgent Specialty Care (including Obstetrics/Gynecology Specialty Care): Appointments</u>	<u>Available within fifteen (15) business days of request for appointment</u>	<u>90%</u>
<u>First Prenatal Visit: Appointments for the first prenatal visit</u>	<u>Available within two (2) weeks of request for appointment</u>	<u>90%</u>
<u>Non-Urgent Ancillary Services: Appointments for non-urgent ancillary services for the diagnosis or treatment of illness, injury, or other health conditions</u>	<u>Available within fifteen (15) business days of request for appointment</u>	<u>90%</u>

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 <u>60%</u>
<u>Appointment for follow-up routine care with a physician behavioral health care provider</u>	<u>Members have a follow-up visit with a physician behavioral health care provider within thirty (30) calendar</u>	<u>60%</u>

	<u>days of initial visit for a specific condition</u>	
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2 4.5 Exceptions to Timeframes for Appointments
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- 4 a. The timeframe to obtain an appointment for the services described in Sections II.~~L~~J.1 through
5 II.~~L~~3-~~J~~4 of this policy may be extended if the referring or treating Provider, or the health care
6 professional providing Triage or Screening Services, acting within the scope of his or her
7 practice, and consistent with professionally recognized standards of practice, has determined
8 and documented in the Member’s record that a longer waiting time will not have a detrimental
9 impact on the Member’s health.
- 10 b. A Provider may offer an appointment for non-urgent Primary Care within the same or next
11 business day from the time the Member requests the appointment, and advance scheduling of an
12 appointment at a later date if the Member prefers not to accept the appointment offered within
13 the same or next business day.
- 14 c. Preventive care services and periodic follow-up care for the services described in Sections
15 II.~~L~~J.1 through II.~~L~~3-~~J4 of this policy may be scheduled in advance, consistent with
16 professionally recognized standards of practice, as determined by the treating Provider acting
17 within the scope of his or her practice.~~
- 18 d. Subsequent routine appointments: Appointments for subsequent routine appointments for
19 prenatal visits shall be available to a Member and shall be scheduled in advance in accordance
20 with applicable Department of Managed Health Care (DMHC) regulations governing timely
21 access to non-emergency health care services. All Medically Necessary services for pregnant
22 Members will be covered. The most current standards or guidelines of the American College of
23 Obstetricians and Gynecologists (ACOG) will be utilized as the minimum measure of quality
24 for perinatal services by CalOptima and its Health Networks.

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29 6. Rescheduling of Appointments: When it is necessary for a Provider or a Member to reschedule an
30 appointment, the appointment shall be promptly rescheduled in a manner appropriate for the
31 Member’s health care needs, and ensures continuity of care consistent with good professional
32 practice.
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34 K. In-office wait times shall not exceed forty-five (45) minutes before a Member is seen by a Provider.
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36 M.L. Certified Nurse-Midwife and Certified Nurse Practitioner Services: If Certified Nurse-Midwife
37 services, as described in CalOptima Policy GG.1713: Nurse-Midwife Practice Guidelines, ~~CalOptima~~
38 ~~Direct~~, or Certified Nurse Practitioner services are not available to a Member; a Member may self-refer
39 to an out-of-network Certified Nurse-Midwife or Certified Nurse Practitioner to receive such services.
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41 N.M. Sensitive Services: Sensitive Services shall be available to a Member within the CalOptima
42 Plan. A Member may self-refer to an out-of-network Provider to receive Sensitive Services, without
43 Prior Authorization, pursuant to CalOptima Policy GG.1508: Authorization and Processing of Referrals.
44

45 O.N. Minor Consent Services: Minor Consent Services shall be available to a Member under the age
46 of eighteen (18) in a confidential manner without parental consent, pursuant to CalOptima Policy
47 GG.1508: Authorization and Processing of Referrals.
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~~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-Physician 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:

<u>LTSS SERVICES</u>		
<u>Provider Type</u>	<u>Standard</u>	<u>Minimum Performance Level</u>
<u>Skilled Nursing Facility (SNF)</u>	<u>Available to a Member within five (5) business days after the date of the request</u>	<u>90%</u>
<u>Intermediate Care Facility / Developmentally Disabled (ICF-DD)</u>	<u>Available to a Member within five (5) business days after the date of the request</u>	<u>90%</u>

~~e.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 <u>Primary Care</u> (OB/GYN)	Obstetrics/Gynecologists to Members	1:2,000

b. Primary Care Practitioner (PCP) availability standards by geographic distribution:

<u>GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS</u>		
<u>Practitioner Type</u>	<u>Measure</u>	<u>Minimum Performance Level</u>
<u>Total Primary Care Practitioners (Adult and Pediatric)</u>	For each practitioner type, there shall be one practitioner within ten (10) miles or thirty (30) minutes of the Member's residence	100%
<u>General Practice/Family Practice</u>		
<u>Internal Medicine</u>		
<u>Pediatrics</u>		
<u>Obstetrics/Gynecology Primary Care (OB/GYN)</u>		

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 annuallySpecialty Care Providers: CalOptima shall identify high-volume specialistsspecialty providers by assessing the volume of claims and encounters by specialty type in a previous calendar year. SpecialtiesSpecialty care providers with the highest utilization shall be determined as a high-volume specialistspecialty care provider. (Obstetrics/gynecology specialistsspecialty care providers shall be categorized as a PCP and a high-volume specialistsspecialty care providers, in accordance with industry standards.)

b.—High volume specialists availability standards by geographic distribution:

<u>GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS</u>		
<u>Practitioner Type</u>	<u>Standard</u>	<u>Minimum Performance Level</u>
<u>Obstetrics/Gynecology (OB/GYN):</u>	<u>One Obstetrics/Gynecologist within thirty (30) miles or forty five (45) minutes of the Member's residence</u>	<u>90%</u>
<u>Cardiology</u>	<u>One Cardiologist within thirty (30) miles or forty five (45) minutes of the Member's residence</u>	<u>90%</u>
<u>Hematology/Oncology</u>	<u>One Hematologist/Oncologist within thirty (30) miles or forty five (45) minutes of the Member's residence</u>	<u>90%</u>

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%

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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

e.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 <u>Specialty Care</u> (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
<u>Psychiatry</u>	<u>Psychiatrists to Members</u>	<u>1:10,000</u>
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

<u>Practitioner Type</u>	<u>High Volume</u>	<u>High Impact</u>	<u>DHCS Core</u>	<u>Standard</u>	<u>Minimum Performance Level</u>
<u>Obstetrics/Gynecology Specialty Care (OB/GYN):</u>	<u>X</u>		<u>X</u>	For each practitioner type, there shall be one Practitioner within fifteen (15) miles or thirty (30) minutes of the Member's residence	100%
<u>Cardiology/Interventional Cardiology</u>	<u>X</u>		<u>X</u>		
<u>Dermatology</u>			<u>X</u>		
<u>Endocrinology</u>		<u>X</u>	<u>X</u>		
<u>ENT/Otolaryngology</u>			<u>X</u>		
<u>Gastroenterology</u>	<u>X</u>		<u>X</u>		
<u>General Surgery</u>	<u>X</u>		<u>X</u>		
<u>Hematology</u>		<u>X</u>	<u>X</u>		
<u>HIV/AIDS Specialist/Infectious Diseases</u>			<u>X</u>		
<u>Nephrology</u>	<u>X</u>	<u>X</u>	<u>X</u>		
<u>Neurology</u>	<u>X</u>		<u>X</u>		
<u>Oncology</u>	<u>X</u>	<u>X</u>	<u>X</u>		
<u>Ophthalmology</u>	<u>X</u>		<u>X</u>		
<u>Orthopedic Surgery</u>	<u>X</u>		<u>X</u>		
<u>Physical Medicine and Rehabilitation</u>			<u>X</u>		
<u>Psychiatry</u>	<u>X</u>		<u>X</u>		
<u>Pulmonology</u>	<u>X</u>		<u>X</u>		

<u>Practitioner Type</u>	<u>Measure</u>	<u>Minimum Performance Level</u>
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 identify 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		
<u>Practitioner Type</u>	<u>Measure</u>	<u>Minimum Performance Level</u>
<u>Psychologist</u>	<u>For each provider type, there shall be one provider within fifteen (15) miles or thirty (30) minutes of the Member’s residence</u>	<u>100%</u>
<u>Licensed Clinical Social Worker</u>		
<u>Marriage and Family Therapist</u>		

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.

1 iii. If a recorded message answers, it shall include the following: “If you feel that this is an
2 emergency, hang up and dial nine-one-one (911) or go to the nearest emergency room.”
3

4 ~~U.T.~~ Cultural and Linguistic Services: Shall be provided, in accordance with CalOptima Policy
5 DD.2002: Cultural and Linguistic Services:
6

7 1. Interpreter services:
8

- 9 a. Oral interpreter services shall be made available to a Member in person, upon the Member’s
10 request, or by telephone at key points of contact, twenty-four (24) hours a day, seven (7) days a
11 week, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.
12
13 b. Interpreter services shall be coordinated with scheduled appointments for health care services,
14 whenever possible, to ensure the provision of interpreter services at the time of appointment.
15

16 2. Written Materials: All written materials shall be made available to Members in Threshold
17 Languages, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.
18

19 3. Alternative Forms of Communication:
20

- 21 a. For a Member with a visual impairment, CalOptima and its Health Networks shall make
22 informational or educational materials available at no cost in Threshold Languages in at least
23 fourteen (14) point size font, audio format, or Braille upon request or as needed within twenty-
24 one (21) days upon receipt of request or within a timely manner that is appropriate for the
25 format requested. CalOptima and its Health Networks shall inform Members of the availability
26 of these materials through the Member Handbook/EOC booklet and other mechanisms,
27 including, but not limited to, posters and flyers distributed at sites where Members receive
28 Covered Services and at Member orientation sessions.
29
30 b. Telecommunication Device for the Deaf (TDD): TDD shall be made available to a Member,
31 upon request, at no cost to the Member.
32

33 ~~4.A. In office wait times shall not exceed forty five (45) minutes before a Member is seen by a~~
34 ~~Provider.~~
35

36 ~~5. Rescheduling of Appointments: When it is necessary for a Provider or a Member to reschedule~~
37 ~~an appointment, the Provider shall promptly reschedule the appointment in a manner~~
38 ~~appropriate to the Member’s health care needs, and that ensures continuity of care consistent~~
39 ~~with good professional practice.~~
40

41 **III. PROCEDURE**
42

43 A. CalOptima shall analyze performance of CalOptima’s and Health Networks’ access and availability
44 against the standards set forth in this policy.
45

46 1. CalOptima shall annually conduct the following:
47

- 48 a. Provider Access Survey (appointment availability and access during and after business
49 hours);
50

- 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.

1 k. Evaluate the effectiveness of interventions for improving access to non-behavioral and
2 behavioral health care services.

3
4 4. CalOptima shall annually develop the following:

- 5
6 a. Accessibility analysis (appointment availability and access during and after business hours)
7 report;
8
9 b. Availability analysis (provider/member ratio and GeoAccess) report;

10
11 B. CalOptima shall submit a complete and accurate Annual Network Certification using the reporting
12 template provided by DHCS that reflects the entire contracted provider network, including providers
13 who serve the needs of children and youth with CCS-Eligible Conditions as part of the CCS
14 Program/Whole Child Model, and all required supporting documentation to DHCS no later than one
15 hundred five (105) calendar days before the contract year begins (or the next business day if the due
16 date occurs on a weekend or holiday), in accordance with DHCS All Plan Letter (APL) 18-005:
17 Network Certification Requirements.

18
19 1. CCS/Whole Child Model Network Certification: In addition to the Annual Network
20 Certification as described in Section III.B, CalOptima shall submit:

21
22 a. Updated policies and procedures, as required by DHCS.

23
24 b. An updated provider network template to ensure the network of providers meets network
25 adequacy standards.

26
27 2. If CalOptima is unable to meet time and distance standards, an Alternative Access Standard
28 (AAS) request shall be submitted to DHCS no later than one hundred five (105) calendar days
29 prior to the beginning of every contract year and a Corrective Action Plan (CAP) may be issued.

30
31 3. If a Corrective Action Plan is issued to CalOptima by DHCS, CalOptima shall allow Members
32 to access Medi-Cal services out-of-network if the services are not available in-network.

33
34 B.C. CalOptima shall provide the Health Networks and the Member Experience Sub-Committee with
35 access and availability reports of CalOptima and Health Networks' performance. These reports shall
36 include CalOptima's assessment results against the access and availability standards set forth in this
37 policy.

38
39 C.D. If the Member Experience Sub-committee identifies deficiencies or non-compliance, the Chair
40 of the Member Experience Sub-Committee, or Designee, may take the following steps:

41
42 1. Request that a Health Network submit a Quality Improvement Plan or Plan-Do-Study-Act
43 (PDSA) cycle(s) for performance measures that are deemed deficient or non-compliant.

44
45 2. Submit a Request for Compliance Action (RCA) to the Office of Compliance to request
46 corrective action. Such corrective action may include the issuance of a request for a Corrective
47 Action Plan (CAP) and/or the imposition of Sanctions, in accordance with CalOptima Policies
48 HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions, respectively; and
49

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

- 1 P. CalOptima Policy GG.1619: Delegation Oversight
- 2 Q. CalOptima Policy HH.2002Δ: Sanctions
- 3 R. CalOptima Policy HH.2003: Health Network Reporting
- 4 S. CalOptima Policy HH.2005Δ: Corrective Action Plan
- 5 T. CalOptima Operational Audit Tool
- 6 U. CalOptima Quality Improvement Plan
- 7 V. DHCS Medi-Cal Managed Care Division (MMCD) Policy Letter 99-007: Individual Health
- 8 Education Behavior Assessment
- 9 W. DHCS MMCD Policy Letter 08-003: Initial Comprehensive Health Assessment
- 10 X. DHCS All Plan Letter (APL) 18-005: Network Certification Requirements
- 11 Y. DCHS All Plan Letter (APL) 18-011: California Children’s Services Whole Child Model Program
- 12 ~~X-Z.~~ National Committee of Quality Assurance (NCQA) standards
- 13 ~~Y-AA.~~ Health and Safety Code §1374.73
- 14 ~~Z-BB.~~ Title 28, California Code of Regulations, §§1300.51(H), 1300.67.2, 1300.67.2.2
- 15 ~~AA-CC.~~ Title 28, Code of Federal Regulations, Part 36
- 16 ~~BB-DD.~~ Title 29, United States Code, §794 (Section 504 of the Rehabilitation Act of 1973)
- 17 ~~CC-EE.~~ Title 42, United States Code, §2000d
- 18 ~~DD-FF.~~ Title 45, Code of Federal Regulations, Part 80, Part 84, and Part 91
- 19 ~~EE-GG.~~ Title VI of the Civil Rights Act of 1964
- 20 ~~FF-HH.~~ Title IX of the Education Amendments of 1973

21

22 **VI. REGULATORY AGENCY APPROVALS**

- 23
- 24 A. 11/13/15: Department of Health Care Services
- 25 B. 06/03/15: Department of Health Care Services
- 26 C. 08/28/14: Department of Health Care Services
- 27 D. 03/21/11: Department of Health Care Services
- 28 E. 12/24/09: Department of Health Care Services

29

30 **VII. BOARD ACTIONS**

- 31
- 32 A. ~~None to Date~~09/06/18: Regular Meeting of the CalOptima Board of Directors
- 33

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2
3

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
<u>Revised</u>	<u>09/06/2018</u>	<u>GG.1600</u>	<u>Access and Availability Standards</u>	<u>Medi-Cal</u>

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5

1 IX. GLOSSARY
 2

Term	Definition
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
<u>Alternative Access Standard (AAS)</u>	<u>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.</u>
Behavioral Health Care	Evaluation and treatment of psychological and substance abuse disorders <u>including specialty mental health services</u> . 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 <u>includes a variety of environmental modification using behavioral stimuli and consequences to produce socially significant improvement</u> <u>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</u> <u>the home and in other community settings.</u>
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. <u>A Qualified Autism Services (QAS) Provider, Professional, or Paraprofessional, as defined with the State Plan Amendment.</u>
<u>California Children’s Services (CCS) Program</u>	<u>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.</u>
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 notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Cultural and Linguistic (C&L) Services	<p>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:</p> <ol style="list-style-type: none"> 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	<p>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:</p> <ol style="list-style-type: none"> 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.
<u>Federally Qualified Health Center (FQHC)</u>	<u>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.</u>
<u>Free Standing Birth Center</u>	<u>Defined by Title 42, United States Code, Section 1396d(I)(3)(B) as a health facility-</u> <ol style="list-style-type: none"> <u>1. That is not a hospital;</u> <u>2. Where childbirth is planned to occur away from a pregnant woman's residence;</u> <u>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</u> <u>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.</u>
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 <u>that</u> 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 <u>or eligible for the Whole Child Model</u> , “Primary Care Practitioner” or “PCP” shall additionally mean any Specialist Physician <u>Specialty Care Provider</u> 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 <u>or Whole Child Model</u> beneficiaries, a PCP may also be a specialist <u>specialty care provider</u> 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.
<u>Provider Network</u>	<u>For purposes of this Policy, the providers with which an organization contracts or makes arrangements to furnish covered health care services to their members.</u>
Qualified Autism Service Paraprofessional	An unlicensed and uncertified individual <u>who is</u> employed and supervised by a Qualified Autism Service <u>QAS</u> 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
<p>Qualified Autism Service <u>Provider</u><u>Professional</u></p>	<p>Either of the following:</p> <p>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.</p> <p>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.</p>
<p><u>Qualified Autism Service Provider</u></p>	<p><u>A licensed practitioner or Board Certified Behavior Analyst (BCBA).</u></p>
<p>Qualified Family Planning Practitioner</p>	<p>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.</p>
<p>Routine Care</p>	<p>Covered Services that are not urgent in nature and may be pre-planned or scheduled in advance.</p>
<p>Routine Physical Exams</p>	<p>A well-care visit that usually emphasizes priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.</p>
<p><u>Rural Health Clinic</u></p>	<p><u>An entity defined in Title 22 CCR Section 51115.5</u></p>
<p>Sanctions</p>	<p>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.</p>
<p>Sensitive Services</p>	<p>Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.</p>
<p>Service Area</p>	<p>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.</p>

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_____

Effective Date: 12/01/99

Last Review Date: 09/06/18

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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.

- 1 H. CalOptima and its Health Networks shall ensure that contracting Providers offer CalOptima Members
 2 hours of operation that are no less than the hours of operation offered to commercial members or
 3 comparable to Medi-Cal Fee-For-Service, if the Provider services only Medi-Cal Members.
 4
- 5 I. Emergency Services: Emergency services shall be available immediately to a Member twenty-four (24)
 6 hours a day, seven (7) days a week.
 7
- 8 1. CalOptima and its Health Networks shall cover emergency medical services without prior
 9 authorizations.
 10
- 11 2. CalOptima shall have a designated emergency service facility within the Service Area, providing
 12 care twenty-four (24) hours a day, seven (7) days a week. This designated emergency service
 13 facility will have one (1) or more physicians and one (1) nurse on duty in the facility at all times.
 14
- 15 3. CalOptima and its Health Networks shall provide adequate follow-up care for those Members who
 16 have been screened in the Emergency Room in accordance with CalOptima Policy GG.1122:
 17 Follow-up for Emergency Department Care.
 18
- 19 4. CalOptima and its Health Networks shall ensure that a Physician is available twenty-four (24) hours
 20 a day, seven (7) days a week, to authorize Medically Necessary post-stabilization care, to coordinate
 21 the transfer of stabilized Members in an emergency department, and for general communication
 22 with emergency room personnel, if necessary, in accordance with CalOptima Policy GG.1508:
 23 Authorization and Processing of Referrals.
 24
- 25 J. CalOptima and its Health Networks shall ensure that Members have effective and appropriate access to
 26 Covered Services in a timely manner, in accordance with the standards of this policy. CalOptima shall
 27 evaluate CalOptima’s and Health Network’s compliance with the appointment access standards against
 28 a minimum performance threshold of ninety percent (90%), unless otherwise indicated.
 29
- 30 1. Urgent Care Services: Available within twenty-four (24) hours of the request for an appointment.
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- 32 2. Primary Care Appointments:
 33
- 34 a. Monitoring of primary care appointments shall include the monitoring of all primary care
 35 practitioners (PCPs) in CalOptima’s provider network.
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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%
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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%

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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

1 Practitioner services are not available to a Member; a Member may self-refer to an out-of-network
2 Certified Nurse-Midwife or Certified Nurse Practitioner to receive such services.
3

4 M. Sensitive Services: Sensitive Services shall be available to a Member within the CalOptima Plan. A
5 Member may self-refer to an out-of-network Provider to receive Sensitive Services, without Prior
6 Authorization, pursuant to CalOptima Policy GG.1508: Authorization and Processing of Referrals.
7

8 N. Minor Consent Services: Minor Consent Services shall be available to a Member under the age of
9 eighteen (18) in a confidential manner without parental consent, pursuant to CalOptima Policy
10 GG.1508: Authorization and Processing of Referrals.
11

12 O. Family Planning Services: Family Planning Services shall be available to a Member, pursuant to
13 CalOptima Policy GG.1118: Family Planning Services, Out-of-Network. A Member may self-refer to
14 any Qualified Family Planning Practitioner, including an out-of-network practitioner to receive Family
15 Planning Services.
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17 P. Behavioral Health Care: Behavioral Health Care Services shall be available to a Member, pursuant to
18 CalOptima Policy GG.1900: Behavioral Health Services.
19

20 Q. Behavioral Health Treatment (BHT): BHT services shall be available to a Member pursuant to guidance
21 provided by the Department of Health Care Services (DHCS), by a State Plan-approved provider, and in
22 accordance with the requirements for access to specialty care services as indicated in CalOptima Policy
23 GG.1548:Authorization for Applied Behavioral Health Analysis for Autism Spectrum Disorder.
24

25 R. Provider Availability: CalOptima and its Health Networks shall maintain a provider network adequate
26 to serve one hundred percent (100%) of all eligible Members in the Service Area.
27

- 28 1. CalOptima shall take into consideration the geographic location of Providers and Members
29 accounting for distance, travel time, and mode of transportation when evaluating adequate access to
30 Covered Services.
31
- 32 2. CalOptima shall take into consideration Members and Providers language and gender when
33 evaluating adequate access to Covered Services.
34
- 35 3. CalOptima shall take into consideration the number of Providers who are not accepting new patients
36 when evaluating adequate access to Covered Services.
37
- 38 4. CalOptima shall take into consideration the anticipated Member enrollment numbers when
39 evaluating adequate access to Covered Services.
40
- 41 5. CalOptima total physician availability standard: Ratio of total physicians to Members shall not be
42 less than 1:1,200.
43
- 44 a. If Non-Physician Medical Practitioners are included in CalOptima's provider network, each
45 individual Non-Physician Medical Practitioners shall not exceed a full-time equivalent network
46 provider/patient caseload of one (1) network provider per one thousand (1,000) patients.
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- 48 6. CalOptima shall ensure full-time equivalent Physician Supervisor to Non-Physician Medical
49 Practitioner ratios do not exceed the following:
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- 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.

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- 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

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- 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	For each provider type, there shall be one provider within fifteen (15) miles or thirty (30) minutes of the Member’s residence	100%
Licensed Clinical Social Worker		
Marriage and Family Therapist		

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

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- 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 Triage 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.

- 1 ii. If live after-hours attendant answers and the call is an emergency, the attendant shall refer
- 2 the Member to nine-one-one (911) emergency services or instruct the Member to go to the
- 3 nearest emergency room.
- 4
- 5 iii. If a recorded message answers, it shall include the following: “If you feel that this is an
- 6 emergency, hang up and dial nine-one-one (911) or go to the nearest emergency room.”
- 7

8 T. Cultural and Linguistic Services: Shall be provided, in accordance with CalOptima Policy DD.2002:
9 Cultural and Linguistic Services:

10 1. Interpreter services:

- 11 a. Oral interpreter services shall be made available to a Member in person, upon the Member’s
- 12 request, or by telephone at key points of contact, twenty-four (24) hours a day, seven (7) days a
- 13 week, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.
- 14
- 15 b. Interpreter services shall be coordinated with scheduled appointments for health care services,
- 16 whenever possible, to ensure the provision of interpreter services at the time of appointment.
- 17
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20 2. Written Materials: All written materials shall be made available to Members in Threshold
21 Languages, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

22 3. Alternative Forms of Communication:

- 23 a. For a Member with a visual impairment, CalOptima and its Health Networks shall make
- 24 informational or educational materials available at no cost in Threshold Languages in at least
- 25 fourteen (14) point size font, audio format, or Braille upon request or as needed within twenty-
- 26 one (21) days upon receipt of request or within a timely manner that is appropriate for the
- 27 format requested. CalOptima and its Health Networks shall inform Members of the availability
- 28 of these materials through the Member Handbook/EOC booklet and other mechanisms,
- 29 including, but not limited to, posters and flyers distributed at sites where Members receive
- 30 Covered Services and at Member orientation sessions.
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- 32 b. Telecommunication Device for the Deaf (TDD): TDD shall be made available to a Member,
- 33 upon request, at no cost to the Member.
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37 **III. PROCEDURE**

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39 A. CalOptima shall analyze performance of CalOptima’s and Health Networks’ access and availability
40 against the standards set forth in this policy.

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42 1. CalOptima shall annually conduct the following:

- 43 a. Provider Access Survey (appointment availability and access during and after business
- 44 hours);
- 45
- 46 b. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys; and
- 47
- 48 c. Primary Care Physician Satisfaction Survey.
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- 1 2. CalOptima shall monitor and/or run reports quarterly for the following:
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 - 3 a. Grievances and appeals data;
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 - 5 b. Availability (provider/member ratio and Geoaccess) data;
 - 6
 - 7 c. Encounter/claims data; and
 - 8
 - 9 d. Potential Quality Issues (PQI).
- 10
- 11 3. CalOptima shall monitor a CalOptima's and Health Networks' access and availability as
- 12 follows:
 - 13
 - 14 a. Track and review access and availability, in accordance with this policy;
 - 15
 - 16 b. Monitor a Health Network's quarterly reporting of Initial Health Assessment (IHA) and
 - 17 Individual Health Education Behavioral Assessment (IHEBA) activity;
 - 18
 - 19 c. Monitor and analyze telephone wait times through quarterly reports from the call center;
 - 20
 - 21 d. Monitor telephone access for call abandonment rates;
 - 22
 - 23 e. Monitor Behavioral Health reports on access and availability of contracted Behavioral
 - 24 Health providers.
 - 25
 - 26 f. Review quarterly reports on Grievances and Complaints related to access;
 - 27
 - 28 g. Review information obtained through Member and Provider surveys conducted on an
 - 29 annual basis related to access;
 - 30
 - 31 h. Review and monitor Triage and Screening Services;
 - 32
 - 33 i. Report access and availability performance against the standards set forth in this policy to
 - 34 the Member Experience Sub-Committee on an annual basis
 - 35
 - 36 j. Analyze and report results of audit and review activities in order to:
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 - 38 i. Prioritize opportunities for improvement identified from analyses.
 - 39
 - 40 ii. Implement interventions on at least one (1) area of opportunity (if applicable) for the
 - 41 following areas:
 - 42
 - 43 (a) Non-behavioral health care services and;
 - 44
 - 45 (b) Behavioral health care services.
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 - 48 k. Evaluate the effectiveness of interventions for improving access to non-behavioral and
 - 49 behavioral health care services.
- 50 4. CalOptima shall annually develop the following:

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- 2 a. Accessibility analysis (appointment availability and access during and after business hours)
- 3 report;
- 4
- 5 b. Availability analysis (provider/member ratio and GeoAccess) report;
- 6
- 7 B. CalOptima shall submit a complete and accurate Annual Network Certification using the reporting
- 8 template provided by DHCS that reflects the entire contracted provider network, including providers
- 9 who serve the needs of children and youth with CCS-Eligible Conditions as part of the CCS
- 10 Program/Whole Child Model, and all required supporting documentation to DHCS no later than one
- 11 hundred five (105) calendar days before the contract year begins (or the next business day if the due
- 12 date occurs on a weekend or holiday), in accordance with DHCS All Plan Letter (APL) 18-005:
- 13 Network Certification Requirements.
- 14
- 15 1. CCS/Whole Child Model Network Certification: In addition to the Annual Network
- 16 Certification as described in Section III.B, CalOptima shall submit:
- 17
- 18 a. Updated policies and procedures, as required by DHCS.
- 19
- 20 b. An updated provider network template to ensure the network of providers meets network
- 21 adequacy standards.
- 22
- 23 2. If CalOptima is unable to meet time and distance standards, an Alternative Access Standard
- 24 (AAS) request shall be submitted to DHCS no later than one hundred five (105) calendar days
- 25 prior to the beginning of every contract year and a Corrective Action Plan (CAP) may be issued.
- 26
- 27 3. If a Corrective Action Plan is issued to CalOptima by DHCS, CalOptima shall allow Members
- 28 to access Medi-Cal services out-of-network if the services are not available in-network.
- 29
- 30 C. CalOptima shall provide the Health Networks and the Member Experience Sub-Committee with
- 31 access and availability reports of CalOptima and Health Networks' performance. These reports shall
- 32 include CalOptima's assessment results against the access and availability standards set forth in this
- 33 policy.
- 34
- 35 D. If the Member Experience Sub-committee identifies deficiencies or non-compliance, the Chair of
- 36 the Member Experience Sub-Committee, or Designee, may take the following steps:
- 37
- 38 1. Request that a Health Network submit a Quality Improvement Plan or Plan-Do-Study-Act
- 39 (PDSA) cycle(s) for performance measures that are deemed deficient or non-compliant.
- 40
- 41 2. Submit a Request for Compliance Action (RCA) to the Office of Compliance to request
- 42 corrective action. Such corrective action may include the issuance of a request for a Corrective
- 43 Action Plan (CAP) and/or the imposition of Sanctions, in accordance with CalOptima Policies
- 44 HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions, respectively; and
- 45
- 46 3. Report the deficiencies or non-compliance to the Audit and Oversight Committee (AOC) and
- 47 Compliance Committee, as appropriate.
- 48
- 49 E. Health Networks shall submit a Quality Improvement Plan or PDSA, if requested. If a CAP is
- 50 issued:

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- 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

- 1 V. DHCS Medi-Cal Managed Care Division (MMCD) Policy Letter 99-007: Individual Health
- 2 Education Behavior Assessment
- 3 W. DHCS MMCD Policy Letter 08-003: Initial Comprehensive Health Assessment
- 4 X. DHCS All Plan Letter (APL) 18-005: Network Certification Requirements
- 5 Y. DCHS All Plan Letter (APL) 18-011: California Children’s Services Whole Child Model Program
- 6 Z. National Committee of Quality Assurance (NCQA) standards
- 7 AA. Health and Safety Code §1374.73
- 8 BB. Title 28, California Code of Regulations, §§1300.51(H), 1300.67.2, 1300.67.2.2
- 9 CC. Title 28, Code of Federal Regulations, Part 36
- 10 DD. Title 29, United States Code, §794 (Section 504 of the Rehabilitation Act of 1973)
- 11 EE. Title 42, United States Code, §2000d
- 12 FF. Title 45, Code of Federal Regulations, Part 80, Part 84, and Part 91
- 13 GG. Title VI of the Civil Rights Act of 1964
- 14 HH. Title IX of the Education Amendments of 1973

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 16 **VI. REGULATORY AGENCY APPROVALS**

- 17 A. 11/13/15: Department of Health Care Services
- 18 B. 06/03/15: Department of Health Care Services
- 19 C. 08/28/14: Department of Health Care Services
- 20 D. 03/21/11: Department of Health Care Services
- 21 E. 12/24/09: Department of Health Care Services

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 24 **VII. BOARD ACTIONS**

- 25 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors

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 28 **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

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1 IX. GLOSSARY
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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	<p>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:</p> <ol style="list-style-type: none"> 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	<p>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:</p> <ol style="list-style-type: none"> 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- <ol style="list-style-type: none"> 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.

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

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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;

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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

1 California and Office of Inspector General (OIG) exclusion, or suspension, list in accordance with
2 CalOptima Policy GG.1607A: Monitoring Adverse Activities.

- 3
- 4 L. If CalOptima declines to include a Practitioner in the CalOptima network, CalOptima shall notify,
5 in writing, such Practitioner within thirty (30) calendar days of the reason for its decision.
6
- 7 M. CalOptima shall not discriminate, in terms of participation, reimbursement, or indemnification,
8 against any Practitioner who is acting within the scope of his or her license, certification, or
9 registration under federal and state law, solely on the basis of the license, or certification. This
10 prohibition shall not preclude CalOptima from:
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- 12 1. Refusing to grant participation to a Practitioner in excess of the number necessary to meet the
13 needs of Members;
 - 14 2. Using different reimbursement amounts for different specialties, or for different Practitioners in
15 the same specialty; and
 - 16 3. Implementing measures designed to maintain quality and control costs consistent with
17 CalOptima's responsibilities.
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- 21 N. CalOptima shall not discriminate against a Practitioner that serves high-risk populations, or
22 specializes in the treatment of costly conditions.
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- 24 O. CalOptima shall not make, or decline, Credentialing and Recredentialing decisions based on a
25 Practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of
26 procedure, or patient, in which the Practitioner specializes.
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- 28 P. CalOptima shall monitor and prevent discriminatory Credentialing decisions as follows:
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- 30 1. Periodic audits of Credentialing files (in-process, denied, and approved files) to ensure
31 Practitioners are not discriminated against at least annually;
 - 32 2. Periodic audits of Practitioner complaints to determine if there are complaints alleging
33 discrimination, including a review by the CPRC of quarterly reports of complaints, including
34 discrimination at least annually;
 - 35 3. Maintaining a heterogeneous Credentialing committee membership; and
36
 - 37 4. Requiring those responsible for Credentialing and Recredentialing decisions to sign a statement
38 affirming that they do not discriminate when making decisions.
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- 42 Q. CalOptima shall maintain the confidentiality of Credentialing files, in accordance with CalOptima
43 Policy GG.1604A: Confidentiality of Credentialing Files.
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- 45 R. CalOptima shall maintain Credentialing files that include documentation of required elements, as
46 described in this Policy.
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- 48 S. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date
49 of licensure verification.
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1 1. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from
2 the date of licensure verification for any Practitioner, during the Practitioner’s Credentialing, or
3 Recredentialing process, the application shall be considered expired.
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5 T. Except as provided in CalOptima Policy GG.1608Δ: Full Scope Site Reviews, CalOptima does not
6 delegate the Facility Site Review and Medical Record Review (MRR) processes to a Health
7 Network. CalOptima assumes all authority, responsibility, and coordination of FSRs, MRRs, and
8 Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to
9 incorporate the documents to support review prior to Credentialing decisions.

10 U. On an annual basis, the CalOptima Board of Directors shall review and approve this Policy.
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13 **III. PROCEDURE**

14 A. Practitioner Initial Credentialing

- 15 1. In conjunction with the CalOptima Provider Relations and Contracting Departments, a
16 Practitioner shall initiate the Credentialing process with CalOptima.
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18 a. Upon receipt of the request from the Practitioner, CalOptima shall send a notification
19 electronically, explaining the expectations for completion and submission of the
20 credentialing application and required documents.
21
22 b. Physician Practitioners shall meet the Minimum Physician Standards as outlined in
23 CalOptima Policy GG.1643Δ: Minimum Physician Standards and CalOptima will verify
24 that the Physician Practitioner meets the minimum standards as provided in this Policy.
25
26 c. Practitioners shall submit a current, signed, and dated application with attestation to
27 CalOptima that attests to:
28
29 i. Any work history gap that exceeds six (6) months, including written clarification;
30
31 ii. The essential functions of the position that the Practitioner cannot perform, with or
32 without accommodation (i.e., health status);
33
34 iii. Lack of present illegal drug use that impairs current ability to practice;
35
36 iv. History of any loss of license and history of felony convictions;
37
38 v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;
39
40 vi. Current malpractice insurance coverage; and
41
42 vii. The correctness and completeness of the application;
43
44 d. All credentialing applications shall be signed. Faxed, digital, electronic, scanned, or
45 photocopied signatures are acceptable; however, signature stamps are not acceptable.
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47 e. A Practitioner shall ensure that all information included in a Credentialing application is no
48 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.1633A: Board Certification Requirements for Physicians; and
 - ~~e.~~ 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.1608A: 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.

~~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.1608A: 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

1 verification time limit. If the reinstatement would be more than thirty (30) calendar days after
2 termination, CalOptima must perform initial credentialing of such Practitioner.
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4 C. Practitioner Rights
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6 1. New applicants for Credentialing will receive Practitioner Rights attached to the CPPA as
7 Addendum A, describing the following:
8

9 a. Right to review information
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11 i. Practitioners will be notified of their right to review information CalOptima has
12 obtained to evaluate their credentialing application, attestation, or curriculum vitae.
13 This includes non-privileged information obtained from any outside source (e.g.,
14 malpractice insurance carriers, state licensing boards), but does not extend to review of
15 information, references, or recommendations protected by law from disclosure.
16

17 b. Right to correct erroneous information
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19 i. All Practitioners will be notified by certified mail when Credentialing information
20 obtained from other sources varies substantially from that provided by the Practitioner;
21

22 ii. All Practitioners have the right to correct erroneous information, as follows:
23

24 a) The Practitioner has forty-eight (48) hours, excluding weekends, from date of
25 notification to correct erroneous information;
26

27 b) Requests for correction of erroneous information must be submitted by certified
28 mail on the Practitioner's letterhead with a detailed explanation regarding erroneous
29 information, as well as copy(ies) of corrected information; and
30

31 c) All submissions will be mailed to CalOptima's Quality Improvement Department
32 using the following address:
33

34 Attention: Quality Improvement Department – Credentialing
35 CalOptima
36 505 City Parkway West
37 Orange, CA 92868
38

39 iii. CalOptima is not required to reveal the source of information, if the information is not
40 obtained to meet CalOptima's Credentialing verification requirements, or if federal or
41 state law prohibits disclosure.
42

43 2. Documentation of receipt of corrections
44

45 a. A Practitioner shall be notified within thirty (30) calendar days via a letter to document
46 CalOptima's receipt of the identified erroneous information.
47

48 3. Right to be notified of application status
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50 a. Practitioners may receive the status of their Credentialing, or Recredentialing, application,
51 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.

1 4. The CPRC shall make recommendations based on the Practitioners' ability to deliver care based
2 on the Credentialing information collected from the file review process, and shall be verified
3 prior to making a Credentialing decision.
4

5 a. The Quality Improvement Department shall send the Practitioner a decision letter, within
6 thirty (30) calendar days of the decision:
7

8 i. Acceptance;
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10 ii. Acceptance with Restrictions along with appeal rights information, in accordance with
11 CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners; or
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13 iii. Denial of the application along with appeal rights information, in accordance with
14 CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, with a letter of
15 explanation forwarded to the applicant.
16

17 b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from
18 the date of licensure verification.
19

20 i. If CalOptima is unable to render a decision within one hundred eighty (180) calendar
21 days from the date of licensure verification for any Practitioner, during the
22 Practitioner's Credentialing, or Recredentialing process, the application shall be
23 considered expired.
24

25 E. CalOptima shall monitor and prevent discriminatory practices, to include, but not be limited to:
26

27 a. Monitoring:
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29 i. CalOptima shall conduct periodic audits of Credentialing files (in-process, denied, and
30 approved files) to ensure that Practitioners are not discriminated against; and
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32 ii. Review Practitioner complaints to determine if there are complaints alleging
33 discrimination.
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35 iii. On a quarterly basis, the QI Department shall review grievances, appeals, and potential
36 quality of care issues for complaints alleging discrimination, and will report outcomes
37 to the CPRC for review and determination.
38

39 b. Prevention:
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41 i. The QI Department shall maintain a heterogeneous Credentialing committee, and will
42 require those responsible for Credentialing decisions to sign a statement affirming that
43 they do not discriminate.
44

45 F. Upon acceptance of the Credentialing application, the CalOptima Quality Improvement Department
46 shall generate a Provider profile and forward the Provider profile to the Contracting and Provider
47 Data Management Service (PDMS) Departments. This provider profile shall be generated from the
48 credentialing database to ensure that the information is consistent with data verified during the
49 Credentialing process (i.e. education, training, board certification and specialty). The PDMS
50 Department will enter the contract and Credentialing data into CalOptima's core business system,
51 which updates pertinent information into the online Provider directory.

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2 **IV. ATTACHMENTS**

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4 A. California Participating Physician Application (CPPA)
5 B. CalOptima Primary Source Verification Table
6 ~~C. Ongoing Monitoring Website Information Matrix~~

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8 **V. REFERENCES**

- 9
10 A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare
11 Advantage
12 B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
13 C. CalOptima PACE Program Agreements
14 D. CalOptima Contract for Health Care Services
15 E. 2017 NCQA Standards and Guidelines
16 F. CalOptima Policy GG.1406: Pharmacy Network Credentialing and Access
17 G. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
18 H. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing
19 Activities
20 I. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities
21 J. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
22 K. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
23 L. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
24 M. CalOptima Policy GG.1643Δ: Minimum Physician Standards
25 N. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of a Healthcare Delivery
26 Organization (HDO)
27 O. CalOptima Policy HH.1101: CalOptima Provider Compliant
28 P. CalOptima Policy MA.9006: Provider Complaint Process
29 Q. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the
30 Department of Health Care Services (DHCS) for Cal MediConnect
31 R. Department of Health Care Services All Plan Letter (APL) 16-009: Adult Immunizations as a
32 Pharmacy Benefit
33 U. Department of Health Care Services All Plan Letter (APL) 17-019: Provider Credentialing /
34 Recredentialing and Screening / Enrollment
35 V. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services
36 Whole Child Model Program
37 S. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 438.12, 438.214, 460.64 and 460.71
38 T. Title 45, Code of Federal Regulations, §455, Subpart E
39 U. Title 42, United States Code, §1320a-7(a)
40 V. Title XVIII and XIV of the Social Security Act
41 W. California Business and Professions Code, ~~Section §~~805
42 X. California Evidence Code, ~~Section §~~1157

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44 **VI. REGULATORY AGENCY APPROVALS**

- 45
46 A. 04/28/15: Department of Health Care Services

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48 **VII. BOARD ACTIONS**

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50 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
51 A.B. 06/01/17: Regular Meeting of the CalOptima Board of Directors

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3**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.1609A	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Retired	06/01/2017	GG.1609A	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Effective	06/01/2017	GG.1650A	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650A	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
<u>Revised</u>	<u>09/06/2018</u>	<u>GG.1650A</u>	<u>Credentialing and Recredentialing of Practitioners</u>	<u>Medi-Cal</u> <u>OneCare</u> <u>OneCare Connect</u> <u>PACE</u>

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1 IX. GLOSSARY
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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.
<u>California Children’s Services Program</u>	<u>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.</u>
<u>California Children’s Services (CCS) Eligible Condition</u>	<u>Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae.</u>
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: <ol style="list-style-type: none"> 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.

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.

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

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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;

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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

1 California and Office of Inspector General (OIG) exclusion, or suspension, list in accordance with
2 CalOptima Policy GG.1607Δ: Monitoring Adverse Activities.

- 3
- 4 L. If CalOptima declines to include a Practitioner in the CalOptima network, CalOptima shall notify,
5 in writing, such Practitioner within thirty (30) calendar days of the reason for its decision.
6
- 7 M. CalOptima shall not discriminate, in terms of participation, reimbursement, or indemnification,
8 against any Practitioner who is acting within the scope of his or her license, certification, or
9 registration under federal and state law, solely on the basis of the license, or certification. This
10 prohibition shall not preclude CalOptima from:
11
- 12 1. Refusing to grant participation to a Practitioner in excess of the number necessary to meet the
13 needs of Members;
 - 14 2. Using different reimbursement amounts for different specialties, or for different Practitioners in
15 the same specialty; and
 - 16 3. Implementing measures designed to maintain quality and control costs consistent with
17 CalOptima’s responsibilities.
18
- 19
- 20 N. CalOptima shall not discriminate against a Practitioner that serves high-risk populations or
21 specializes in the treatment of costly conditions.
22
- 23 O. CalOptima shall not make, or decline, Credentialing and Recredentialing decisions based on a
24 Practitioner’s race, ethnicity, national identity, gender, age, sexual orientation, or the type of
25 procedure, or patient, in which the Practitioner specializes.
26
- 27 P. CalOptima shall monitor and prevent discriminatory Credentialing decisions as follows:
28
- 29 1. Periodic audits of Credentialing files (in-process, denied, and approved files) to ensure
30 Practitioners are not discriminated against at least annually;
 - 31 2. Periodic audits of Practitioner complaints to determine if there are complaints alleging
32 discrimination, including a review by the CPRC of quarterly reports of complaints, including
33 discrimination at least annually;
 - 34 3. Maintaining a heterogeneous Credentialing committee membership; and
 - 35 4. Requiring those responsible for Credentialing and Recredentialing decisions to sign a statement
36 affirming that they do not discriminate when making decisions.
37
- 38
- 39 Q. CalOptima shall maintain the confidentiality of Credentialing files, in accordance with CalOptima
40 Policy GG.1604Δ: Confidentiality of Credentialing Files.
41
- 42 R. CalOptima shall maintain Credentialing files that include documentation of required elements, as
43 described in this Policy.
44
- 45 S. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date
46 of licensure verification.
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1 1. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from
2 the date of licensure verification for any Practitioner, during the Practitioner’s Credentialing, or
3 Recredentialing process, the application shall be considered expired.
4

5 T. Except as provided in CalOptima Policy GG.1608Δ: Full Scope Site Reviews, CalOptima does not
6 delegate the Facility Site Review and Medical Record Review (MRR) processes to a Health
7 Network. CalOptima assumes all authority, responsibility, and coordination of FSRs, MRRs, and
8 Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to
9 incorporate the documents to support review prior to Credentialing decisions.
10

11 U. On an annual basis, the CalOptima Board of Directors shall review and approve this Policy.
12

13 **III. PROCEDURE**

14 A. Practitioner Initial Credentialing

- 15 1. In conjunction with the CalOptima Provider Relations and Contracting Departments, a
16 Practitioner shall initiate the Credentialing process with CalOptima.
17
18 a. Upon receipt of the request from the Practitioner, CalOptima shall send a notification
19 electronically, explaining the expectations for completion and submission of the
20 credentialing application and required documents.
21
22 b. Physician Practitioners shall meet the Minimum Physician Standards as outlined in
23 CalOptima Policy GG.1643Δ: Minimum Physician Standards and CalOptima will verify
24 that the Physician Practitioner meets the minimum standards as provided in this Policy.
25
26 c. Practitioners shall submit a current, signed, and dated application with attestation to
27 CalOptima that attests to:
28
29 i. Any work history gap that exceeds six (6) months, including written clarification;
30
31 ii. The essential functions of the position that the Practitioner cannot perform, with or
32 without accommodation (i.e., health status);
33
34 iii. Lack of present illegal drug use that impairs current ability to practice;
35
36 iv. History of any loss of license and history of felony convictions;
37
38 v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;
39
40 vi. Current malpractice insurance coverage; and
41
42 vii. The correctness and completeness of the application;
43
44 d. All credentialing applications shall be signed. Faxed, digital, electronic, scanned, or
45 photocopied signatures are acceptable; however, signature stamps are not acceptable.
46
47 e. A Practitioner shall ensure that all information included in a Credentialing application is no
48 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.1633A: 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;

- 1 g. Practitioner information entered into the National Practitioner Data Bank (NPDB), if
- 2 applicable;
- 3
- 4 h. No exclusion, suspension, or ineligibility to participate in any state and federal health care
- 5 program at the time of the Credentialing decision;
- 6
- 7 i. A review of any Grievances, or quality, cases filed against a Practitioner in the last five (5)
- 8 years;
- 9
- 10 j. No exclusion from participation at any time in federal, or state, health care programs based
- 11 on conduct within the last ten (10) years that supports a mandatory exclusion under the
- 12 Medicare program, as set forth in Title 42, United States Code, Section 1320a-7(a), as
- 13 follows:
- 14
- 15 i. A conviction of a criminal offense related to the delivery of an item, or service, under
- 16 federal, or state, health care programs;
- 17
- 18 ii. A felony conviction related to neglect, or abuse, of patients in connection with the
- 19 delivery of a health care item, or service;
- 20
- 21 iii. A felony conviction related to health care Fraud; or
- 22
- 23 iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or
- 24 dispensing of a controlled substance.
- 25
- 26 k. History of professional liability claims that resulted in settlements or judgments, paid by, or
- 27 on behalf of, the Practitioner;
- 28
- 29 l. History of state sanctions, restrictions on licensure or limitations on scope of practice;
- 30
- 31 m. Human Immunodeficiency Virus (HIV) specialist attestation, if applicable;
- 32
- 33 n. Full or provisional California Children’s Services (CCS)- paneled approval status, with a
- 34 current active panel status;
- 35
- 36 o. Current IRS Form W-9;
- 37
- 38 p. Current (within last three (3) years) Full Scope FSR/MRR, and PARS, as applicable,
- 39 pursuant to CalOptima Policy GG.1608A: Full Scope Site Reviews; and
- 40
- 41 q. Active enrollment status with Medi-Cal
- 42
- 43 r. Active enrollment status with Medicare for OneCare, or OneCare Connect, Practitioners.
- 44

45 B. Practitioner Recredentialing

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- 47 1. CalOptima shall Recredential a Practitioner at least every three (3) years after initial
- 48 Credentialing. At the time of Recredentialing, CalOptima shall:
- 49

- 1 a. Collect and verify, at a minimum, all of the information required for initial credentialing, as
2 set forth in Section III.A of this policy, including any change in work history, except
3 historical data already verified at the time of the initial credentialing of the Practitioner; and
4
- 5 b. Incorporate the following data in the decision-making process:
6
 - 7 i. Member Grievances and Appeals, including number and type during the past three (3)
8 years;
 - 9 ii. Information from quality review activities;
 - 10 iii. Board Certification, if applicable;
 - 11
 - 12 iii. Board Certification, if applicable;
 - 13
 - 14 iv. Member satisfaction, if applicable;
 - 15
 - 16 v. Medical Record Reviews, if applicable;
 - 17
 - 18 vi. Facility Site Review (FSR) results and Physical Accessibility Review Survey (PARS)
19 results, if applicable; and
 - 20
 - 21 vii. Compliance with the terms of the Practitioner’s contract.
 - 22
- 23 c. All Recredentialing applications shall be signed. Faxed, digital, electronic, scanned, or
24 photocopied signatures are acceptable; however, signature stamps are not acceptable.
25
- 26 2. Current (within the last three (3) years) Full Scope FSR/MRR and PARS, as applicable,
27 pursuant to CalOptima Policy GG.1608A: Full Scope Site Reviews.
28
- 29 3. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug
30 Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval
31 between Credentialing cycles.
32
- 33 4. If CalOptima terminates a Practitioner during the Recredentialing process for administrative
34 reasons (i.e., the Practitioner failed to provide complete credentialing information) and not for
35 quality reasons (i.e., medical disciplinary cause or reason), it may reinstate the Practitioner
36 within thirty (30) calendar days of termination and is not required to perform initial
37 credentialing. However, CalOptima must re-verify credentials that are no longer within the
38 verification time limit. If the reinstatement would be more than thirty (30) calendar days after
39 termination, CalOptima must perform initial credentialing of such Practitioner.
40

41 C. Practitioner Rights

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- 43 1. New applicants for Credentialing will receive Practitioner Rights attached to the CPPA as
44 Addendum A, describing the following:
45
 - 46 a. Right to review information
47
 - 48 i. Practitioners will be notified of their right to review information CalOptima has
49 obtained to evaluate their credentialing application, attestation, or curriculum vitae.
50 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.

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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.1616A: Fair Hearing Plan for Practitioners; or

1 iii. Denial of the application along with appeal rights information, in accordance with
2 CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, with a letter of
3 explanation forwarded to the applicant.
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5 b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from
6 the date of licensure verification.
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8 i. If CalOptima is unable to render a decision within one hundred eighty (180) calendar
9 days from the date of licensure verification for any Practitioner, during the
10 Practitioner’s Credentialing, or Recredentialing process, the application shall be
11 considered expired.
12

13 E. CalOptima shall monitor and prevent discriminatory practices, to include, but not be limited to:
14

15 a. Monitoring:
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17 i. CalOptima shall conduct periodic audits of Credentialing files (in-process, denied, and
18 approved files) to ensure that Practitioners are not discriminated against; and
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20 ii. Review Practitioner complaints to determine if there are complaints alleging
21 discrimination.
22

23 iii. On a quarterly basis, the QI Department shall review grievances, appeals, and potential
24 quality of care issues for complaints alleging discrimination, and will report outcomes
25 to the CPRC for review and determination.
26

27 b. Prevention:
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29 i. The QI Department shall maintain a heterogeneous Credentialing committee, and will
30 require those responsible for Credentialing decisions to sign a statement affirming that
31 they do not discriminate.
32

33 F. Upon acceptance of the Credentialing application, the CalOptima Quality Improvement Department
34 shall generate a Provider profile and forward the Provider profile to the Contracting and Provider
35 Data Management Service (PDMS) Departments. This provider profile shall be generated from the
36 credentialing database to ensure that the information is consistent with data verified during the
37 Credentialing process (i.e. education, training, board certification and specialty). The PDMS
38 Department will enter the contract and Credentialing data into CalOptima’s core business system,
39 which updates pertinent information into the online Provider directory.
40

41 **IV. ATTACHMENTS**
42

43 A. California Participating Physician Application (CPPA)

44 B. CalOptima Primary Source Verification Table
45

46 **V. REFERENCES**
47

48 A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare
49 Advantage

50 B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal

51 C. CalOptima PACE Program Agreements

- 1 D. CalOptima Contract for Health Care Services
 2 E. 2017 NCQA Standards and Guidelines
 3 F. CalOptima Policy GG.1406: Pharmacy Network Credentialing and Access
 4 G. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
 5 H. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing
 6 Activities
 7 I. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities
 8 J. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
 9 K. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
 10 L. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
 11 M. CalOptima Policy GG.1643Δ: Minimum Physician Standards
 12 N. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of a Healthcare Delivery
 13 Organization (HDO)
 14 O. CalOptima Policy HH.1101: CalOptima Provider Compliant
 15 P. CalOptima Policy MA.9006: Provider Complaint Process
 16 Q. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the
 17 Department of Health Care Services (DHCS) for Cal MediConnect
 18 R. Department of Health Care Services All Plan Letter (APL) 16-009: Adult Immunizations as a
 19 Pharmacy Benefit
 20 U. Department of Health Care Services All Plan Letter (APL) 17-019: Provider Credentialing /
 21 Recredentialing and Screening / Enrollment
 22 V. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services
 23 Whole Child Model Program
 24 S. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 438.12, 438.214, 460.64 and 460.71
 25 T. Title 45, Code of Federal Regulations, §455, Subpart E
 26 U. Title 42, United States Code, §1320a-7(a)
 27 V. Title XVIII and XIV of the Social Security Act
 28 W. California Business and Professions Code, §805
 29 X. California Evidence Code, §1157

31 VI. REGULATORY AGENCY APPROVALS

- 32
 33 A. 04/28/15: Department of Health Care Services
 34

35 VII. BOARD ACTIONS

- 36
 37 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
 38 B. 06/01/17: Regular Meeting of the CalOptima Board of Directors
 39

40 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

1 IX. GLOSSARY
2

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 (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.
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: <ol style="list-style-type: none"> 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.

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.

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: _____

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 #: _____

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
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

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		
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tertiary
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tertiary
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tertiary
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> 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):

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): _____

VII. Medical Licensure & Certifications

California State Medical License Number	Issue Date	Expiration Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
Drug Enforcement Agency (DEA) Registration Number	Schedules	Expiration Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
Controlled Dangerous Substances Certificate (CDS) (if applicable)		Expiration Date
<input type="text"/>		<input type="text"/>
ECFMG Number (applicable to foreign medical graduates)		Issue Date
<input type="text"/>		<input type="text"/>
Individual National Physician Identifier (NPI)	Medi-Cal/Medicaid Number	Individual Medicare PTAN Number
<input type="text"/>	<input type="text"/>	<input type="text"/>

All Other State Medical Licenses

State	License Number	Issue Date	Expiration Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other Certifications (e.g., Fluoroscopy, Radiography, ACLS/BLS/PALS, etc.)

Type of Certification	License Number	Expiration Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

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)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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:	_____	Describe here: _____ _____ _____
Board Name:	_____	
Exam Date:	_____	

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:	_____
Medical Staff Phone:	_____	Medical Staff Fax:	_____	From (mm/yy):	_____
				To (mm/yy):	_____
Hospital Name:	_____	Department Name :	_____	Status (active, provisional, courtesy, temporary, etc.):	_____
Secondary Hospital Address:	_____				
City:	_____	State:	_____	Zip Code:	_____
Medical Staff Phone:	_____	Medical Staff Fax:	_____	From (mm/yy):	_____
				To (mm/yy):	_____
Hospital Name:	_____	Department Name :	_____	Status (active, provisional, courtesy, temporary, etc.):	_____
Other Institution Address:	_____				
City:	_____	State:	_____	Zip Code:	_____
Medical Staff Phone:	_____	Medical Staff Fax:	_____	From (mm/yy):	_____
				To (mm/yy):	_____
Hospital Name:	_____	Department Name :	_____	Status (active, provisional, courtesy, temporary, etc.):	_____
Other Institution Address:	_____				
City:	_____	State:	_____	Zip Code:	_____
Medical Staff Phone:	_____	Medical Staff Fax:	_____	From (mm/yy):	_____
				To (mm/yy):	_____

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:			

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 not 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: _____

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
- Child Health and Disability Prevention Program (CHDP)
- California Children Services (CCS)
- Other
- The Medical Quality Commission (TMQC)
- Comprehensive Perinatal Services Program (CPSP)
- Family Planning

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
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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 recertifying 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

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. Practitioner 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: _____

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

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 (or)	Print out
	AMA Physician Master File Copy of current DEA certificate	Visual inspection/ print out

Primary Source Verification – Board Certification

Board Certification	www.Boardcertifieddocs.com (or)	Print out
	https://www.doprofiles.org/	Print out
	American Board of Podiatric Surgery http://www.abps.org/	Print out

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 (or)	Print out of AMA with education “verified” not “being verified” or “being re-verified” ; Print out
	AOA Official Osteopathic Physician Profile Report https://www.doprofiles.org/ (or)	AOA Profile
	Contact the training institution to verify the highest level of training. State Licensing Agency, as applicable	Letter from institution stating that practitioner successfully completed the training in good standing or provide an explanation if the practitioner was ever disciplined.

CalOptima Primary Source Verification Table

Primary Source Verification – Malpractice History

Malpractice History	NPDB-HIPDB Http://www.npdb-hippdb.hrsa.gov	Print out of report
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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)
	State Licensing agencies	In Credentialing file



JENNIER KENT
DIRECTOR

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



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 Rule¹, 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 laws³ and regulations⁴, 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

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

C. Grievance

While the state definition⁷ does not specifically distinguish “Grievances” from “Appeals,” federal regulations⁸ 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 regulations¹² 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)

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)

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)

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 regulations²³, state laws²⁴, 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

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)

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 days³² 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)

- 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 Hearing⁴⁰ and IMR⁴¹ 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/>

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 laws⁴² 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 Contract⁴³ 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 federal⁴⁴ and state⁴⁵ 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 federal⁴⁶ and state⁴⁷ 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 laws⁴⁸ and regulations⁴⁹, 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 federal⁵⁰ and state⁵¹ 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 regulations⁵⁴ 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)

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 laws⁵⁵ and regulations⁵⁶ 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 laws⁵⁷ and regulations⁵⁸ 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 regulations⁵⁹ 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 Contract⁶⁰, as well as in both state⁶¹ and federal⁶² 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 federal⁶³ and state⁶⁴ 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 Contract⁶⁶ 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 laws⁶⁹ and regulations⁷⁰, 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 laws⁷² and regulations⁷³, which do not distinguish Grievances from Appeals, require expedited resolution of Grievances within three calendar days, which is inclusive of Appeals. Federal regulations⁷⁴ 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)

- 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)

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 regulations⁹² and state laws⁹³ currently require beneficiaries to request a State Hearing within 90 days from the date of the NOA. However, new federal regulations⁹⁴ 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

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 Rule⁹⁸ to implement Section 1557. Federal regulations⁹⁹ 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 regulations¹⁰⁰, state laws¹⁰¹, 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 apply¹¹⁵:

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)

ALL PLAN LETTER 17-006
Page 23

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)

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 <i>(Effective 07/01/17)</i>
DEFINITIONS		
	“Action”	“Adverse Benefit Determination”
	“Grievance System”	“Grievance and Appeal System”
“Grievance”	<ul style="list-style-type: none"> 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”	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 30 calendar days (State)* 90 days but based on State-established standard (Federal) 	30 calendar days
Exempt Resolution	24 hours	24 hours
Expedited Resolution	<ul style="list-style-type: none"> 3 calendar days (State)* Expedited Grievances not defined (Federal) 	72 hours
APPEALS		
Filing	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 30 calendar days (State)* 45 days (Federal) 	30 calendar days
Expedited Resolution	<ul style="list-style-type: none"> 3 calendar days (State)* 3 working days (Federal) 	72 hours
Extension	14 calendar days	14 calendar days
Notification of Extension	No specified timeframe	<ul style="list-style-type: none"> Reasonable efforts to provide prompt oral notice

TOPIC	EXISTING REQUIREMENT	NEW REQUIREMENT <i>(Effective 07/01/17)</i>
		<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Clear & Concise • Criteria/Guideline • Clinical Reason 	<ul style="list-style-type: none"> • 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



JENNIFER KENT
DIRECTOR

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



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-FC⁴ 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 E⁵ 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 providers⁶ 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 Portal¹⁰ 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>

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 6216¹⁴); 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 (MCO) 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

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

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

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>

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 MCO contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

Attachment 1: Provider Types and Categories of Risk³⁴/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

- 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.

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

- 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.



JENNIFER KENT
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

DATE: February 16, 2018

ALL PLAN LETTER 18-005

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS¹

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=fd4e77a29e6327c6ff8475948c57df7&mc=true&node=pt42.4.438&rqn=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.

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 midwives, 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.

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

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=\(sc.Default\)](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 providers²⁶ 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) MCP²⁹ 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.

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)

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 Manual³⁴ 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 program³⁵
- Trained per contractual requirements³⁶

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.

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>

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-compliance³⁹ 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>

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 sanctions⁴¹ 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 change⁴³ 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)



JENNIFER KENT
DIRECTOR

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



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.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.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC§ionNum=123850.

⁴ See Welfare and Institutions Code (WIC) Section 14094.11, which is available at: https://leginfo.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/CCSWwholeChildModel.aspx>

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§ionNum=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.

⁹ See WIC Section 14093.06(b), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=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§ionNum=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)
- EPSDT¹⁶
- 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 Section 14094.11(b)(1)-(6), which is available at:

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=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§ionNum=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 Management²¹

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§ionNum=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 17-010²⁷ 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§ionNum=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

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>

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

12. Consider Approval of Proposed Updated Behavioral Health Policy and Form to Support the Administration of Behavioral Health Treatment Services for Medi-Cal Members

Contact

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

Recommended Action

Approve the updated CalOptima Policy GG.1548: Authorization for Behavioral Health Treatment (BHT) Services.

Background

Behavioral Health Treatment (BHT) is the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of the targeted behavior. BHT services include a variety of evidenced-based behavioral interventions, including but not limited to Applied Behavior Analysis (ABA).

On December 7, 2017, the CalOptima Board of Directors approved CalOptima Policy GG.1548: Applied Behavioral Analysis for Autism Spectrum Disorder. This policy addresses processes for ABA, services eligibility, medical necessity criteria, prior authorization rules, and information related to appeals and grievances. On March 2, 2018, the Department of Health Care Services (DHCS) issued All Plan Letter (APL) 18-006: Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21. The purpose of this APL is to update guidance to Medi-Cal managed care plans about the provision of medically necessary BHT services for all members that meet the eligibility criteria for services with or without a diagnosis of Autism Spectrum Disorder (ASD). Specifically, effective July 1, 2018, DHCS will transition the provision of medically necessary BHT services for eligible Orange County members under 21 years of age without an ASD diagnosis from Regional Centers to CalOptima. DHCS has approved a three-month transition period (July, August, and September) for CalOptima members. CalOptima staff is meeting weekly with Regional Center of Orange County clinical team to ensure no disruption of services during this transition period.

In order to meet the requirements of the APL, Staff is recommending Board approval of the CalOptima Policy GG.1548, Authorization for Behavioral Health Treatment (BHT) Services. Below is a summary of the changes:

1. Replaced the term Applied Behavior Analysis (ABA) with Behavioral Health Treatment (BHT) to reflect the language in the APL.
2. Added new statutory reference to align with DHCS requirements.
3. Added additional criteria for behavioral treatment plan to comply with the APL.
4. Updated the process for requesting prior authorization.
5. Updated terminology.
6. Updated the Behavioral Health – Authorization Request Form to align with new terminologies.

Fiscal Impact

The recommended action to approve the updated CalOptima Policy GG.1548: Authorization for Behavioral Health Treatment (BHT) Services does not have a material fiscal impact as the projected current year medical and administrative expenses associated with this transition are included in the Board-approved CalOptima Fiscal Year 2018-19 Operating Budget.

Rationale for Recommendation

CalOptima staff has updated GG.1548 to ensure a clear process exists for prior authorization of services specifically related to BHT services. The policy supports the recent changes to Medi-Cal BHT services and helps to ensure compliance with applicable regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Policy GG.1548: Authorization for Behavioral Health Treatment (BHT) Services
2. All Plan Letter (APL) 18-006; Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
3. Board Action dated December 7, 2017, Consider Approval of Proposed New Behavioral Health Policies and Forms to Support the Administration of Behavioral Health (BH) Services for Medi-Cal Members Within CalOptima Internal Operations

/s/ Michael Schrader
Authorized Signature

8/29/2018
Date



Policy #: GG.1548
Title: Authorization for ~~Applied Behavioral Analysis for Autism Spectrum Disorder~~ Health Treatment (BHT) Services

Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 01/01/18
Last Review Date: ~~09/06/18~~ Not Applicable
Last Revised Date: ~~09/06/18~~ Not Applicable

1 **I. PURPOSE**

2
3 This policy defines the process by which CalOptima Members may obtain Medically Necessary
4 ~~Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder (ASD)~~ Health Treatment (BHT)
5 ~~services~~ and ~~to provide~~ provides guidance to Providers on Prior Authorization requirements for the
6 provision of ~~Behavioral Health Treatment (BHT) services to Medi-Cal beneficiaries under twenty one~~
7 ~~(21) years of age diagnosed with Autism Spectrum Disorder (ASD)~~ BHT services.
8

9 **II. POLICY**

10
11 A. CalOptima shall provide ~~ABA services~~ BHT services, as part of the provision of Early and Periodic
12 Screening, Diagnosis, and Treatment (EPSDT) services, to eligible Medi-Cal Members under
13 twenty-one (21) years of age when Medically Necessary and in accordance with CalOptima Policy
14 GG-1121: ~~Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, Title 22,~~
15 ~~California Code of Regulations (CCR), Section 51340, and Department of Health Care Services~~
16 ~~(DHCS) All Plan Letter (APL) 15-025: Responsibilities for Behavioral Health, and Treatment~~
17 ~~Coverage for Children Diagnosed with Autism Spectrum Disorder~~ Services.
18

19 B. A Member shall be eligible to receive ~~ABA~~ BHT services, if all the following criteria are met:

20
21 1. ~~The Member is~~ Be under age ~~twenty-one (21), and for those under three (3) years of age, have~~
22 ~~provisional diagnosis;~~

23
24 2. ~~A~~ Have a recommendation from a licensed medical professional, physician and surgeon or a
25 licensed psychologist ~~diagnosed the Member with ASD;~~

26
27 3. ~~2. A licensed medical professional or licensed psychologist made a recommendation that the~~
28 ~~Member should have a Functional Behavioral Assessment (FBA) to evaluate if there~~ evidence-
29 based BHT services ~~are behaviors secondary to ASD that can be addressed through~~
30 ~~ABA~~ Medically Necessary;
31

32 4. ~~3. The Member is~~ Be medically stable; and

33
34 5. ~~4. The Member is~~ Be without a need for ~~twenty four (24)-hour~~ hour medical/nursing monitoring or
35 procedures provided in a hospital or intermediate care facility for persons with intellectual
36 disabilities; ~~and (ICF/ID).~~

37
38 C. The ABA Covered BHT services ~~are necessary~~ must be:
39

Policy #: GG.1548

Title: Authorization for ~~Applied~~ Behavioral
Analysis for Autism Spectrum
Disorder Health Treatment (BHT) Services

Effective/Revised Date: 09/06/18/01/18

1 ~~6.1. Medically Necessary to correct or ameliorate defects related to ASD and are generally accepted~~
2 ~~by the medical community behavioral conditions as effectively defined in Section 1905(r) of the~~
3 ~~Social Security Act and as determined by a licensed physician and proven treatments for ASD,~~
4 ~~surgeon or a licensed psychologist; and~~

5
6 ~~C. Provided and supervised under a CalOptima shall ensure that the criteria for Medical Necessity for~~
7 ~~ABA services is based on the most current best practices in the approved behavioral treatment of~~
8 ~~developmental disorders in accordance with plan developed by a contracted, CalOptima Policy~~
9 ~~GG.1535: Utilization Criteria and Guidelines, and as follows:~~

10 ~~1. A complete assessment utilizing validated tools and standardized developmental norms;~~

11 ~~2. Symptom focused interventions; and~~

12 ~~3. Caregiver participation and measurable goals.~~

13
14
15 ~~2. An ABA-credentialed BHT service provider as specified in California State Plan Amendment~~
16 ~~(SPA) 14-026.~~

17
18
19
20 ~~D. A BHT service provider shall obtain Prior Authorization for ABA provide BHT services in~~
21 ~~accordance with this Policy and CalOptima Policies GG.1113: Referral Practitioner~~
22 ~~Responsibilities, GG.1500: Authorization Instructions for CalOptima Direct and CalOptima~~
23 ~~Community Network Providers, and GG.1508: Authorization and Processing of Referrals.~~

24
25 ~~E. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or are~~
26 ~~no longer Medically Necessary.~~

27
28 ~~F. The following services do not meet Medical Necessity criteria, or qualify as Medi-Cal-covered BHT~~
29 ~~services for reimbursement:~~

30
31 ~~1. Services rendered when continued clinical benefit is not expected;~~

32
33 ~~2. Providing or coordinating respite, day care, or educational services, or reimbursement of a~~
34 ~~parent, legal guardian, or legally responsible person for costs associated with participation under~~
35 ~~the behavioral treatment plan;~~

36
37 ~~3. Treatment whose sole purpose is vocationally or recreationally-based;~~

38
39 ~~4. Custodial care. For purposes of BHT services, custodial care:~~

40
41 ~~i. Is provided primarily for maintaining the Member's or anyone else's safety; and~~

42
43 ~~ii. Could be provided by persons without professional skills or training.~~

44
45 ~~5. Services, supplies or procedures performed in a non-conventional setting including, but not~~
46 ~~limited to, resorts, spas, and camps;~~

47
48 ~~6. Services rendered by a parent, legal guardian, or legally responsible person; and~~

1
2 7. Services that are not evidence-based behavioral intervention practices.

3
4 G. CalOptima shall provide continuity of care for BHT services for new Members or Members
5 transitioning from BHT services provided through the Regional Center to services provided by
6 CalOptima in accordance with APL 18-008: Continuity of Care for Medi-Cal Members Who
7 Transition into Medi-Cal Managed Care and CalOptima Policy GG.1325: Coordination of Care for
8 Newly Enrolled Medi-Cal Members into CalOptima.

9
10 E.H. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima
11 Policies GG.1510: Appeals Process for Decisions Regarding Care and Services, HH.1102:
12 CalOptima Member Complaint, and HH.1108: State Hearing Process and Procedures.

13
14 I. CalOptima shall be responsible for coordinating the provision of BHT services with the other
15 entities including but not limited to Regional Center, Department of Developmental Services, and
16 Local Education Authority (LEA), to ensure CalOptima and the other entities are not providing
17 duplicative services.

18
19 **III. PROCEDURE**

20
21 A. Before initiating BHT services for a Member, CalOptima will select and provide authorization for
22 an appropriate provider to conduct a complete diagnostic and developmental evaluation. The
23 evaluation shall include:

24
25 1. Diagnosis of behavioral health condition(s);

26
27 2. Identification of impairing behaviors;

28
29 3. Assessment of intellectual capacity for services;

30
31 4. Verify results of medical history and physical, including audiology evaluation;

32
33 5. Identify ongoing role of medical and behavioral health providers;

34
35 6. Review LEA/Individualized Education Plan (IEP) plan;

36
37 7. Identify ongoing role of LEA, and

38
39 8. Make appropriate recommendations for BHT Assessment or other interventions.

40
41 B. Upon completion of a diagnostic and developmental evaluation that includes a recommendation for
42 BHT Assessment, CalOptima will select and provide authorization for a BHT Service Provider to
43 conduct a BHT Assessment. A BHT Assessment shall be completed on a CalOptima-approved
44 template and include:

45
46 1. Description of the targeted symptoms, behaviors, and functional impairments related to
47 underlying behavioral health disorder that have been identified as appropriate for behavioral
48 health treatment

1
2 2. Documentation of the serious dysfunction in daily living for child or adolescent such as:

3
4 a. Serious dysfunction in interpersonal interactions (e.g., impulsive or abusive behavior);

5
6 ~~A. Significant A Provider shall submit Prior Authorization requests for ABA services as follows:~~

7
8 ~~Mail: CalOptima UM Department~~

9 ~~— Attention: BH Prior Authorization~~

10 ~~— CalOptima~~

11 ~~— P.O. Box 11033~~

12 ~~— Orange, CA, 92856; or~~

13
14 ~~Facsimile: (714) 954-2300~~

15
16 b. Prior withdrawal and avoidance of almost all social interaction;

17
18 c. Consistent failure to achieve self-care as appropriate to age or developmental level; and

19
20 d. Severely diminished ability to assess consequences of own actions (e.g., acts of property
21 damage).

22
23 3. CalOptima-approved cognitive and adaptive testing tools (e.g., Vineland, Adaptive Behavior
24 Assessment System-ABAS, Developmental Assessment of Young Children-DAYC) to assess the
25 Member's age-specific impairments.

26
27 4. A Member-specific behavioral treatment plan that meets the following criteria:

28
29 a. Developed by a qualified BHT Service Provider as prescribed by California SPA for the
30 specific Member being treated;

31
32 b. Includes:

33
34 i. Reason for referral;

35
36 ii. Brief background information (demographics, living situation, home/school/work
37 information);

38
39 iii. Clinical interview;

40
41 iv. Review of recent assessment/reports;

42
43 v. Assessment procedures and results; and

44
45 vi. Recommended evidence-based BHT services;

46
47 c. Be person-centered and based upon individualized measurable goals and objectives over a
48 specific timeline;

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- d. Delineates both the frequency of baseline behaviors and the treatment planned to address the behaviors;
- e. Identifies measurable long, intermediate and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation;
- f. Includes outcome measurement assessment criteria that will be used to measure achievement of behavior objectives;
- g. Includes the current level (baseline behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, modified (include explanation);
- h. Utilizes evidence-based BHT services with demonstrated clinical efficacy tailored to the Member;
- i. Clearly identifies:
 - i. Number of hours of direct service;
 - ii. Number of hours of observation and direction;
 - iii. Number of hours of parent/guardian training;
 - iv. Parent/guardian support and participation needed to achieve the goals and objectives;
 - v. Frequency at which the Member's progress is measured and reported;
 - vi. Transition plan;
 - vii. Crisis plan; and
 - viii. Each individual BHT service provider responsible for delivering the services;
- j. Includes care coordination involving the parents or caregiver(s), school, state disability programs, and others, as applicable;
- k. Considers the Member's age, school attendance requirements, and other daily activities when determining the number of hours of Medically Necessary direct service and supervision;
- l. Delivers the BHT services in a home or community-based setting, including clinics. Any portion of Medically Necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and community; and

1
2 m. Includes an exit plan/criteria for completing BHT Services.

3
4 C. Prior Authorization requests for initial BHT services shall be submitted as described in CalOptima
5 Policy GG.1508: Authorization and Processing of Referrals, and shall:

6
7 ~~B.1. Be submitted on the Behavioral Health -Authorization for initial requests for ABA~~
8 ~~services shall include: Request Form (BH-ARF),~~

9
10 ~~1. A Include licensed medical professional or licensed psychologist diagnosis of ASD;~~

11
12 ~~2. A licensed medical professional-physician and surgeon or licensed psychologist~~
13 ~~recommendation for evidenced-based ABABHT services; and~~

14
15 ~~3. A previously authorized FBA that identifies:~~

16
17 ~~a. Using validated assessment tools (e.g. Vineland, ABAS), the Member's age specific~~
18 ~~impairments such as:~~

19
20 ~~i. Persistent deficits in social communication Include a completed BHT Assessment and~~
21 ~~social interaction that have been identified as deficient relative to age expected norms;~~
22 ~~Treatment Plan by a BHT~~

23 ~~ii. Significant restricted, repetitive patterns of behavior or interests; and~~

24
25 ~~iii. Significant property destruction or aggression related to the Member's ASD.~~

26
27 ~~b. Antecedents, consequences, and reinforcers that maintain the behavioral impairments; and~~

28
29 ~~c. Possible functions of the behavioral impairments.~~

30
31 ~~4. Documentation which describes the Member specific treatment plan that includes:~~

32
33 ~~a. The identified behavioral, psychological, family, and medical concerns;~~

34
35 ~~b. Measurable goals in objective and measurable terms based on standardized assessments that~~
36 ~~address the behaviors and impairments for which the intervention is to be applied. For each~~
37 ~~goal, baseline measurements, progress to date and anticipated timeline for achievement~~
38 ~~based on both the initial assessment and subsequent interim assessments over the duration~~
39 ~~of the intervention; and~~

40
41 ~~3. Information that identifies the delivery of ABA services by a Qualified Autism Service~~
42 ~~Provider, aligned with provisions set forth in All Plan Letter (using the CalOptima-approved~~
43 ~~template.~~

44
45 ~~e.4. CalOptima shall process the BH-ARF in accordance with CalOptima Policy GG.1508:~~
46 ~~Authorization and Processing of Referrals, MCG Behavioral Healthcare 22nd Edition, Applied~~
47 ~~Behavioral Analysis, B- 806-T, and APL) 15-025 18-006: Responsibilities for Behavioral~~

~~Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder and defined in Health and Safety Code, Section 1374.73(e)(3), Members Under the Age of 21.~~

~~5. The Member is medically stable;~~

~~6. The Member is without need for twenty four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities;~~

~~7. The ABA services are necessary to correct or ameliorate defects related to ASD and are generally accepted by the medical community as effective and proven treatments for ASD; and~~

~~8. The predicted beneficial outcome of the services outweighs potential harmful effects of ABA such as prompt dependence.~~

~~D. CalOptima shall process Prior Authorization requests for continuation of ABA services requires that the following information be BHT services in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals and shall:~~

~~C. Be submitted:~~

~~1. The Member has met the following criteria related to the initial course of ABA:~~

~~a. A licensed medical professional or licensed psychologist continues to diagnose ASD;~~

~~b. A licensed medical professional or licensed psychologist continues to make a recommendation for evidenced based ABA services;~~

~~e.1. The Member specific treatment plan has been updated and submitted on the BH-ARF no less than every six (6) months by the ABA provider BHT Service Provider or more frequently when warranted by the individual circumstances;~~

~~2. Include an updated Member-specific behavioral treatment plan using the CalOptima-approved template that updates all components of the treatment plan including:~~

~~d.a. The anticipated timeline for achievement of each goal in the Member specific treatment plan that has been updated based on both the initial assessment and subsequent interim assessments;~~

~~e.b. The Member specific treatment plan includes measures/Measures of progress for each goal using validated assessments/assessment of adaptive functioning;~~

~~f.c. There has been documentation of caregivers/Caregivers continued participation in the treatment and demonstration of the ability to apply those skills in naturalized settings;~~

~~g.d. Improvements toward developmental norms and behavior goals/Behavioral improvements cannot be maintained if care was reduced;~~

1 ~~h.e.~~ Behavior issues are not exacerbated and have not become dependent on prompts by the
2 treatment process; and

3
4 ~~i.f.~~ The Member has the required cognitive capacity to benefit from the care provided and ~~to~~
5 retain ~~and generalize~~ treatment gains.

6
7 ~~2.3.~~ Documentation of ongoing coordination of care and communication with the Member's other
8 medical ~~provider~~ and behavioral providers; and

9
10 ~~3.4.~~ Documentation of ongoing coordination of care and communication with the ~~member's Local~~
11 ~~Education Agency~~ Member's LEA, as applicable.

12
13 ~~4.~~ Information that identifies the delivery of ABA services by a Qualified Autism Service
14 Provider.

15
16 ~~5.~~ CalOptima shall process the BH-ARF is in accordance with CalOptima Policy GG.1508:
17 Authorization and Processing of Referrals, MCG Behavioral Healthcare 22nd Edition, Applied
18 Behavioral Analysis, B- 806-T, and All Plan Letter 18-006: Responsibilities for Behavioral
19 Health Treatment Coverage for Members Under the Age of 21.

20
21 ~~D.E.~~ If a request for ABABHT services is denied or modified on the basis that the services are not
22 Medically Necessary, and the Member, Authorized Representative, or provider appeals the decision,
23 the decision shall be subject to review in accordance with CalOptima Policies GG.1507:
24 Notification Requirements Required for Covered Services Requiring Prior Authorization, GG.1510:
25 Appeals Process for Decisions Regarding Care and Services, and HH.1108: State Hearing Process
26 and Procedures.

27
28 ~~E.~~ Discharge from ABA services are based on the following criteria:

29
30 ~~1.~~ Functional improvement is sufficient;

31
32 ~~2.~~ Symptom relief is sufficient;

33
34 ~~3.~~ Risk status is minimized for dangerousness or property destruction;

35
36 ~~4.~~ Continued clinical benefit is not expected from the services being rendered and care is judged
37 no longer appropriate as:

38
39 ~~a.~~ Behavioral issues are exacerbated by the treatment;

40
41 ~~b.~~ Member is unlikely to maintain gains from continued care;

42
43 ~~c.~~ Member does not demonstrate progress towards goals for successive authorization periods;

44
45 ~~d.~~ The services being used in the treatment of ASD are not evidence-based practices;
46

Policy #: GG.1548

Title: Authorization for ~~Applied~~ Behavioral
Analysis for Autism Spectrum
Disorder Health Treatment (BHT) Services

Effective/Revised Date: 09/06/18/01/18

- 1 e. ~~The services being rendered provide or coordinate respite, day care, or educational services,~~
2 ~~or reimbursement of a parent, legal guardian, or legally responsible person for costs~~
3 ~~associated with participation under the behavioral treatment plan;~~
4
5 f. ~~The services, supplies, or procedures are performed in a non-conventional setting including,~~
6 ~~but not limited to, resorts, spas, and camps;~~
7
8 g. ~~The sole purpose of the treatment is vocationally or recreationally based;~~
9
10 h. ~~The services could be provided by persons without professional skills or training to~~
11 ~~maintain the Member's or anyone else's safety; and~~
12
13 i. ~~The services are being rendered by a parent, legal guardian, or legally responsible person.~~
14

15 IV. ATTACHMENTS

16 A. Behavioral Health - Authorization Request Form (BH-ARF)

17 V. REFERENCES

- 18
19
20
21 A. American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and
22 treatment of children and adolescents with autism spectrum disorder. February, 2014
23 B. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth
24 Edition. DSM-5. American Psychiatric Association. Washington, DC. May, 2013
25 C. BACB Applied Behavior Analysis Treatment of ASD Practice Guidelines for Healthcare Funders
26 and Managers, 2014
27 D. Blumberg, Stephen, et al, Diagnosis lost: Differences between children who had and who currently
28 have an autism spectrum disorder diagnosis. Autism 1-13, 2015
29 ~~A. American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment~~
30 ~~and treatment of children and adolescents with autism spectrum disorder. February, 2014~~
31 ~~B. BACB Applied Behavior Analysis Treatment of ASD Practice Guidelines for Healthcare Funders and~~
32 ~~Managers, 2014~~
33 ~~C. Blumberg, Stephen, et al, Diagnosis lost: Differences between children who had and who currently have~~
34 ~~an autism spectrum disorder diagnosis. Autism 1-13, 2015~~
35 ~~B. California Welfare and Institutions Code, Section 14132~~
36 ~~C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal~~
37 ~~Social Security Act (SSA), §§1905(a) and 1905(r)~~
38 ~~Title 22, California Code of Regulations (CCR), § 51340~~
39 ~~Health & Safety Code, § 1374.73~~
40 E. California State Plan Amendment (SPA) 14-026
41 Department of Health Care Services (DHCS) All Plan Letter 18-006: Responsibilities for
42 Behavioral Health Treatment (BHT) Coverage for Members under the Age of 21
43 F. G. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
44 G. CalOptima Policy GG.1113: Referral Practitioner Responsibilities
45 B.H. H. CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment
46 (EPSDT) Services
47 C.I.I. CalOptima Policy GG1113: Referral Practitioner ResponsibilitiesGG.1304: Continuity of Care
48 During Health Network or Provider Termination

Policy #: GG.1548

Title: Authorization for ~~Applied~~ Behavioral
Analysis for Autism Spectrum
Disorder Health Treatment (BHT) Services

~~Effective~~ Revised Date: 09/06/18 01/01/18

1 ~~J. J.—~~ CalOptima Policy GG.1325: Coordination of Care for Newly enrolled Medi-Cal Members into
2 CalOptima

3 ~~D.K.~~ CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima
4 Community Network Providers

5 ~~E.L.~~ CalOptima Policy GG.1508: Authorization and Processing of Referral

6 ~~F.M.~~ CalOptima Policy ~~GG.1507~~ GG.1507: Notification Required for Covered Services Requiring
7 Prior Authorization

8 ~~G.N.~~ CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services

9 ~~H.O.~~ CalOptima Policy GG.1535: Utilization Criteria and Guidelines

10 ~~I.P.~~ CalOptima Policy HH.1102: CalOptima Member Complaint

11 ~~J.Q.~~ CalOptima Policy HH.1108: State Hearing Process and Procedures

12 ~~MCG Behavioral Healthcare 22nd Edition, Applied Behavioral Analysis, B- 806-T~~
13 ~~American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition-~~
14 ~~DSM 5. American Psychiatric Association. Washington, DC. May, 2013~~

15 ~~K.R.~~ Christine Fountain, Alix S. Winter and Peter S. Bearman. Six Developmental Trajectories
16 Characterize Children ~~With~~ Autism. Pediatrics 129, May 1, 2012

17 ~~S.~~ Department of Health Care Services (DHCS) All Plan Letter 18-006: Responsibilities for
18 Behavioral Health Treatment (BHT) Coverage for Members under the Age of 21

19 ~~T.~~ Health & Safety Code, § 1374.73

20 ~~L.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 15-025: Responsibilities for
21 Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder
22 ~~M.~~ Health & Safety Code, Section 1374.73 American Psychiatric Association. Diagnostic and Statistical
23 Manual of Mental Disorders, Fifth Edition. DSM 5. American Psychiatric Association. Washington, DC.
24 ~~May, 2013~~

25 ~~U.~~ Lovaas, O. I., Behavior treatment and normal educational and intellectual functioning in young
26 autistic recipient. Journal of Consulting and Clinical Psychology, 55, 3-9, 1987

27 ~~V.~~ MCG Behavioral Healthcare 22nd Edition, Applied Behavioral Analysis, B- 806-T

28 ~~—~~ Social Security Act (SSA), §§1905(a) and 1905(r)

29 ~~W.~~

30 ~~Title 22, California Code of Regulations (CCR), § 51340~~

31 ~~N.X.~~

32 ~~O.~~ MCG 21st Ed Applied Behavioral Analysis ORG: B-012 AOP (BHG)

33 ~~P.~~ Title 22, California Code of Regulations (C.C.R.), § 51340

34 35 VI. REGULATORY AGENCY APPROVALS

36
37 A. 01/04/31/18:- Department of Health Care Services

38 39 VII. BOARD ACTIONS

40
41 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors

42 B. 12/07/17: Regular Meeting of the CalOptima Board of Directors

43 44 VIII. REVIEW/REVISION HISTORY

Policy #: GG.1548

Title: Authorization for ~~Applied Behavioral Analysis for Autism Spectrum Disorder~~ Health Treatment (BHT) Services

~~Effective~~ Revised Date: 09/06/18~~01/01/18~~

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2018	GG.1548	Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder	Medi-Cal
<u>Revised</u>	<u>09/06/2018</u>	<u>GG.1548</u>	<u>Authorization for Behavioral Health Treatment (BHT) Services</u>	<u>Medi-Cal</u>

1

DRAFT

IX. GLOSSARY

Term	Definition
Applied Behavior Analysis (ABA)	Applied Behavior Analysis refer to the use of behavioral learning principles (i.e. behavior consequence paradigm) to produce changes in behavior, specifically the development of skills in areas of need (e.g. language) and the reduction in maladaptive behaviors (e.g. aggression, self injury). ABA therapy may be comprehensive in nature, teaching adaptive techniques to address multiple behavioral and functional concerns, or may be problem-focused and targeted towards addressing specifically identified problematic behaviors (e.g. aggression). (MCG Behavioral Health 21st Edition)
Authorized Representative	Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, 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 <i>in loco parentis</i> 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.30093009Δ: Access, Use, and Disclosure of PHI to a by Member's Authorized <u>Personal</u> Representative.
Autism Spectrum Disorder (ASD)	ASD is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome.
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, restore, to the maximum extent practicable, the functioning of an individual with ASD. BHT is the design, implementation, and evaluation of environmental modification <u>modifications</u>, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, <u>including the direct observation, measurement and functional analysis of the relations between environment and behavior.</u> BHT services teach skills through the use of behavioral <u>observation and reinforcement, or through prompting to teach each step of targeted behavior.</u> BHT services are based on reliable evidence and are <u>not experimental.</u> BHT services include a variety of behavioral interventions that <u>have been identified as evidenced-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence and are designed to be delivered primarily in the home and in other community settings.</u>
Functional Behavior <u>Behavioral Health Treatment (BHT) Assessment (FBA)</u>	By gathering data and conducting experiments that evaluated the effects of environmental variables on the behavior, evaluators decipher the meaning of the behaviors (i.e., what emotion or message was being communicated through the actions), determine why they were occurring, and develop behavior change programs to help the disabled individual display more appropriate behavior in meeting his or her needs.

Policy #: GG.1548

Title: Authorization for ~~Applied~~ Behavioral
~~Analysis for Autism Spectrum~~
~~Disorder~~ Health Treatment (BHT) Services

Effective/Revised Date: 09/06/18/01/18

Term	Definition
<u>Medically Necessary or Medical Necessity</u>	<u>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.</u>
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
<u>Qualified Autism Behavioral Health Treatment (BHT) Service Provider</u>	<p>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. <u>Three classifications:</u></p> <ol style="list-style-type: none"><u>1. Qualified Autism Services (QAS) Provider – A licensed practitioner or Board Certified Behavior Analyst (BCBA)</u><u>2. QAS Professional – A Behavior Management Consultant (BMC), BCBA, Behavior Management Assistant (BMA), or Behavior Analyst Associate (Board Certified Assistant Behavior Analyst)</u><u>3. QAS Paraprofessional – Minimum high school level with 40 hours of BHT training who is employed and supervised by a QAS provider</u>

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Policy #: GG.1548
Title: **Authorization for Behavioral Health Treatment (BHT) Services**
Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 01/01/18
Last Review Date: 09/06/18
Last Revised Date: 09/06/18

1 **I. PURPOSE**

2
3 This policy defines the process by which CalOptima Members may obtain Medically Necessary
4 Behavioral Health Treatment (BHT) services and provides guidance to Providers on Prior Authorization
5 requirements for the provision of BHT services.
6

7 **II. POLICY**

8
9 A. CalOptima shall provide BHT services, as part of the provision of Early and Periodic Screening,
10 Diagnosis, and Treatment (EPSDT) services, to eligible Medi-Cal Members under twenty-one (21)
11 years of age when Medically Necessary and in accordance with CalOptima Policy GG:1121: Early
12 and Periodic Screening, Diagnosis, and Treatment Services.
13

14 B. A Member shall be eligible to receive BHT services, if all the following criteria are met:

- 15 1. Be under twenty-one (21) years of age;
- 16 2. Have a recommendation from a licensed physician and surgeon or a licensed psychologist that
17 evidence-based BHT services are Medically Necessary;
- 18 3. Be medically stable; and
- 19 4. Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital
20 or intermediate care facility for persons with intellectual disabilities (ICF/ID).
21

22 C. Covered BHT services must be:

- 23 1. Medically Necessary to correct or ameliorate behavioral conditions as defined in Section
24 1905(r) of the Social Security Act and as determined by a licensed physician and surgeon or a
25 licensed psychologist; and
- 26 2. Provided and supervised under a CalOptima-approved behavioral treatment plan developed by a
27 contracted, CalOptima-credentialed BHT service provider as specified in California State Plan
28 Amendment (SPA) 14-026.
29

30 D. A BHT service provider shall provide BHT services in accordance with this Policy and CalOptima
31 Policies GG.1113: Referral Practitioner Responsibilities, GG.1500: Authorization Instructions for
32 CalOptima Direct and CalOptima Community Network Providers, and GG.1508: Authorization and
33 Processing of Referrals.
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- 1 E. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or are
2 no longer Medically Necessary.
3
- 4 F. The following services do not meet Medical Necessity criteria, or qualify as Medi-Cal-covered BHT
5 services for reimbursement:
6
- 7 1. Services rendered when continued clinical benefit is not expected;
8
 - 9 2. Providing or coordinating respite, day care, or educational services, or reimbursement of a
10 parent, legal guardian, or legally responsible person for costs associated with participation under
11 the behavioral treatment plan;
12
 - 13 3. Treatment whose sole purpose is vocationally or recreationally-based;
14
 - 15 4. Custodial care. For purposes of BHT services, custodial care:
16
 - 17 i. Is provided primarily for maintaining the Member's or anyone else's safety; and
18
 - 19 ii. Could be provided by persons without professional skills or training.
20
 - 21 5. Services, supplies or procedures performed in a non-conventional setting including, but not
22 limited to, resorts, spas, and camps;
23
 - 24 6. Services rendered by a parent, legal guardian, or legally responsible person; and
25
 - 26 7. Services that are not evidence-based behavioral intervention practices.
27
- 28 G. CalOptima shall provide continuity of care for BHT services for new Members or Members
29 transitioning from BHT services provided through the Regional Center to services provided by
30 CalOptima in accordance with APL 18-008: Continuity of Care for Medi-Cal Members Who
31 Transition into Medi-Cal Managed Care and CalOptima Policy GG.1325: Coordination of Care for
32 Newly Enrolled Medi-Cal Members into CalOptima.
33
- 34 H. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima
35 Policies GG.1510: Appeals Process for Decisions Regarding Care and Services, HH.1102:
36 CalOptima Member Complaint, and HH.1108: State Hearing Process and Procedures.
37
- 38 I. CalOptima shall be responsible for coordinating the provision of BHT services with the other
39 entities including but not limited to Regional Center, Department of Developmental Services, and
40 Local Education Authority (LEA), to ensure CalOptima and the other entities are not providing
41 duplicative services.
42

43 III. PROCEDURE

- 44
- 45 A. Before initiating BHT services for a Member, CalOptima will select and provide authorization for
46 an appropriate provider to conduct a complete diagnostic and developmental evaluation. The
47 evaluation shall include:
48
- 49 1. Diagnosis of behavioral health condition(s);

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2. Identification of impairing behaviors;
 3. Assessment of intellectual capacity for services;
 4. Verify results of medical history and physical, including audiology evaluation;
 5. Identify ongoing role of medical and behavioral health providers;
 6. Review LEA/Individualized Education Plan (IEP) plan;
 7. Identify ongoing role of LEA, and
 8. Make appropriate recommendations for BHT Assessment or other interventions.
- B. Upon completion of a diagnostic and developmental evaluation that includes a recommendation for BHT Assessment, CalOptima will select and provide authorization for a BHT Service Provider to conduct a BHT Assessment. A BHT Assessment shall be completed on a CalOptima-approved template and include:
1. Description of the targeted symptoms, behaviors, and functional impairments related to underlying behavioral health disorder that have been identified as appropriate for behavioral health treatment
 2. Documentation of the serious dysfunction in daily living for child or adolescent such as:
 - a. Serious dysfunction in interpersonal interactions (e.g., impulsive or abusive behavior);
 - b. Significant withdrawal and avoidance of almost all social interaction;
 - c. Consistent failure to achieve self-care as appropriate to age or developmental level; and
 - d. Severely diminished ability to assess consequences of own actions (e.g., acts of property damage).
 3. CalOptima-approved cognitive and adaptive testing tools (e.g., Vineland, Adaptive Behavior Assessment System-ABAS, Developmental Assessment of Young Children-DAYC) to assess the Member's age-specific impairments.
 4. A Member-specific behavioral treatment plan that meets the following criteria:
 - a. Developed by a qualified BHT Service Provider as prescribed by California SPA for the specific Member being treated;
 - b. Includes:
 - i. Reason for referral;

- 1 ii. Brief background information (demographics, living situation, home/school/work
2 information);
3
4 iii. Clinical interview;
5
6 iv. Review of recent assessment/reports;
7
8 v. Assessment procedures and results; and
9
10 vi. Recommended evidence-based BHT services;
11
12 c. Be person-centered and based upon individualized measurable goals and objectives over a
13 specific timeline;
14
15 d. Delineates both the frequency of baseline behaviors and the treatment planned to address
16 the behaviors;
17
18 e. Identifies measurable long, intermediate and short-term goals and objectives that are
19 specific, behaviorally defined, developmentally appropriate, socially significant, and based
20 upon clinical observation;
21
22 f. Includes outcome measurement assessment criteria that will be used to measure
23 achievement of behavior objectives;
24
25 g. Includes the current level (baseline behavior parent/guardian is expected to demonstrate,
26 including condition under which it must be demonstrated and mastery criteria [the objective
27 goal]), date of introduction, estimated date of mastery, specify plan for generalization and
28 report goal as met, not met, modified (include explanation);
29
30 h. Utilizes evidence-based BHT services with demonstrated clinical efficacy tailored to the
31 Member;
32
33 i. Clearly identifies:
34
35 i. Number of hours of direct service;
36
37 ii. Number of hours of observation and direction;
38
39 iii. Number of hours of parent/guardian training;
40
41 iv. Parent/guardian support and participation needed to achieve the goals and objectives;
42
43 v. Frequency at which the Member's progress is measured and reported;
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45 vi. Transition plan;
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47 vii. Crisis plan; and
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49 viii. Each individual BHT service provider responsible for delivering the services;

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- j. Includes care coordination involving the parents or caregiver(s), school, state disability programs, and others, as applicable;
 - k. Considers the Member’s age, school attendance requirements, and other daily activities when determining the number of hours of Medically Necessary direct service and supervision;
 - l. Delivers the BHT services in a home or community-based setting, including clinics. Any portion of Medically Necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and community; and
 - m. Includes an exit plan/criteria for completing BHT Services.
- C. Prior Authorization requests for initial BHT services shall be submitted as described in CalOptima Policy GG.1508: Authorization and Processing of Referrals, and shall:
- 1. Be submitted on the Behavioral Health -Authorization Request Form (BH-ARF),
 - 2. Include licensed physician and surgeon or licensed psychologist recommendation for evidenced-based BHT services; and
 - 3. Include a completed BHT Assessment and Treatment Plan by a BHT Service Provider, using the CalOptima-approved template.
 - 4. CalOptima shall process the BH-ARF in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals, MCG Behavioral Healthcare 22nd Edition, Applied Behavioral Analysis, B- 806-T, and APL 18-006: Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21.
- D. CalOptima shall process Prior Authorization requests for continuation of BHT services in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals and shall:
- 1. Be submitted on the BH-ARF no less than every six (6) months by the BHT Service Provider or more frequently when warranted by the individual circumstances;
 - 2. Include an updated Member-specific behavioral treatment plan using the CalOptima-approved template that updates all components of the treatment plan including:
 - a. The anticipated timeline for achievement of each goal that has been updated based on both the initial assessment and subsequent interim assessments;
 - b. Measures of progress for each goal using validated assessment of adaptive functioning;
 - c. Caregivers continued participation in the treatment and demonstration of the ability to apply those skills in naturalized settings;
 - d. Behavioral improvements cannot be maintained if care was reduced;

- e. Behavior issues are not exacerbated and have not become dependent on prompts by the treatment process; and
 - f. The Member has the required cognitive capacity to benefit from the care provided and retain treatment gains
3. Documentation of ongoing coordination of care and communication with the Member's other medical and behavioral providers; and
 4. Documentation of ongoing coordination of care and communication with the Member's LEA, as applicable.
 5. CalOptima shall process the BH-ARF is in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals, MCG Behavioral Healthcare 22nd Edition, Applied Behavioral Analysis, B- 806-T, and All Plan Letter 18-006: Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21.
- E. If a request for BHT services is denied or modified on the basis that the services are not Medically Necessary, and the Member, Authorized Representative, or provider appeals the decision, the decision shall be subject to review in accordance with CalOptima Policies GG.1507: Notification Required for Covered Services Requiring Prior Authorization, GG.1510: Appeals Process for Decisions Regarding Care and Services, and HH.1108: State Hearing Process and Procedures.

IV. ATTACHMENTS

- A. Behavioral Health - Authorization Request Form (BH-ARF)

V. REFERENCES

- A. American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with autism spectrum disorder. February, 2014
- B. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May, 2013
- C. BACB Applied Behavior Analysis Treatment of ASD Practice Guidelines for Healthcare Funders and Managers, 2014
- D. Blumberg, Stephen, et al, Diagnosis lost: Differences between children who had and who currently have an autism spectrum disorder diagnosis. Autism 1-13, 2015
- E. California State Plan Amendment (SPA) 14-026
- F. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- G. CalOptima Policy GG.1113: Referral Practitioner Responsibilities
- H. CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
- I. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
- J. CalOptima Policy GG.1325: Coordination of Care for Newly enrolled Medi-Cal Members into CalOptima
- K. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
- L. CalOptima Policy GG.1508: Authorization and Processing of Referral

- 1 M. CalOptima Policy GG.1507: Notification Required for Covered Services Requiring Prior
- 2 Authorization
- 3 N. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
- 4 O. CalOptima Policy GG.1535: Utilization Criteria and Guidelines
- 5 P. CalOptima Policy HH.1102: CalOptima Member Complaint
- 6 Q. CalOptima Policy HH.1108: State Hearing Process and Procedures
- 7 R. Christine Fountain, Alix S. Winter and Peter S. Bearman. Six Developmental Trajectories
- 8 Characterize Children with Autism. Pediatrics 129, May 1, 2012
- 9 S. Department of Health Care Services (DHCS) All Plan Letter 18-006: Responsibilities for
- 10 Behavioral Health Treatment (BHT) Coverage for Members under the Age of 21
- 11 T. Health & Safety Code, § 1374.73
- 12 U. Lovaas, O. I., Behavior treatment and normal educational and intellectual functioning in young
- 13 autistic recipient. Journal of Consulting and Clinical Psychology, 55, 3-9, 1987
- 14 V. MCG Behavioral Healthcare 22nd Edition, Applied Behavioral Analysis, B- 806-T
- 15 W. Social Security Act (SSA), §§1905(a) and 1905(r)
- 16 X. Title 22, California Code of Regulations (CCR), § 51340

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 18 **VI. REGULATORY AGENCY APPROVALS**

- 19 A. 01/31/18: Department of Health Care Services

20
 21
 22 **VII. BOARD ACTIONS**

- 23 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
- 24 B. 12/07/17: Regular Meeting of the CalOptima Board of Directors

25
 26
 27 **VIII. REVIEW/REVISION HISTORY**

28

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2018	GG.1548	Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder	Medi-Cal
Revised	09/06/2018	GG.1548	Authorization for Behavioral Health Treatment (BHT) Services	Medi-Cal

29

1 IX. GLOSSARY
 2

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, 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 <i>in loco parentis</i> 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.
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3

Behavioral Health-Authorization Request Form (BH-ARF)

ROUTINE

Behavioral Health Fax: 714-954-2300

*** IN ORDER TO PROCESS YOUR REQUEST, BH-ARF MUST BE COMPLETE 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 Rendering Service (Physician, Facility, Vendor):
Provider NPI#: _____ TIN#: _____	Provider NPI#: _____ TIN#: _____
Medi-Cal ID#: _____	Medi-Cal ID#: _____
Address: _____ Phone: _____	Address: _____ Phone: _____
Fax: _____	Fax: _____
Office Contact: _____	Office Contact: _____
Physician's Signature: _____	
Diagnosis: _____	ICD-10: _____

AUTHORIZATION REQUEST

List ALL procedures requested along with the appropriate CPT/HCPCS. Supporting Documentation to include:

For ~~Applied Behavior Analysis~~ Behavioral Health Treatment:

- ~~Functional Behavioral Analysis Report~~ Behavioral Health Treatment Assessment
- Psychological Testing Request Form
- ~~Comprehensive Diagnostic Evaluation~~ Diagnostic and Development Evaluation
- PCP, Local Education Agency, ST/OT/PT Communications

For Testing and Report: _____

REQUESTED PROCEDURES

UNITES & DURATION

CODE (CPT or HCPCS)

— QUANTITY

(REQUIRED)

For Applied Behavior Analysis (Request in hours per week/month)

Mental Health assessment, by non-physician	H0031	_____
Mental Health service plan development by non-physician (Non-BCBA)	H0032-HN	_____
Mental Health service plan development by non-physician (BCBA)	H0032-HO	_____
Skills training and development	H2014	_____
Therapeutic behavioral services	H2019	_____
Home care training to home care client	S5108	_____
Home care training, family	S5110	_____
Testing and Reports		
Psychological Testing (number of hours)	96101	_____
Neurobehavioral status exam	96116	_____
Neuropsychological Testing (number of hours)	96118	_____
Other (Please provide CPT code)		_____

[Back to Agenda](#)

Behavioral Health-Authorization Request Form (BH-ARF)

ROUTINE

Behavioral Health Fax: 714-954-2300

*** IN ORDER TO PROCESS YOUR REQUEST, BH-ARF MUST BE COMPLETE 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 Rendering Service (Physician, Facility, Vendor):
Provider NPI#: _____ TIN#: _____	Provider NPI#: _____ TIN#: _____
Medi-Cal ID#: _____	Medi-Cal ID#: _____
Address: _____ Phone: _____	Address: _____ Phone: _____
Fax: _____	Fax: _____
Office Contact: _____	Office Contact: _____
Physician's Signature: _____	
Diagnosis: _____	ICD-10: _____

AUTHORIZATION REQUEST

List ALL procedures requested along with the appropriate CPT/HCPCS. Supporting Documentation to include:

For Behavioral Health Treatment:

- Behavioral Health Treatment Assessment
- Diagnostic and Development Evaluation
- PCP, Local Education Agency, ST/OT/PT Communications

For Testing and Report:

- Psychological Testing Request Form

REQUESTED PROCEDURES	CODE (CPT or HCPCS)	UNITS & DURATION
For Applied Behavior Analysis		
Mental Health assessment, by non-physician	H0031	
Mental Health service plan development by non-physician (Non-BCBA)	H0032-HN	
Mental Health service plan development by non-physician (BCBA)	H0032-HO	
Skills training and development	H2014	
Therapeutic behavioral services	H2019	
Home care training to home care client	S5108	
Home care training, family	S5110	
Testing and Reports		
Psychological Testing	96101	
Neurobehavioral status exam	96116	
Neuropsychological Testing	96118	
Other (Please provide CPT code)		



JENNIFER KENT
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

DATE: March 2, 2018

ALL PLAN LETTER 18-006
SUPERSEDES ALL PLAN LETTER 15-025

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: RESPONSIBILITIES FOR BEHAVIORAL HEALTH TREATMENT
COVERAGE FOR MEMBERS UNDER THE AGE OF 21

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) about the provision of medically necessary Behavioral Health Treatment (BHT) services to eligible Medi-Cal members under 21 years of age as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate.¹ This APL supersedes APL 15-025.

BACKGROUND:

BHT is the design, implementation and evaluation of environmental modifications, 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.² 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 based on reliable evidence and are not experimental. BHT services include a variety of behavioral interventions that have been identified as evidenced-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence and are designed to be delivered primarily in the home and in other community settings.

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 (SSA) for EPSDT.^{3, 4} Section 1905(r) of the SSA defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic and treatment services for low-income individuals under 21 years of age. States are required

¹ See Title 42 of the United States Code (USC), Section 1396d(a)(4)(B). 42 USC is available at:

<http://uscode.house.gov/browse/prelim@title42&edition=prelim>

² See California Government Code (GOV), Section 95021, at:

http://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV§ionNum=95021.

³ The CMS Informational Bulletin dated July 7, 2014, is available at:

<http://www.medicare.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf>.

⁴ Section 1905 of the SSA is available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm

to provide any Medicaid covered service listed in Section 1905(a) of the SSA 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 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 SSA regardless of whether or not they have been approved under a State Plan Amendment (SPA).

CMS guidance clarified that all children must receive EPSDT screenings designed to identify health and developmental issues as early as possible. All children enrolled in Medicaid (Medi-Cal) must be screened at regular intervals in accordance with recommendations for preventive pediatric health care developed by the American Academy of Pediatrics “Bright Futures” guidelines. 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.

On September 30, 2014, in response to CMS guidance and in accordance with Title 42 of the Code of Federal Regulations (CFR), Section 440.130(c), the Department of Health Care Services (DHCS) included BHT services as a Medi-Cal covered benefit for members under 21 years of age when medically necessary, based upon recommendation of a licensed physician and surgeon or a licensed psychologist, after a diagnosis of Autism Spectrum Disorder (ASD).^{5, 6} In 2016, over the course of several months, DHCS completed the transition of BHT services for members with an ASD diagnosis from the Department of Developmental Services (DDS) Regional Centers (RCs) to the MCPs.

Upon renewals for the 1915(c) Home and Community-Based Services Waiver and 1915(i) Home and Community-Based Services SPAs, CMS asserted that under the EPSDT benefit, Medi-Cal must cover medically necessary BHT services for all members under 21 years of age.⁷ Accordingly, effective July 1, 2018, MCPs are

⁵ 42 CFR 440.130(c) defines “preventive services” as “services recommended by a physician or other licensed practitioner of the healing arts within the scope of authorized 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”. 42 CFR, Part 440, is available at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=5a4149f390cdecf30c385d48cb76202d&mc=true&node=pt42.4.440&rgn=div5>

⁶ 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 in the Diagnostic and Statistical Manual (DSM) V.

⁷ Home and Community-Based Services 1915(c) Waiver and 1915(i) SPAs are available at: <http://www.dds.ca.gov/waiver/index.cfm>

responsible for providing medically necessary BHT services for all members that meet the eligibility criteria for services as stated in 1905(r) of the SSA and outlined in this APL, even without a diagnosis of ASD, based upon medical necessity as determined by a licensed physician and surgeon or a licensed psychologist.

On July 1, 2018, DHCS will transition the provision of medically necessary BHT services for eligible members under 21 years of age without an ASD diagnosis from the RCs to the MCPs. Members receiving BHT services through DDS prior to July 1, 2018, will continue to receive the RC-coordinated BHT services at the RCs until the transition date. Beginning on July 1, 2018, the authorization and payment of BHT services will transition from the RCs to the MCPs.

POLICY:

In accordance with existing Medi-Cal contracts and federal EPSDT requirements, MCPs are responsible for the provision of EPSDT services for members under 21 years of age (see APL 18-007,⁸ *Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21* for additional information). MCPs must:

- 1) Inform members that EPSDT services are available for members under 21 years of age.
- 2) Provide access to comprehensive screening and prevention services, at designated intervals or at other intervals indicated as medically necessary, in accordance with the most current Bright Futures periodicity schedule, including, but not limited to:
 - a health and developmental history
 - a comprehensive unclothed physical examination
 - appropriate immunizations
 - lab tests and lead toxicity screening
 - screening services to identify developmental issues as early as possible.
- 3) Provide access to medically necessary diagnostic and treatment services, including but not limited to, BHT services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist.

The provision of EPSDT services for members under 21 years of age, which includes medically necessary, evidence-based BHT services that prevent or minimize behavioral conditions and promote, to the maximum extent practicable, the functioning of a member, will become the responsibility of MCPs effective on the date of the member's transition from the RC or, for new members, upon MCP enrollment. MCPs must ensure

⁸ DHCS All Plan Letters are available at: <http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

that appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the MCP contract.

CRITERIA FOR BHT SERVICES:

In order to be eligible for BHT services, a Medi-Cal member must meet all of the following coverage criteria:

- 1) Be under 21 years of age.
- 2) Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT services are medically necessary.
- 3) Be medically stable.
- 4) Be 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).

MCPs are responsible for coordinating the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services.

COVERED SERVICES:

Medi-Cal covered BHT services must be:

- 1) Medically necessary to correct or ameliorate behavioral conditions as defined in Section 1905(r) of the SSA and as determined by a licensed physician and surgeon or licensed psychologist.
- 2) Delivered in accordance with the member's MCP-approved behavioral treatment plan.
- 3) Provided by California State Plan approved providers as defined in SPA 14-026.⁹
- 4) Provided and supervised according to an MCP-approved behavioral treatment plan developed by a BHT service provider credentialed as specified in SPA 14-026 ("BHT Service Provider").

BHT services are provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific member being treated and that has been developed by a BHT Service Provider. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT Service Provider. The behavioral treatment plan may be modified if medically necessary. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

⁹ California SPAs are available at:

<http://www.dhcs.ca.gov/formsandpubs/laws/Pages/ApprovedSPA.aspx>

The following services do not meet medical necessity criteria or qualify as Medi-Cal covered BHT services for reimbursement:

- 1) Services rendered when continued clinical benefit is not expected.
- 2) Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
- 3) Treatment whose sole purpose is vocationally- or recreationally-based.
- 4) Custodial care. For purposes of BHT services, custodial care:
 - Is provided primarily for maintaining the member's or anyone else's safety.
 - 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, resorts, spas and camps.
- 6) Services rendered by a parent, legal guardian or legally responsible person.
- 7) Services that are not evidence-based behavioral intervention practices.

BEHAVIORAL TREATMENT PLAN:

BHT services must be provided, observed and directed under an approved behavioral treatment plan.

The approved behavioral treatment plan must meet the following criteria:

- 1) Be developed by a BHT Service Provider for the specific member being treated.
- 2) Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
- 3) Be person-centered and based upon individualized, measurable goals and objectives over a specific timeline.
- 4) Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
- 5) Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
- 6) Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
- 7) Include the current level (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, modified (include explanation).

- 8) Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
- 9) Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual BHT service provider responsible for delivering the services.
- 10) Include care coordination involving the parents or caregiver(s), school, state disability programs and others as applicable.
- 11) Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
- 12) Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and community.
- 13) Include an exit plan/criteria.

CONTINUITY OF CARE:

Continuity of care requirements for new members who did not receive BHT services from an RC prior to July 1, 2018, are set forth in APL 18-008, *Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care*.

Members under 21 years of age transitioning from an RC to an MCP will not have to independently request continuity of care from the MCP. Instead, the MCP must automatically initiate the continuity of care process prior to the member's transition to the MCP for BHT services. At least 45 days prior to the transition date, DHCS will provide MCPs with a list of members for whom the responsibility for BHT services will transition from RCs to MCPs, as well as member-specific utilization data. The utilization data file will include information about services and rendering providers recently accessed by members. MCPs will be required to utilize the data and treatment information provided by DHCS, the RC, or the rendering provider to determine BHT service needs and associated rendering providers. This information should be used to determine if the current BHT provider is in the MCP's network and if a continuity of care arrangement is necessary. MCPs must make a good faith effort to proactively contact the provider to begin the continuity of care process.

An MCP must offer members continued access to an out-of-network provider of BHT services (continuity of care) for up to 12 months, in accordance with existing contract requirements and APL 18-008, if all of the following conditions are met:

- 1) The member has an existing relationship with a qualified provider of BHT services. An existing relationship means the member has seen the provider at least one time during the six months prior to either the transition of services from the RC to the MCP or the date of the member's initial enrollment in the MCP if enrollment occurred on or after July 1, 2018.
- 2) The provider and the MCP can agree to a rate, with the minimum rate offered by the MCP being the established Medi-Cal fee-for-service (FFS) rate for the applicable BHT service.
- 3) The provider does not have any documented quality of care concerns that would cause him/her to be excluded from the MCP's network.
- 4) The provider is a California State Plan approved provider.
- 5) The provider supplies the MCP with all relevant treatment information for the purposes of determining medical necessity, as well as a current treatment plan, subject to federal and state privacy laws and regulations.

Additionally, if a member has an existing relationship, as defined above, with an in-network BHT service provider, the MCP must assign the member to that provider to continue BHT services.

BHT services should not be discontinued or changed during the continuity of care period until a new behavioral treatment plan has been completed and approved by the MCP, regardless of whether the services are provided by the RC provider under continuity of care or a new, in-network MCP provider.

If a continuity of care agreement cannot be reached with the RC provider by the date of transition to the MCP, the MCP must appropriately transition the member to a new, in-network BHT service provider and ensure that neither a gap nor a change in services occurs until such time as the MCP approves a new assessment and behavioral treatment plan from an in-network BHT service provider.

OUTBOUND CALL CAMPAIGN:

To inform members who are transitioning from RCs of their automatic continuity of care rights, MCPs must conduct an Outbound Call Campaign, as described below.

MCPs must:

- 1) Call the member (or his/her parent/guardian) after 60-day member informing notices are mailed and prior to the date of transition.
- 2) Make five call attempts to reach the member (or his/her parent/guardian).
- 3) Inform the member of the transition and the continuity of care process.
- 4) Not call members who have explicitly requested not to be called.

REPORTING AND MONITORING:

MCPs must report metrics to DHCS related to the requirements outlined in this APL in a manner determined by DHCS.

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 applicable APLs, Policy Letters, and Dual Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

For 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
Department of Health Care Services

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

18. Consider Approval of Proposed New Behavioral Health Policies and Forms to Support the Administration of Behavioral Health (BH) Services for Medi-Cal Members Within CalOptima Internal Operations

Contact

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

Recommended Actions

1. Approve CalOptima Policy GG:1548, Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder; and
2. Approve CalOptima Policy GG:1549, Authorization for Psychological Testing for Mental Health Condition

Background

CalOptima currently contracts with Human Affairs International of California, Inc., dba Magellan Healthcare (Magellan) as its Managed Behavioral Health Organization serving Medi-Cal, OneCare, and OneCare Connect members. On September 7, 2017, the Board approved the integration of administration of Medi-Cal covered BH, which includes Mental Health (MH) and Applied Behavior Analysis (ABA) services, within CalOptima internal operations effective January 1, 2018. As part of the implementation process, CalOptima staff has reviewed all relevant policies and identified the need to develop two new ones to address the utilization management of psychological testing and ABA services.

The following Policies and associated forms are being presented, requiring CalOptima Board approval:

	Policy No./Name	Summary/Reason for New Policy
1.	GG.1548: Applied Behavioral Analysis for Autism Spectrum Disorder	<ul style="list-style-type: none">• New Policy developed to ensure an ABA policy and process is developed for the assumption of Behavioral Health Services by CalOptima effective 1/1/18• This policy addresses processes for ABA services eligibility, medical necessity criteria, prior authorization rules, and information related to appeals and grievances• Attached Behavioral Health- Authorization Referral Form (BH-ARF) form for authorization of ABA services
2.	GG.1549: Authorization for Psychological	<ul style="list-style-type: none">• New Policy developed to ensure a Psychological Testing policy and process is developed for the assumption of Behavioral Health Services by CalOptima effective 1/1/18

Testing for Mental Health Conditions	<ul style="list-style-type: none">• This policy addresses processes and criteria to meet eligibility for Psychological Testing, prior authorization and grievances and appeals process• Attached Psychological Testing Request Form for authorization of Psychological Testing services
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Fiscal Impact

There is no anticipated fiscal impact.

Rationale for Recommendation

CalOptima staff has developed two new policies, GG.1548 and GG.1549, to ensure a clear process exists for prior authorization of services specifically related to behavioral health benefits, e.g. psychological testing for mental health conditions and applied behavioral analysis for autism spectrum disorder services. Both policies support the integration of administration of Medi-Cal BH services into CalOptima’s operations and help to ensure compliance with applicable regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Policy GG.1548: Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder
2. Policy GG.1549: Authorization for Psychological Testing for Mental Health Conditions
3. Board Action dated September 7, 2017, Consider Further Actions Related to the Provisions of Behavioral Health Services for CalOptima Medi-Cal Members

/s/ Michael Schrader
Authorized Signature

11/30/2017
Date



Policy #: GG.1548
Title: **Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder**
Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 01/01/18
Last Review Date: Not Applicable
Last Revised Date: Not Applicable

1 **I. PURPOSE**

2
3 This policy defines the process by which CalOptima Members may obtain Medically Necessary Applied
4 Behavioral Analysis (ABA) to treat Autism Spectrum Disorder (ASD) and to provide guidance to
5 Providers on Prior Authorization requirements for the provision of Behavioral Health Treatment (BHT)
6 services to Medi-Cal beneficiaries under twenty-one (21) years of age diagnosed with Autism Spectrum
7 Disorder (ASD).
8

9 **II. POLICY**

10
11 A. CalOptima shall provide ABA services to eligible Medi-Cal Members when Medically Necessary
12 and in accordance with CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and
13 Treatment (EPSDT) Services, Title 22, California Code of Regulations (CCR), Section 51340, and
14 Department of Health Care Services (DHCS) All Plan Letter (APL) 15-025: Responsibilities for
15 Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder.
16

17 B. A Member shall be eligible to receive ABA services, if all the following criteria are met:

- 18
19 1. The Member is under age twenty-one (21); and
20 2. If under three (3) years of age, must have provisional diagnosis 954-2300.
21

22 C. Prior Authorization for initial requests for ABA services shall include:

- 23
24 1. A licensed medical professional or licensed psychologist diagnosis of ASD;
25
26 2. A licensed medical professional or licensed psychologist recommendation for evidenced-based
27 ABA services;
28
29 3. A previously authorized Functional Behavior Assessment (FBA) that identifies:
30
31 a. Using validated assessment tools (e.g. Vineland, ABAS), the Member's age-specific
32 impairments such as:
33
34 i. Persistent deficits in social communication and social interaction that have been
35 identified as deficient relative to age expected norms;
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37 ii. Significant restricted, repetitive patterns of behavior or interests; and
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39 iii. Significant property destruction or aggression related to the Member's ASD.

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- b. Antecedents, consequences, and reinforcers that maintain the behavioral impairments; and
 - c. Possible functions of the behavioral impairments.
4. Documentation which describes the Member-specific treatment plan that includes:
 - a. The identified behavioral, psychological, family, and medical concerns;
 - b. Measurable goals in objective and measurable terms based on standardized assessments that address the behaviors and impairments for which the intervention is to be applied. For each goal, baseline measurements, progress to date and anticipated timeline for achievement based on both the initial assessment and subsequent interim assessments over the duration of the intervention; and
 - c. Information that identifies the delivery of ABA services by a Qualified Autism Service Provider, aligned with provisions set forth in All Plan Letter (APL) 15-025: Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder and defined in Health and & Safety Code Section 1374.73(c)(3),
 5. The Member is medically stable;
 6. The Member is without need for twenty-four (24)-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities;
 7. The ABA services are necessary to correct or ameliorate defects related to ASD, and are generally accepted by the medical community as effective and proven treatments for ASD; and
 8. The predicted beneficial outcome of the services outweighs potential harmful effects of ABA such as prompt dependence.
- D. Prior Authorization for continuation of ABA services requires that the following information be submitted:
1. The Member has met the following criteria related to the initial course of ABA:
 - a. A licensed medical professional or licensed psychologist continues to diagnose ASD;
 - b. A licensed medical professional or licensed psychologist continues to make a recommendation for evidenced-based ABA services;
 - c. The Member-specific treatment plan has been updated and submitted every six (6) months by the ABA provider or more frequently when warranted by the individual circumstances;
 - d. The anticipated timeline for achievement of each goal in the Member-specific treatment plan has been based on both the initial assessment and subsequent interim assessments;

- 1 e. the Member-specific treatment plan includes measures of progress for each goal using
2 validated assessments of adaptive functioning;
3
- 4 f. There has been documentation of caregivers continued participation in the treatment and
5 demonstration of the ability to apply those skills in naturalized settings;
6
- 7 g. Improvements toward developmental norms and behavior goals cannot be maintained if
8 care was reduced;
9
- 10 h. Behavior issues are not exacerbated and have not become dependent on prompts by the
11 treatment process; and
12
- 13 i. The Member has the required cognitive capacity to benefit from the care provided and to
14 retain and generalize treatment gains.
15
- 16 2. Documentation of ongoing coordination of care and communication with the Member's medical
17 provider; and
18
- 19 3. Documentation of ongoing coordination of care and communication with the member's Local
20 Education Agency, as applicable.
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- 22 4. Information that identifies the delivery of ABA services by a Qualified Autism Service
23 Provider.
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- 25 E. If a request for ABA services is denied or modified on the basis that the services are not Medically
26 Necessary, and the Member, Authorized Representative, or provider appeals the decision, the
27 decision shall be subject to review in accordance with CalOptima Policies GG.1507: Notification
28 Required for Covered Services Requiring Prior Authorization, GG.1510: Appeals Process for
29 Decisions Regarding Care and Services, and HH.1108: State Hearing Process and Procedures.
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- 31 F. Discharge from ABA services are based on the following criteria:
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- 33 1. Functional improvement is sufficient;
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- 35 2. Symptom relief is sufficient;
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- 37 3. Risk status is minimized for dangerousness or property destruction;
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- 39 4. Continued clinical benefit is not expected from the services being rendered and care is judged
40 no longer appropriate as:
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- 42 a. Behavioral issues are exacerbated by the treatment;
43
- 44 b. Member is unlikely to maintain gains from continued care;
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- 46 c. Member does not demonstrate progress towards goals for successive authorization periods;
47
- 48 d. The services being used in the treatment of ASD are not evidence-based practices;
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- e. The services being rendered provide or coordinate respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan;
- f. The services, supplies or procedures are performed in a non-conventional setting including, but not limited to, resorts, spas and camps;
- g. The sole purpose of the treatment is vocationally or recreationally-based;
- h. the services could be provided by persons without professional skills or training to maintain the beneficiary's or anyone else's safety; and
- i. the services are being rendered by a parent, legal guardian or legally responsible person.

IV. ATTACHMENTS

- A. Behavioral Health - Authorization Request Form (BH-ARF)

V. REFERENCES

- A. American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with autism spectrum disorder. February, 2014
- B. BACB Applied Behavior Analysis Treatment of ASD Practice Guidelines for Healthcare Funders and Managers, 2016
- C. Blumberg, Stephen, et al, Diagnosis lost: Differences between children who had and who currently have an autism spectrum disorder diagnosis. Autism 1-13, 2015
- B. California Welfare and Institutions Code, Section 14132
- C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- B. CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
- C. CalOptima Policy GG1113: Referral Practitioner Responsibilities
- D. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
- E. CalOptima Policy GG.1508: Authorization and Processing of Referral
- F. CalOptima Policy GG1507: Notification Required for Covered Services Requiring Prior Authorization
- G. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
- H. CalOptima Policy GG.1535: Utilization Criteria and Guidelines
- I. CalOptima Policy HH.1102: CalOptima Member Complaint
- J. CalOptima Policy HH.1108: State Hearing Process and Procedures
- K. Christine Fountain, Alix S. Winter and Peter S. Bearman. Six Developmental Trajectories Characterize Children With Autism. Pediatrics 129, May 1, 2012
- L. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-025: Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder
- M. Health & Safety Code, Section 1374.73 American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May, 2013
- N. Lovaas, O. I., Behavior treatment and normal educational and intellectual functioning in young autistic recipient. Journal of Consulting and Clinical Psychology, 55, 3-9, 1987

- O. MCG 21st Ed Applied Behavioral Analysis ORG: B-a12-AOP (BHG)
- P. Title 22, California Code of Regulations (C.C.R.), § 51340

B. REGULATORY AGENCY APPROVALS

None to Date

C. BOARD ACTIONS

12/07/17: Regular Meeting of the CalOptima Board of Directors

D. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2018	GG.1548	Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder	Medi-Cal

1 E. **GLOSSARY**
2

Term	Definition
Applied Behavior Analysis (ABA)	Applied Behavior Analysis refer to the use of behavioral learning principles (i.e. behavior-consequence paradigm) to produce changes in behavior, specifically the development of skills in areas of need (e.g. language) and the reduction in maladaptive behaviors (e.g. aggression, self-injury). ABA therapy may be comprehensive in nature, teaching adaptive techniques to address multiple behavioral and functional concerns, or may be problem-focused and targeted towards addressing specifically identified problematic behaviors (e.g. aggression). (MCG Behavioral Health 21st Edition)
Authorized Representative	Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, 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 <i>in loco parentis</i> 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, Use, and Disclosure of PHI to a Member's Authorized Representative.
Autism Spectrum Disorder (ASD)	ASD is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome.
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, 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
Functional Behavior Assessment (FBA)	By gathering data and conducting experiments that evaluated the effects of environmental variables on the behavior, evaluators decipher the meaning of the behaviors (i.e., what emotion or message was being communicated through the actions), determine why they were occurring, and develop behavior change programs to help the disabled individual display more appropriate behavior in meeting his or her needs.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Qualified Autism Service Provider	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.

3

Behavioral Health-Authorization Request Form (BH-ARF)

ROUTINE

Behavioral Health Fax: 714-954-2300

*** IN ORDER TO PROCESS YOUR REQUEST, BH-ARF MUST BE COMPLETE 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 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

List ALL procedures requested along with the appropriate CPT/HCPCS. Supporting Documentation to include:

For Applied Behavior Analysis:

- Functional Behavioral Analysis Report
- Comprehensive Diagnostic Evaluation
- PCP, Local Education Agency, ST/OT/PT Communications

For Testing and Report:

- Psychological Testing Request Form

REQUESTED PROCEDURES	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)
For Applied Behavior Analysis (Request in hours per week/month)		
Mental Health assessment, by non-physician	H0031	_____
Mental Health service plan development by non-physician (Non-BCBA)	H0032-HN	_____
Mental Health service plan development by non-physician (BCBA)	H0032-HO	_____
Skills training and development	H2014	_____
Therapeutic behavioral services	H2019	_____
Home care training to home care client	S5108	_____
Home care training, family	S5110	_____
Testing and Reports		
Psychological Testing (number of hours)	96101	_____
Neurobehavioral status exam	96116	_____
Neuropsychological Testing (number of hours)	96118	_____
Other (Please provide CPT code)	_____	_____

Policy #: GG.1549
 Title: **Authorization for Psychological Testing for Mental Health Conditions**
 Department: Medical Affairs
 Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 01/01/18
 Last Review Date: Not Applicable
 Last Revised Date: Not Applicable

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I. PURPOSE

This policy defines the process by which CalOptima Members may obtain Medically Necessary Psychological Testing for Mental Health Conditions.

II. POLICY

- A. CalOptima shall provide Psychological Testing to Members when Medically Necessary, and after submission of a CalOptima Behavioral Health Authorization Request Form by the psychologist who has evaluated the Member.
- B. Criteria for Medical Necessity for Psychological Testing is based on the most current guidelines pursuant to CalOptima Policy GG.1535: Utilization Criteria and Guidelines.
- C. Psychological Testing excludes educational testing or testing requested by the legal system.
- D. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies GG.1510: Appeals Process for Decisions Regarding Care and Services, HH.1102: CalOptima Member Complaint, and HH.1108: State Hearing Process and Procedures.

III. PROCEDURE

- A. CalOptima shall ensure that, unless otherwise excluded, all Psychological Testing for Medi-Cal Members are provided by CalOptima’s Behavioral Health Providers.
- B. CalOptima’s Behavioral Health Providers shall submit Prior Authorization requests for Psychological Testing, in accordance with this policy.
- C. Prior Authorization criteria for Psychological Testing requires all of the following:
 - 1. Be clinically indicated to evaluate a mental health condition;
 - 2. An evaluation by a psychiatrist or psychologist to identify specific diagnostic questions of concern;
 - 3. Tests must be published, valid, and in general use as evidenced by their presence in the current edition of the Mental Measurement Yearbook, or Tests in Print or Most Current Edition by their

1 conformity to the Standards for Educational and Psychological Tests of the American
2 Psychological Association;

- 3
4 4. Testing is not routine (e.g., a standard test battery administered to all new members); and
5
6 5. Tests are administered by a licensed psychologist and or other clinician for whom testing falls
7 within the scope of their clinical license and who has specialized training in psychological
8 testing.
9

- 10 D. If a request for Psychological Testing is denied on the basis that the services are not Medically
11 Necessary, and the Member, the Member's Authorized Representative, or provider appeals the
12 decision, the decision shall be subject to review in accordance with CalOptima Policies GG.1510:
13 Appeals Process for Decisions Regarding Care and Services, and HH.1108: State Hearing Process
14 and Procedures.
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16 **III. ATTACHMENTS**

- 17
18 A. Authorization Request Form (ARF)
19 B. Psychological Testing Request
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21 **IV. REFERENCES**

- 22
23 A. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth
24 Edition. DSM-5. American Psychiatric Association. Washington, DC. May, 2013
25 B. CalOptima Policy GG.1113: Referral Practitioner Responsibilities
26 C. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima
27 Community Network Providers
28 D. CalOptima Policy GG.1508: Authorization and Processing of Referral
29 E. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
30 F. CalOptima Policy GG.1535: Utilization Criteria and Guidelines
31 G. CalOptima Policy HH.1102: CalOptima Member Complaint
32 H. CalOptima Policy HH.1108: State Hearing Process and Procedures
33 I. Department of Health Care Services (DHCS) All Plan Letter (APL) 13-021: Medi-Cal Managed
34 Care Plan Responsibilities for Outpatient Mental Health Services
35 J. MCG 21st Ed Psychological Testing B-807-T
36 K. MCG 21st Ed Neuropsychological Testing B-805-T
37 L. Title 22, California Code of Regulations, § 51340
38

39 **VI. REGULATORY AGENCY APPROVALS**

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41 None to Date
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43 **VII. BOARD ACTIONS**

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45 A. 12/07/17: 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	01/01/2018	GG.1549	Authorization for Psychological Testing for Mental Health Conditions	Medi-Cal

DRAFT

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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, 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 <i>in loco parentis</i> 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, Use, and Disclosure of PHI to a Member's Authorized Representative.
Medical Necessity/Medically Necessary	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.
Mental Health Conditions	Disorders that affect your mood, thinking and behavior.
Psychological Testing	Psychological Testing is the use of standardized assessment tools to gather information relevant to a member's intellectual and psychological functioning. Psychological testing can be used to determine differential diagnosis and assess overall cognitive functioning related to a member's mental health or substance use status. Test results may have important implications for treatment planning

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DRAFT

Behavioral Health-Authorization Request Form (BH-ARF)

ROUTINE

Behavioral Health Fax: 714-954-2300

*** IN ORDER TO PROCESS YOUR REQUEST, BH-ARF MUST BE COMPLETE 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 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

List ALL procedures requested along with the appropriate CPT/HCPCS. Supporting Documentation to include:

For Applied Behavior Analysis:

- Functional Behavioral Analysis Report
- Comprehensive Diagnostic Evaluation
- PCP, Local Education Agency, ST/OT/PT Communications

For Testing and Report:

- Psychological Testing Request Form

REQUESTED PROCEDURES	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)
For Applied Behavior Analysis (Request in hours per week/month)		
Mental Health assessment, by non-physician	H0031	_____
Mental Health service plan development by non-physician (Non-BCBA)	H0032-HN	_____
Mental Health service plan development by non-physician (BCBA)	H0032-HO	_____
Skills training and development	H2014	_____
Therapeutic behavioral services	H2019	_____
Home care training to home care client	S5108	_____
Home care training, family	S5110	_____
Testing and Reports		
Psychological Testing (number of hours)	96101	_____
Neurobehavioral status exam	96116	_____
Neuropsychological Testing (number of hours)	96118	_____
Other (Please provide CPT code)	_____	_____

PSYCHOLOGICAL TESTING FORM

This form should be completed by the clinician who has a thorough knowledge of the member's current clinical situation and/or treatment history.

All psychological testing requests must be pre-authorized using this form. Requests for testing should be made only after a comprehensive clinical evaluation has been conducted. This evaluation would normally included direct clinical interviews, relevant history, a review of prior evaluations and testing and contact with the member's school personnel (teacher, guidance counselor), etc. if member is a child. Please note that psychological testing conducted primarily for educational or legal reasons is not a covered service.

This form should be attached to the CalOptima Authorization Request.

****Services performed without prior authorization, or authorization requests that are received after the date of testing, will not be approved.**

Date psychological comprehensive clinical evaluation completed (required): _____

Member Name: _____ D.O.B.: ____/____/____

Plan ID Number: _____

Name and discipline of referring clinician (please indicate if you are a Developmental/Behavioral Pediatrician):

Provider Agency & Phone #: _____

Name of Psychologist/Provider who will do testing (if known): _____

Testing Agency & Phone # _____

Provider ID # _____

NPI # _____

This request was submitted by: Referring Clinician _____ or Psychologist who will do testing _____

What are the member's current symptoms? _____

Is the member currently in outpatient treatment? Yes No

Date OP treatment began: _____

Please list specific question(s) to be addressed by psychological testing:

- _____
- _____
- _____

Please list what has been done to date to answer these clinical question(s) prior to requesting psychological testing (please be specific):

- _____
- _____
- _____

How will results of psychological testing facilitate treatment goals and/or provide information beyond what is currently available? **(please be specific)**

- _____
- _____
- _____

Has the member had psychopharmacological consultation? Yes No

By whom? _____

Academic issues (if applicable): _____

- Special Education? Yes No
- IEP? Yes No
- Dates of any previous psychological or neuropsychological testing _____

Medical issues (including any known pregnancy/birth complications, brain injury, head trauma, lead poisoning):

- _____
- _____

History of Substance Use/Abuse: Yes No

- If Yes, what substances? _____
- Last use? _____
- Age at first use: _____

Diagnosis: Axis I _____ ICD-10 _____

Please list the psychological tests requested with time required for administration and scoring (in 1 hour units):

_____	= hr(s)	_____	=	_____	hr(s)	_____	=	_____	hr(s)
_____	= hr(s)	_____	=	_____	hr(s)	_____	=	_____	hr(s)
_____	= hr(s)	_____	=	_____	hr(s)	_____	=	_____	hr(s)

Please check one:

- 96101 Psychological Testing [includes assessment or personality and intellectual abilities, e.g. WAIS-R, Rorschach, TAT, MMPI]
- 96118 Neuropsychological Testing by Psychologist

Total Units [Hours] Requested: _____

Dates requested for testing: From ____/____/____ To ____/____/____

Best time and phone number to reach psychologist if needed? _____

Signature of clinician completing request: _____ Date: _____

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

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;

- 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:
 - Develop authorization processes for ABA services and psychological testing;
 - 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.

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



CalOptima
Better. Together.

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**

Agenda

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

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

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

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

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

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

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)

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

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

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	

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

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

Fiscal Impact

- Estimated cost

- \$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

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.

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.

CalOptima's Mission

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

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;~~
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.~~

Continued
to
9/7/2017
Board
Meeting

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

CalOptima Board Action Agenda Referral
Consider Actions Related to the Provision of Behavioral
Health Services for CalOptima Medi-Cal Members
Page 2

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

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.

CalOptima Board Action Agenda Referral
Consider Actions Related to the Provision of Behavioral
Health Services for CalOptima Medi-Cal Members
Page 4

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:

- \$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

Rev.
8/3/17

CalOptima Board Action Agenda Referral
Consider Actions Related to the Provision of Behavioral
Health Services for CalOptima Medi-Cal Members
Page 5

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



CalOptima
Better. Together.

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**

Agenda

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

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

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)

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

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

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)

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

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;

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.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

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

Background

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

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

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

[Back to Agenda](#)

CalOptima Board Action Agenda Referral
Consider Authorization of Contract with a 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
Page 2

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

CalOptima Board Action Agenda Referral

Consider Authorization of Contract with a 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

Page 3

- 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.

CalOptima Board Action Agenda Referral
Consider Authorization of Contract with a 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
Page 4

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
Authorized Signature

8/25/2016
Date

[Back to Agenda](#)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contact

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

Recommended Action

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

Background

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

Discussion

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

Operational

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

CalOptima Board Action Agenda Referral
Authorize the CEO to Contract with CHIPA for the Provision of
Medi-Cal Outpatient Mental Health Services Beginning January 1, 2014
Page 2

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
Authorized Signature

11/27/2013
Date

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

CalOptima Board Action Agenda Referral
Authorize and Direct the Chairman of the Board to
Execute Amendments to the Primary Agreement between the
DHCS and CalOptima to Implement the BHT Benefit
Page 2

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

Authorized Signature

9/26/2014

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

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

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

CalOptima Board Action Agenda Referral

Ratify Amendment of CalOptima's Contract with CHIPA to Include BHT Services, Including ABA Services, to Meet DHCS Requirements; Authorize the Development of Policies and Procedures as Necessary to Implement the BHT Benefit

Page 2

- 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 Behavioral 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.

CalOptima Board Action Agenda Referral
Ratify Amendment of CalOptima's Contract with CHIPA to Include
BHT Services, Including ABA Services, to Meet DHCS Requirements;
Authorize the Development of Policies and Procedures as Necessary to
Implement the BHT Benefit
Page 3

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

CalOptima Board Action Agenda Referral
Ratify Amendment of CalOptima's Contract with CHIPA to Include
BHT Services, Including ABA Services, to Meet DHCS Requirements;
Authorize the Development of Policies and Procedures as Necessary to
Implement the BHT Benefit
Page 4

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
Authorized Signature

9/26/2014
Date



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



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 ASD¹. 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

ALL PLAN LETTER 14-011

Page 3 of 7

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;

- 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.);

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 evaluation² 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.

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.

ALL PLAN LETTER 14-011

Page 7 of 7

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



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



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.



TOBY DOUGLAS
DIRECTOR

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



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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>



TOBY DOUGLAS
DIRECTOR

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



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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
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>

Page 2-CMCS Informational Bulletin

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”

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 as 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,

Page 5-CMCS Informational Bulletin

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.

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.~~
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.

Revised
5/7/15

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.

CalOptima Board Action Agenda Referral
Authorize Contract for Behavioral Health Services with
Windstone Behavioral Health for Cal MediConnect/OneCare
Connect, and Extend the Current OneCare Contract
Page 2

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
Authorized Signature

5/1/2015
Date

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.

CalOptima Board Action Agenda Referral
Authorize Extension of the Cal MediConnect/OneCare Connect
Contract with Windstone Behavioral Health for Behavioral Health
Services; Authorize Contract for Consulting Services Related to RFP
Development and Delivery Model Optimization for the Behavioral
Health Benefit
Page 2

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

CalOptima Board Action Agenda Referral
Authorize Extension of the Cal MediConnect/OneCare Connect
Contract with Windstone Behavioral Health for Behavioral Health
Services; Authorize Contract for Consulting Services Related to RFP
Development and Delivery Model Optimization for the Behavioral
Health Benefit
Page 3

\$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

Attachment to:
February 4, 2016
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

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Revised
5/7/15

Background and Discussion

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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.

CalOptima Board Action Agenda Referral
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Page 2

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
Authorized Signature

5/1/2015
Date



CalOptima
Better. Together.

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

**Board of Directors Meeting
September 1, 2016**

**Richard Helmer, M.D., Chief Medical Officer
Donald Sharps, M.D., Medical Director**

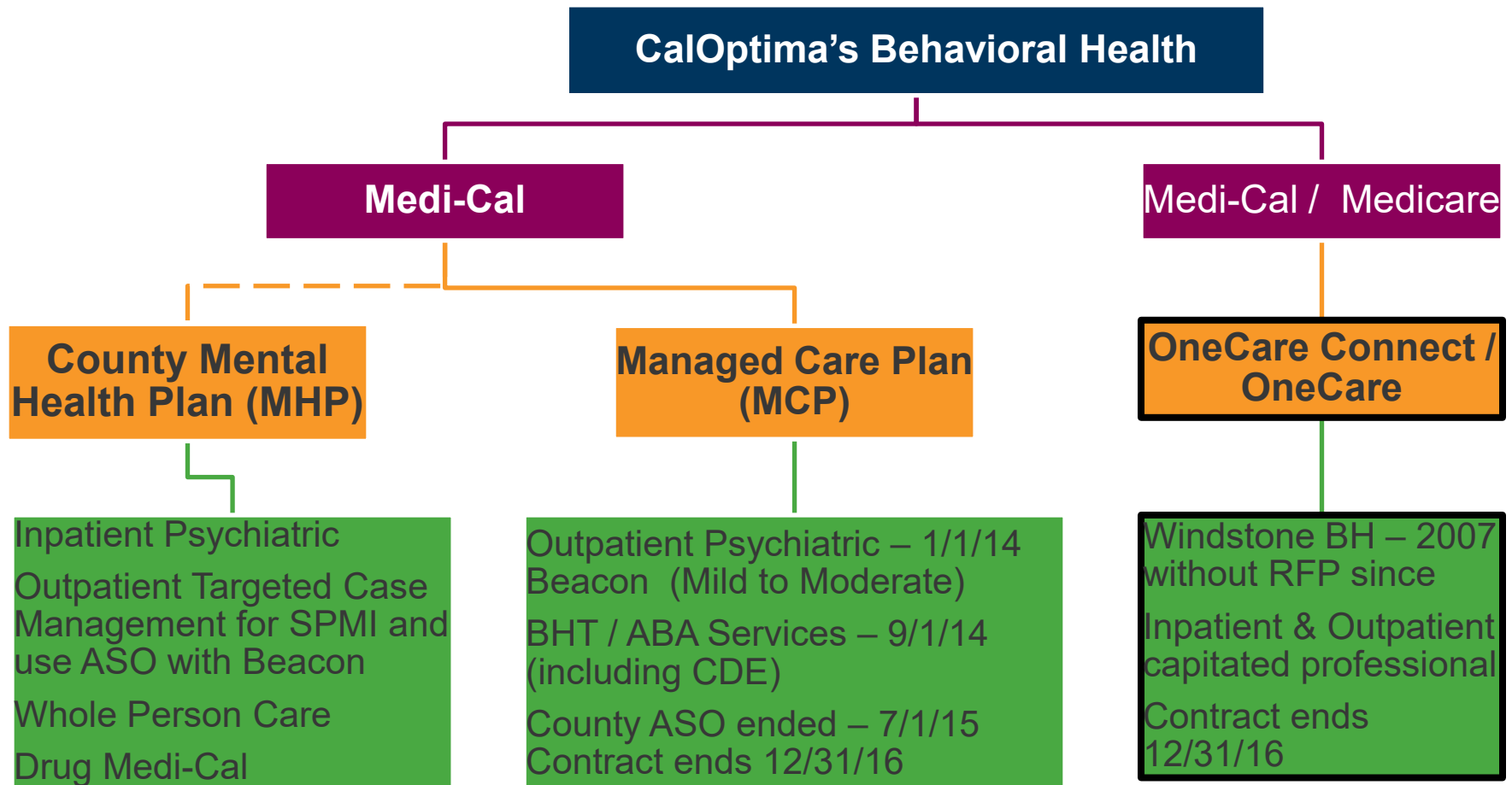
Today's Agenda

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

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

Behavioral Health Services at CalOptima



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

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

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

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"

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

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

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

MBHO Written Proposal Scores

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

[Back to Agenda](#)

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

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

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

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

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

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.

CalOptima's Mission

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

13. Consider Authorization of Expenditure Plan for Intergovernmental Transfer (IGT) 6 and 7 Funds, Including the Release of Requests for Proposals (RFPs) for Community Grants to Address Children’s Mental Health, Opioid and Other Substance Overuse, and Other Community Needs Identified by the CalOptima Member Health Needs Assessment

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve the expenditure plan for allocation of IGT 6 and 7 funds in the amount of \$21.1 million for the Department of Health Care Services (DHCS)-approved and Board-approved priority areas; and
2. Authorize the release of Requests for Proposal (RFPs) for community grants and internal project applications, with staff returning at a future Board meeting with evaluation of proposals and recommendations for award(s) being granted.

Background

Intergovernmental Transfers are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program, thus funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately \$22 million were approved to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children’s Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the above referenced priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

Priority Area	# of LOIs
Children’s Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	117

[Back to Agenda](#)

Staff performed an examination of all the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

In late May 2018, CalOptima received final IGT 6 and 7 funding from DHCS, resulting in a total of \$31.1 million for CalOptima’s share of the combined IGT transaction. IGT 6/7 funds totaled \$31.1 million rather than the initially projected \$22 million due to an adjustment in the enrollment numbers estimated by the California Department of Health Care Services and the higher federal match for the expansion population. On August 2, 2018, CalOptima’s Board of Directors approved a \$10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program; resulting in a remaining available balance of \$21.1 million.

The IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do, and Directors Nguyen and Schoeffel, met on July 20 and July 27 to discuss the results of the 117 RFI/LOI responses for the Children’s Mental Health, Opioid and other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the staff evaluation process and RFP recommendations, the Ad Hoc committee and staff determined allocation amounts and descriptions for each of the proposed six (6) Request for Proposals (RFPs). In addition, staff is recommending an allocation of IGT dollars for internal projects and program administration in the amounts indicated.

The Ad Hoc committee is recommending the following allocation of approximately \$17.7 million for IGT 6 and 7 Board-approved priority areas through six (6) RFPs. Please note that multiple applicants may be selected per RFP to receive a grant award.

Community Grants

Request for Proposal	Priority Area	Allocation Amount
Access to Outpatient Mental Health Services	Children’s Mental Health	\$2,700,000 \$4,850,000
Integrate Mental Health Services into Primary Care Settings	Children’s Mental Health	\$7,000,000 \$4,850,000
Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	\$6,000,000

Rev.
9/6/18

Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA/ <u>Childhood Obesity and Children’s Health</u>	\$500,000
Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA/ <u>Childhood Obesity and Children’s Health</u>	\$1,000,000
Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA/ <u>Older Adult Health</u>	\$500,000
TOTAL		\$17,700,000

Internal Projects and Program Administration

In addition, staff is also recommending an allocation of approximately \$3.4 million for internal projects and IGT program administration to manage all IGT program projects as follows:

Internal Project Examples: - IS and other infrastructure projects	\$2,500,000
IGT Program Administration - Support for two (2) existing staff positions for three years - Grant Management System license, and other administrative costs for three years	\$949,289 <i>(Approx. \$317,000 per year for three years)</i>
TOTAL	\$3,449,289

Staff anticipates returning with recommendations of RFP grantee awards and internal project(s) for Board approval following the completion of the community grant and internal project RFP application processes at the February 2019 Board meeting. The staff positions are Manager, Strategic Development, and Program Assistant, and the above proposed funding is in addition to \$10 million allocated from IGT 6/7 for Homeless Health on August 2, 2018.

Fiscal Impact

The recommended action to approve the expenditure plan and allocation of \$21.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima’s operating budget because IGT funds are accounted for separately. 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.



CalOptima
Better. Together.

IGT 6 & 7 Expenditure Plan Allocation

**Board of Directors Meeting
September 6, 2018**

**Cheryl Meronk
Director, Strategic Development**

IGT 6 & 7 - Background

- Board Established 3 New Priority Areas
 1. **Homeless Health**
 2. **Opioid and Other Substance Overuse**
 3. **Children's Mental Health**
 - Community needs identified by MHNA
 - Internal projects and IGT program administration
- Received 117 LOIs
- \$10.0M allocated for County HCA for Homeless Health/WPC Recuperative Care
- Ad Hoc met to discuss recommendations for other categories

IGT 6 & 7 Funding

- **\$31.1M** CalOptima's share
- **\$10.0M** to County HCA for WPC Recuperative Care
- **\$21.1M** remaining for recommended distribution
 - \$17.7M for Community Grants
 - Six Request for Proposals (RFPs)
 - 2 RFPs in Children's Mental Health
 - 1 RFP in Opioid and other Substance Overuse
 - 3 RFPs for MHNA identified needs
 - \$3.4M for Internal Projects and Program Administration

IGT 6 & 7 LOI Summary

Priority Area	# Received
Children's Mental Health	57
Homeless Health	36
Opioid & Other Substance Overuse	22
Other/multiple categories	2
Total	117

Children's Mental Health – 2 RFPs

RFP #	RFP Description	Funding Amount
1	Expand Access to Outpatient Mental Health Services	\$2.7 million
2	Integrate Mental Health Services into Primary Care Settings	\$7.0 million
	Total	\$9.7 million

* Multiple awardees may be selected per RFP

RFP 1

Expand Access to Outpatient Children's Mental Health Services

- **Funding Amount:** \$2,700,000
- **Description:**
 - Access to outpatient services
 - Create/expand school or resource center-based mental health services for children.
 - Provide services on-site, in-home, and/or afternoon/evening
 - Use an integrated model with community health workers to target vulnerable populations such as children experiencing homelessness, who have experienced traumatic incidences, homeless etc.
 - Provide additional support services to help promote stability and success

RFP 2

Integrate Children's Mental Health Services into Primary Care Settings

- **Funding Amount:** \$7 million
- **Description:**
 - Integrate mental health services provided in primary care settings
 - Include behavioral health providers in clinics and/or other settings where children are provided health care services
 - Provide culturally sensitive services
 - Provide efficient and immediate access to mental health consultation
 - Provide health navigation/scheduling coordinator to ensure availability and follow-up of services

Opioid & Other Substance Overuse – 1 RFP

RFP #	RFP Description	Funding Amount
3	Increase access to Medication-Assisted Treatment	\$6.0 million
	Total	\$6.0 million

*Multiple awardees may be selected per RFP

RFP 3

Increase access to Medication-Assisted Treatment

Funding Amount: \$6.0 million

- **Description:**

- Increase access to Medication-Assisted Treatment (MAT) Programs
 - Combine behavioral and physical health services
 - Manage oversight and prescribing of FDA-approved medications and program administration
 - Provide management of patients' overall care coordination
- Integrate pain management services
- Ensure availability of providers/staff to deliver appropriate services
- Establish a partnership with the Orange County Health Care Agency Drug Medi-Cal Organized Delivery System (ODS) for referrals/collaboration

Community Needs Identified by MHNA: Food Access – 3 RFPs

RFP #	RFP Description	Funding Amount
4	Expand Mobile Food Distribution Services	\$500K
5	Expand Access and Food Distribution focused on Children and Families	\$1 million
6	Expand Access to Older Adults Meal Programs	\$500K
	Total	\$2 million

*Multiple awardees may be selected per RFP

RFP 4

Expand Mobile Food Distribution Services

- **Funding Amount:** \$500,000
- **Description:**
 - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
 - Increase availability and access to healthy food options in areas of where fresh food/grocery stores are limited
 - Ensure additional mobile food trucks/vehicles to distribute healthy food options such as fresh produce/groceries that are culturally appropriate in areas of greatest need
 - Enroll members in mobile food distribution services programs
 - Provide education to prepare nutritious meals and/or pre-made meal options and simple recipes

RFP 5

Expand Access and Food Distribution Services focused on Children and Families

- **Funding Amount:** \$1 million
- **Description:**
 - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
 - Access to healthy food options such as fresh fruits, vegetables and other groceries
 - Increase access to culturally appropriate food options
 - Enroll/connect members to food distribution service programs
 - Provide education and simple recipes to help families on a limited budget
 - Provide take-home meals for children/families who may not have access to cooking facilities

RFP 6

Expand Access to Older Adult Meal Programs

- **Funding Amount:** \$500,000
- **Description:**
 - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
 - Increase access to:
 - Healthy options such as fresh fruits, vegetables and other groceries in areas of highest need
 - Culturally appropriate food options
 - Home delivered meals
 - Enroll/connect member food distribution service programs

Internal Projects/Program Admin.

Description	Amount
IS and Other Infrastructure Projects	\$2.5 million
Support for staff and administrative costs	~\$315K/year (for 3 years)

Next Steps*

- IGT 6 & 7 RFP Recommendations: September 6, 2018 Board Meeting
- Release of RFPs: September 2018
- RFPs due: November 2018
- IGT Ad Hoc review of recommended grant awards: January 2019
- Recommended awards: February 2019 Board Meeting

* Dates are subject to change based on Board approval

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

14. Consider Ratification of the Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9)

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

Ratify and authorize the following activities to secure Medi-Cal funds through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program:

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9);
2. Pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9), and;
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 9 funds.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in seven Rate Range IGT transactions. Funds from IGTs 1 – 7 have been received and IGT 8 funds are expected in the first quarter of 2019. IGT 1 – 7 funds were retrospective payments for prior rate range years and have been used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. These funds have been best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

The IGT funds that have been received to date have supported special projects that address unmet needs for CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing unmet needs.

Discussion

Beginning with IGT 8, the IGT program covers the current fiscal year and funds will be incorporated into the contract between DHCS and CalOptima for the current fiscal year. Unlike previous IGTs (1-7), IGT funds must now be used in the current rate year for CalOptima covered

services per DHCS instructions. CalOptima may determine how to spend the IGT funds (net proceeds) as long as they are for CalOptima covered services for Medi-Cal beneficiaries.

On July 31, 2018, CalOptima received notification from DHCS regarding the State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Intergovernmental Transfer Program (IGT 9). CalOptima's proposal, along with the funding entities' supporting documents were due to DHCS on August 31, 2018.

The five eligible funding entities from the previous IGT transactions were contacted regarding their interest in participation. All five funding entities have submitted letters of interest regarding participation in the IGT program this year. These entities are:

1. University of California, Irvine,
2. Children and Families Commission of Orange County,
3. County of Orange,
4. City of Orange, and
5. City of Newport Beach.

Board approval is requested to ratify the submission of the proposal letter to DHCS for participation in the 2018-19 Voluntary IGT Rate Range Program and to authorize the Chief Executive Officer to enter into agreements with the five proposed funding entities or their designated providers for the purpose of securing available IGT funds. Consistent with the eight prior IGT transactions, it is anticipated that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Staff will return to your Board with more information regarding the IGT 9 transaction and an expenditure plan for CalOptima's share of the net proceeds at a later date.

Fiscal Impact

The recommended action to ratify and authorize activities to secure Medi-Cal funds through IGT 9 will generate one-time IGT revenue that will be invested in Board-approved programs/initiatives. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. As such, there is no net fiscal impact on CalOptima's current or future operating budgets as IGT funds have been accounted for separately.

Rationale for Recommendation

Consistent with the previous eight IGT transactions, ratification of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2018-19 (IGT 9).

Concurrence

Gary Crockett, Chief Counsel

Attachment

Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

/s/ Michael Schrader
Authorized Signature

8/29/2018
Date



JENNIFER KENT
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

July 31, 2018

Greg Hamblin
Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Mr. Hamblin:

The 2018-19 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of July 1, 2018 through June 30, 2019 (SFY 2018-19).

DHCS shall not direct the MCP's expenditure of payments received under the 2018-19 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the 2018-2019 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR SFY 2018-19:

MCPs should refer to the estimated SFY 2018-19 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the 2018-19 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. If an MCP elect to participate in the 2018-19 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the 2018-19 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:
 1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.

2. The MCP's primary contact information (name, e-mail address, mailing address, and phone number).
 3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for SFY 2018-19. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
 4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the "supplemental attachment" described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.
- The MCP must obtain a **letter of interest** (using the format provided in Attachment A) from each governmental funding entity included in the MCP's proposal to DHCS. An individual authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest. Each letter of interest must specify:
 1. The governmental funding entity's name and Federal Tax Identification Number,
 2. The dollar amount or percentage of the total available rate range the governmental funding entity will contribute for each MCP and county/region, and
 3. The governmental funding entity's primary contact information (name, e-mail address, mailing address, phone number).
 - The MCP must distribute to governmental funding entities and ensure submission to DHCS of the **SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Friday, August 31, 2018.
 - The proposals and letters of interest are due to DHCS **by 5pm on Friday, August 31, 2018**. Please send a PDF copy of the required documents by e-mail to Sandra.Dixon@dhcs.ca.gov. **Failure to submit all required documents by the due date may result in exclusion from the SFY 2018-19 Voluntary Rate Range Program.**

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their

Greg Hamblin
Page 4

uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the 2018-19 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Sandra Dixon at (916) 345-8269 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,



Jennifer Lopez
Division Chief
Capitated Rates Development Division

Attachments

cc: Michael Schrader, Chief Executive Officer
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Financial Management Section
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

ATTACHMENT A – LETTER OF INTEREST TEMPLATE

Jennifer Lopez
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Lopez:

This letter confirms the interest of Insert Participating Funding Entity Name, a governmental entity, federal I.D. Number Insert Federal Tax I.D. Number, in working with Managed Care Plan's Name (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the period of July 1, 2018, to June 30, 2019. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

Insert Participating Funding Entity Name is willing to contribute up to \$ for the SFY 2018-19 rating period as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,
Signature

Attachment B
SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment

Provider Name:
 County:
 Health Plan:

Instructions

Complete all yellow-highlighted fields. Submit this completed form via e-mail to Sandra Dixon (sandra.dixon@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by Friday, August 31, 2018.

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from July 1, 2016 through June 30, 2017.

Service Type	Charges	Payments	Net Charges
Inpatient			
Outpatient			
All Other			
Total			

* Include payments received and anticipated to be received for service dates of July 1, 2016 through June 30, 2017.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)?
 If No, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. For any capitation payments to be funded by the IGT, please provide the following:

(i) The name of the entity transferring funds:

(ii) The operational nature of the entity (state, county, city, other):

(iii) The source of the funds:
 (Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations.)

(iv) Does the transferring entity have general taxing authority?

(v) Does the transferring entity receive appropriations from a state, county, city, or other local government jurisdiction?

5. Comments / Notes

ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

Orange County Organized Health System dba Cal Optima - Orange (HCP 506)
 IGT - 2018/19 (July 2018 - June 2019)

	Total	50% FMAP (Non-MCHIP and OE)	88% FMAP (MCHIP)	Optional Expansion (93.5%)
Total Funds Available	\$ 138,114,451	\$ 68,412,249	\$ 7,133,302	\$ 62,568,900
Federal Match	\$ 98,985,353	\$ 34,206,125	\$ 6,277,306	\$ 58,501,922
Governmental Funding Entity's Portion	\$ 39,129,098	\$ 34,206,124	\$ 855,996	\$ 4,066,978
	28.3%	50.0%	12.0%	6.5%

Rate Categories ¹	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Dept. Usage ²	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	2,474,781	\$ 84.85	\$ 89.93	\$ 5.08	-	\$ 5.08	\$ 12,571,887
Child - MCHIP	1,273,587	\$ 84.85	\$ 89.93	\$ 5.08	-	\$ 5.08	\$ 6,469,822
Adult - non MCHIP	1,082,406	\$ 299.18	\$ 316.64	\$ 17.46	-	\$ 17.46	\$ 18,898,809
Adult - MCHIP	38,000	\$ 299.18	\$ 316.64	\$ 17.46	-	\$ 17.46	\$ 663,480
SPD	466,754	\$ 755.18	\$ 798.48	\$ 43.30	-	\$ 43.30	\$ 20,210,448
SPD/Full-Dual	22,704	\$ 219.25	\$ 229.52	\$ 10.27	-	\$ 10.27	\$ 233,170
BCCTP	7,156	\$ 1,225.69	\$ 1,296.82	\$ 71.13	-	\$ 71.13	\$ 509,006
LTC	14,686	\$ 10,472.34	\$ 10,858.28	\$ 385.94	-	\$ 385.94	\$ 5,667,915
LTC/Full-Dual	0	\$ 6,036.73	\$ 6,235.58	\$ 198.85	-	\$ 198.85	\$ -
OBRA	0	\$ -	\$ -	\$ -	-	\$ -	\$ -
Whole Child Model	74,642	\$ 1,824.65	\$ 1,962.92	\$ 138.27	-	\$ 138.27	\$ 10,321,014
Optional Expansion	2,853,119	\$ 442.21	\$ 471.45	\$ 29.24	7.31	\$ 21.93	\$ 62,568,900
	8,307,835	\$ 309.49	\$ 328.62	\$ 19.14	2.51	\$ 16.62	\$ 138,114,451

¹The supplemental payments (Maternity, BHT and HEP C) are not included in the rate range calculation.

²Other Departmental Usages decreases available rate range funding.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

15. Consider Approval of Process for Considering 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

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Action

Authorize the CEO to implement a process to consider requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima, with all final decisions subject to Board approval.

Background

PACE is a comprehensive health care program that CalOptima provides for frail seniors in Orange County. The PACE model is a person-centered, community-based alternative to nursing home care. PACE supports elders and their families by providing preventive and primary care, and coordinating behavioral health and acute care, as well as long-term services and supports. The intensive care coordination helps individuals with complex chronic care needs to continue living in the community as long as possible. CalOptima opened Orange County's first PACE center in October 2013, and the program has grown to nearly 300 participants. CalOptima recently launched several new initiatives designed to expand access to PACE, including partnerships with Community-Based Adult Services (CBAS) centers, a greater role for community-based physicians in caring for PACE participants, and a larger PACE service area to reach all eligible seniors in Orange County.

On October 27, 2017, and on August 17, 2018, the Department of Health Care Services (DHCS) issued PACE policy letters regarding the PACE application process, including guidance on operation of an independent PACE facility in County Organized Health System (COHS) counties including Orange County. Historically, the only entity that could operate a PACE program in a COHS county was the designated Medi-Cal managed care plan. Welfare & Institutions code section 14087.5 *et seq.* provides that a managed care plan that elects to organize as a COHS holds the exclusive right to contract for Medi-Cal services, including PACE, in the respective county.

However, the above-referenced DHCS policy letters describe a process by which an organization interested in becoming an independent PACE Organization (PO) in a COHS county may, with the formal support of the local COHS plan, be considered to operate in that county(s). Specifically, DHCS will only consider an application from an independent PO in a COHS county if its application to DHCS includes a letter of support from the COHS Medi-Cal managed care plan. In the letter, the COHS plan must take the significant step of requesting that DHCS submit a formal request to the federal Centers for Medicare & Medicaid Services (CMS) requesting an amendment to California's existing Section 1115 Medicaid Waiver as part of the independent PO application process to make an exception to the existing

law that governs COHS plans. COHS plans, including CalOptima, are under no obligation to provide such letters of support.

Specific to the application process for organizations seeking to operate in COHS counties, the COHS plans' only role is to issue (or not issue) a letter of support. If the COHS plan does not issue a letter of support, DHCS will not approve the application; if the COHS does provide a letter of support, it will be up to state and federal regulators to make all subsequent decisions on the application.

Since the release of the DHCS policy letters, staff has received informal inquiries from groups interested in applying to become independent POs in Orange County on how and whether CalOptima intends to respond to any requests for letters of support requesting that DHCS seek formal modification of California law governing the COHS framework.

Should CalOptima decide to provide one or more letters of support to independent POs, the decision would then be out of CalOptima's hands, and the independent POs would follow an application process first involving DHCS, and if DHCS submits the request, CMS would consider whether to approve the requested waiver amendment. If CMS approves the waiver amendment, DHCS would then evaluate the independent PO application, and if approved, the application would go to CMS for final approval.

Separate from considering requests from independent POs, CalOptima staff is continuing Board-approved expansion efforts through collaboration with community partners. These include expanding CBAS center use through Alternative Care Setting sites, continuing to cultivate referrals from contracted community-based physicians, enrollment efforts in South Orange County, increasing current sales and marketing efforts, adding a Veteran's Choice option to encourage enrollment by veterans, and adding a Medicare-only members option.

Discussion

In response to the DHCS policy letters and independent PO inquiries, staff is recommending that the Board approve an internal review process for the evaluation of requests for letters of support from organizations seeking to establish independent PACE operations in Orange County and making recommendations to the Board.

Elements of the process to consider letter of support requests include, but are not limited to:

1. **Application timeline window:** Subject to Board approval, staff anticipates accepting letters of support requests beginning November 1, 2018, to January 31, 2019.
2. **Geographic ZIP code designation:** Consistent with the DHCS and CMS PACE organization application process and policy, independent PO letter of support requests will include the specific ZIP codes the independent PO is interested in serving.
3. **Threshold Criteria (2050% weighting):** All letter of support requests from independent POs shall include and will be evaluated based on the following criteria:
 - a. PACE operating experience
 - i. Show a minimum of five (5) years of operating experience
 - ii. Provide proof of regulatory audits with no sanctions

Rev.
9/6/18

- iii. Submit operational policies and procedures
 - iv. Obtain reference letters from member advocates, providers and community stakeholders
 - b. Financial soundness
 - i. Submit financial statements (income statements and balance sheets) for the three most recent consecutive years
 - ii. Report financial metrics (i.e. liquidity, debt ratio, short-term viability, delinquency)
 - iii. Obtain third-party risk report via Dunn and Bradstreet (where available)
 - c. Quality performance/metrics
 - i. Report performance against current CalPACE averages in areas of participants residing in nursing homes, hospital admissions, hospital days, hospital readmission rate, emergency room visits and participant satisfaction rating
 - d. Demographic competence
 - i. Provide a general PACE demographic profile data of the ZIP code area of interest
 - ii. Demonstrate staff experience and/or understanding in serving PACE participants similar to those in the potential geographic area
 - 1. Training in cultural competency
 - 2. Language capability
 - 3. Accommodations for low literacy
 - 4. Response to socioeconomic factors
4. **Primary Criteria (80 50% weighting):** Potential impact on CalOptima PACE program/operations and other POs operating in Orange County, if any.
- a. For POs with strong demonstrated performance on the Threshold Criteria, the focus would be on, for example, evaluation overlap with existing PACE facilities in the County (e.g., also considering likelihood of adverse member selection, geographic separation, etc.); how the PO's application demonstrates that they are proposing to offer complementary PACE services (e.g., for unique member populations, serving remote/underserved geographic areas of the County, bringing new providers, or in some other meaningful ways, enhancing existing PACE facilities).
5. **Return to the Board with Recommendations.** After analyzing PO proposals and requests for letters of support, staff will return to the Board with recommendations.

Rev.
9/6/18

Fiscal Impact

The recommended action is projected to be budget neutral. CalOptima's Fiscal Year 2018–19 Operating Budget, approved by the Board on June 7, 2018, included projected revenues and expenses related to the continuation of PACE expansion.

Staff anticipates that the administrative expenses included in the Board-approved operating budget are sufficient to cover the anticipated costs related to the recommended action.

Rationale for Recommendation

Staff recommends that the Board adopt a process for considering requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima. As a public agency, CalOptima should be prepared to respond to such potential requests.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS PACE Policy Letter 17-03, issued on October 27, 2017.
2. DHCS PACE Policy Letter 18-01, issued on August 17, 2018.
3. Presentation: PACE Response to Regulatory Guidance

/s/ Michael Schrader
Authorized Signature

8/29/2018
Date



JENNIFER KENT
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

Date: October 27, 2017

Policy Letter 17-03

Replacing PACE Policy Letter 16-01

To: Program for All-Inclusive Care for the Elderly (PACE) Organizations

Subject: PACE Application Process

Purpose

The purpose of this Policy Letter is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (POs) and potential applicant organizations of the revised Department of Health Care Services (DHCS) application review process and timeline for new PO applications and PACE Expansion applications.

Background

In 2016, the California Legislature passed the PACE Modernization Act Trailer Bill (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016) including updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of POs that could operate in the state, and allowed for-profit entities to become POs. As a result, DHCS has seen renewed interest in PACE and an increase in new/expansion applications submitted to DHCS for review. Therefore, DHCS is issuing revised guidance to clarify the Department's expectations with respect to the competitive nature of the review process.

The Centers for Medicare & Medicaid Services (CMS) released the 2017 PACE Application Guidance on January 17, 2017, to address its electronic PACE application submission timelines and review process. Effective immediately, all new and expansion PACE applications are required to be submitted to CMS through the web-based Health Plan Management System (HPMS). Applicants should review this guidance and be aware of CMS requirements for accessing HPMS. The downloadable PDF of the application and additional information can be found at: <https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html>

Application Review Process

All new and expansion PACE applications must go through an initial review process by DHCS in order to move forward with submission to CMS via HPMS. The initial submission components are detailed in this letter, which aims to provide DHCS with key organizational background and financial viability documentation. This information is necessary for the State to complete/sign the State Assurance pages and authorize the submission of the full application to DHCS and CMS via HPMS.

Upon submission of the full application to CMS, the State will align its review of the remaining application with the CMS initial 45/90-day clock cycle, dependent on type of application, to create a concurrent review process. The initial CMS 45/90-day clock review begins upon receipt of the completed full application in HPMS, which must include the signed State Assurance pages.

DHCS will review the application according to state and federal laws and regulations. Prior to entering into a contract for the provision of Medi-Cal managed health care services, DHCS may consider any factor it determines to be necessary for consideration (Welfare & Institutions Code §§ 14095 and 14592(b)). This includes considering any information relevant to the issue of whether the application could result in unnecessary duplication of services or impair the financial or service viability of an existing program (42 USCA § 1395eee(e)(2)(B)).

Initial State Review

All new and expansion applications received by DHCS will follow the below initial state review timeframes for application submission:

Action	Due Date	Documents for Submission	Reviewer	Review Timeframe
Notification of Intent to DHCS	30 days prior to Initial Application Submission to DHCS	<ul style="list-style-type: none"> Letter of Intent Letter for Support from COHS (if applicable) 	DHCS	N/A
Initial Application Submission to DHCS	60 days prior to CMS application submission deadline	<ul style="list-style-type: none"> Market Feasibility Study Letters of Support Application sections (see Attachment 1) 	DHCS	60 Calendar Days
Full Application Submission in HPMS	Align with CMS PACE Application Submission Deadline	<ul style="list-style-type: none"> Remaining application sections State Assurance Page 	DHCS/CMS	Align with CMS 45/90 day review clock

Concurrent Federal and State Review

The CMS review process of the PACE Application will include a series of attestations and uploads based on the type of application received, (Initial Application or Service Area Expansion).

Upon completion of the initial CMS 45/90-day clock review of the full application, CMS and/or DHCS may issue a Request for Additional Information (RAI) to the applicant. In the event a RAI is issued, the application is taken off the review clock during this period while the applicant responds to either the CMS and/or DHCS RAI. DHCS will align its remaining review and RAI (if necessary) with CMS timelines and ensure that any necessary changes are communicated to CMS. It is also during this period that DHCS conducts the Readiness Review (RR) onsite survey of the applicant PACE Center, as required. All initial applications and any Service Area Expansion (SAE) application that includes the addition of a new PACE center requires a RR of

the new center. All deficiencies that may be identified during the DHCS Readiness Review onsite survey of the applicant PACE Center must be addressed through a corrective action plan submitted and accepted by DHCS.

Once CMS and/or DHCS have accepted the applicant's RAI response and the Readiness Review onsite survey has been completed by DHCS and the applicant and accepted by CMS, CMS will reinitiate the final 45/90-day clock review cycle. Conclusion of this cycle results in CMS notification to the applicant of final approval or denial.

PACE Growth and Expansion

All PACE growth and expansion falls into one of the below categories:

New PACE Organization – New entity applying to establish a PO

- Entity must identify specific zip codes to be served in one or more counties
- Entity must be able to serve all requested zip codes from PACE Center (subject to 60-minute one way travel time adult day health center (ADHC) requirement)
- Rate development required for each county requested

Existing PO Expansion (Existing County) – PO adding additional zip codes within existing county service area, opening a new PACE Center within existing county service area, or both

- Entity must be able to serve all requested zip codes from PACE Center(s) (subject to 60-minute one way travel time ADHC requirement)
- POs can add zip codes and use Alternative Care Settings (ACS) and Community-based physician waiver as an interim step before building new PACE Center
- Consider rate development/adjustment to account for expansion within the county and account for potential variance and/or changes in utilization
- Zip code only expansions subject to shorter State/CMS review period

Existing PO Expansion (New County) – PO adding zip codes in a new county of operation

- Usually requires a new PACE Center unless the zip codes requested fall within the required radius to be served by existing PACE Center and interdisciplinary team (IDT)
- Requires new rate development

Program Start Date

To align with state budget and rate development processes, all new PO applications and expansion applications requiring new rate development will only be able to begin operations on either January 1 or July 1 of a given year following receipt of final approval from CMS and DHCS. Prospective POs and expansion applicants requiring new rate development should take the available start dates into consideration when preparing to submit an application. Any delays in the application submission or review process may result in the program start getting pushed back to the next available program start date of either January 1 or July 1.

Key Dates for CMS Application Submission

The downloadable PDF of the application and additional information such as application submission deadlines can be found at: https://www.cms.gov/Medicare/Health-Plans/PACE/Downloads/PACE_Application_Training_Feb_2017.pdf.

Initial Application Submission Components

Letter of Intent

All applicants must submit a Letter of Intent (LOI) to DHCS indicating their plans to submit a PACE application. The LOI should identify the applicant; the proposed service area, including a listing of proposed zip codes and a service area map; and the proposed site location for the applicant’s PACE center. New applicants proposing to serve an area with an existing or pending PACE plan must identify the overlapping zip codes in their LOI. If an applicant has any questions about whether there is an existing or pending PO operating in its proposed service area it can refer to the DHCS PACE website for a listing of all zip codes by county that POs currently operate in at: <http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx>. Pending applications for new or expansion POs will also be posted to the DHCS website.

Based on the CMS application submission deadlines, LOI to DHCS would follow the below timeframes:

Letter of Intent to DHCS no later than...	Initial Application Submission to DHCS no later than...	CMS Application Submission Deadlines *last business day of Quarter
October 1, 2017	November 1, 2017	January 1, 2018
January 1, 2018	February 1, 2018	April 1, 2018
April 1, 2018	May 1, 2018	July 1, 2018
July 1, 2018	August 1, 2018	October 1, 2018

Letters of Support

All PACE applicants must submit letters of support from local entities in the area that the applicant proposes to serve. These may include but are not limited to County Board of Supervisors, County Health and Human Services (HHS) Director, local hospitals, Medi-Cal managed care plans, Independent Physician Associations (IPAs), Commission on Aging, Area Agencies on Aging (AAA), local Multipurpose Senior Services Program (MSSP) Waiver sites, etc. Letters of support should be attached to the LOI. The minimum requirements for letters of support in County Organized Health System counties is provided below.

Market Feasibility Study

All PACE applicants must submit a market analysis of the area that they propose to serve. The feasibility study should include the following:

- Estimate of the number of PACE-eligible individuals
- Description of the methodology/assumptions used to determine potential membership

- Identify all competitive factors impacting the market, such as:
 - Existing POs
 - Managed care plans (MCPs)
 - Demonstration County MCPs (Cal MediConnect and Managed Long-Term Services and Supports (LTSS))
 - Medi-Cal Waiver Programs
 - In-Home Supportive Services (IHSS)
- Identify projected market capture/saturation rates
- Demonstrate that there is an unmet need for PACE in the proposed service area
 - Please note that when multiple applications are received for the same county/zip code service area the order of submission and number of pre-existing plans may have an impact on the decision to approve / deny an application.

Application Narrative

The following PACE application sections must be submitted to DHCS for initial review (see Attachment 1):

New PACE Application	Service Area Expansion (Existing and New County)
<ul style="list-style-type: none"> • 3.1 – Service Area • 3.2 – Legal Entity and Organization Structure • 3.3 – Governing Body • 3.4 – Fiscal Soundness 	<ul style="list-style-type: none"> • 3.1 – Service Area • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services

In addition to the attestations and documents required in the PACE application, DHCS requires detailed narrative in each of these sections to better understand the organizational background and financial standing of the applicant.

Additional Considerations and Limitations

Overlapping service area

New applicants proposing to enter an area already served by an existing PO must identify the overlapping zip codes in their LOI. DHCS will immediately notify any existing and/or pending POs of the new applicant’s intent, and the existing and/or pending PO(s) will have an opportunity to submit their own market analysis in response. The counter-analysis must be submitted to DHCS by the initial application submission date. Overlapping service areas are determined at the zip code level. Therefore, if a PO is only servicing a portion of a county and a new or expansion application is requesting a zip code not in the POs service area, by zip code, then the new or expansion application would not trigger notification to the existing/pending PO for an overlapping service area competing market analysis.

DHCS will conduct its own analysis using Medi-Cal data to verify the market feasibility studies that applicants/POs submit. DHCS will evaluate actual numbers of Medi-Cal beneficiaries by age and aid code and will use historical trends of clinical eligibility and market capture to compare against market analyses submitted by applicants/existing POs.

DHCS, in consultation with other State Administering Agencies, has developed a review tool to assist in considering prospective PO applications and the overlapping service area they propose to enter. The review tool is included as Attachment II (Service Area Overlap Review Criteria) to this letter. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Restrictions on Delegation

DHCS is using this PACE Policy Letter to provide explicit clarification to its policy on the use of delegation in the PACE model. DHCS prohibits existing and applicant POs from delegating a separate entity to operate existing and/or additional (expansion) PACE Centers and IDTs. POs are responsible for coordinating and delivering the medical and long term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department has serious concerns with arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. DHCS intends to amend its PACE contracts to include this prohibition. The validity of the DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000, and was confirmed as “grandfathered” in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department’s prior written approval.

Please note that DHCS’ prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant’s home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

POs in County Organized Health System Counties

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code §14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a

third party PO in a COHS county if the applicant includes a COHS' letter of support that includes the following:

- The COHS's support for the establishment of the independent PO in the county, and;
- The COHS request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county.

The COHS letter of support should be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. DHCS will ultimately decide whether to move forward with a PACE applicant in a COHS and recommend an 1115 Waiver amendment. Any recommendation from DHCS will be subject to CMS review and approval. In the instance that independent operation of a third party PO is approved, the third party PO must contract directly with the State (DHCS) and CMS as the PACE entity in the three-way program agreement. It is not acceptable for the COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement and delegate operation of the PO to a separate entity.

This policy reflects the process that was utilized to approve the operation of Redwood Coast PACE in Humboldt County. Redwood Coast PACE was approved to operate independently from the COHS because its PACE application was submitted and accepted prior to the launch of the rural Medi-Cal managed care expansion. The COHS (Partnership Health Plan) endorsed the Redwood Coast PACE application and the exception was made possible by an amendment to California's existing 1115(a)(1) Bridge to Reform Demonstration Waiver.

Licensing

PACE Centers must maintain both a Primary Care Clinic License and an ADHC License. POs must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. Assembly bills 847 (Chapter 315 of 2005) and 577 (Chapter 456 of 2009) established the authority for CDPH/DHCS to authorize exemptions to a PO from licensing and regulatory requirements applicable to clinics, adult day health care services, and home health agencies. If requesting exemption from licensure, a PO must maintain at least one of the PACE Center required licenses (Clinic or ADHC) for each PACE Center. Applicants should consult with the California Department of Public Health (CDPH) to verify licensing requirements. CMS will not accept State Readiness Review until all required licenses are secured. Licensure applications can be found at:

<https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx> .

Replacement PACE Centers

Existing POs may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a service area expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan,

PACE Policy Letter 17-03

notification to participants, and details of any changes in staffing, policies and procedures, etc.

POs seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care contract manager.

Sincerely,

Jacey Cooper, Acting Division Chief
Integrated System of Care Division

Enclosures

Attachment 1
Attachment 2

Attachment I - PACE Application Required Attestations and Uploads

Attestation Topic	Section #	Initial	SAE	Upload Required (Initial)	Upload Required (SAE)
Service Area	3.1	X	X	X	X
Legal Entity and Organizational	3.2	X		X	
Governing Body	3.3	X		X	
Fiscal Soundness	3.4	X	X	X	X
Marketing	3.5	X	X	X	X
Explanation of Rights	3.6	X		X	
Grievance	3.7	X		X	
Appeals	3.8	X		X	
Enrollment	3.9	X		X	
Disenrollment	3.10	X		X	
Personnel Compliance	3.11	X			
Program Integrity	3.12	X			
Contracted Services	3.13	X	X		
Required Services	3.14	X			
Service Delivery	3.15	X			
Infection Control	3.16	X			
Interdisciplinary Team	3.17	X			
Participant Assessment	3.18	X			
Plan of Care	3.19	X			
Restraints	3.20	X			
Physical Environment	3.21	X			
Emergency and Disaster Preparedness	3.22	X			
Transportation Services	3.23	X	X		
Dietary Services	3.24	X			
Termination	3.25	X		X	
Maintenance of Records & Reporting	3.26	X			
Medical Records	3.27	X			
Quality Assessment Performance Improvement	3.28	X		X	
State Attestations	3.29	X		X	X
Waivers	3.30	X		X (as applicable)	
Application Attestations	3.31	X	X	X	X
State Readiness Review	3.32	X	X (as applicable)	X	X (as applicable)

Attachment II: Service Area Overlap Review Criteria

This tool identifies criteria that DHCS will take into consideration when evaluating applications requesting overlap of existing PACE service areas. DHCS is not limited to the use of only this criteria and will take under consideration additional factors as it determines appropriate to fully assess the application. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Category	Subcategory	Criteria
Service Area Overlap with Existing PACE Operator	Service Area Overlap	Overlap includes less than 25% of potential participants in existing service area
		Overlap includes between 25% and 50% of potential participants in existing service area
		Overlap includes between 50% and 75% of potential participants in existing service area
		Overlap includes over 75% of potential participants in existing service area
	Facility Overlap	Proposed service area includes existing PACE facility or alternative care setting
		Proposed service area does not include existing PACE facility or alternative care setting
Level of Success & Investment of Existing PACE Operators/ Applicants	Market Penetration of Existing Operators in Proposed Service Area	Market penetration under 10%
		Market penetration between 10% and 30%
		Market penetration over 30%
	Recent Investments by Existing PACE Operator(s) and Recent Applicant(s) in Proposed Service Area	Facility investment over \$5M in the past year
		Facility investment over \$5M between 1 and 2 years
		Facility investment over \$5M between 2 and 3 years
No facility investments over \$5M in last 3 years		
Local Support	Local Government Support	Formal vote of city council or comparable body in support of new applicant
		Letter of support from city council member or comparable official
		No written support from local government official
	Local Service Provider Involvement	Lead applicant is a services provider in proposed service area
		Supporting applicant is a services provider in proposed service area
		No part of applying entity is services provider in proposed service area



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



EDMUND G. BROWN JR.
GOVERNOR

Date: August 17, 2018

Policy Letter 18-01
Supersedes PACE Policy Letter 17-03

To: Program for All-Inclusive Care for the Elderly (PACE) Organizations

Subject: PACE Application Process

Purpose

The purpose of this Policy Letter is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (POs) and potential applicant organizations of the updated Department of Health Care Services (DHCS) application review process and timeline for new PO applications and PACE Expansion applications.

Background

In 2016, the California Legislature passed the PACE Modernization Act Trailer Bill (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016) including updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of POs that could operate in the state, and allowed for-profit entities to become POs. As a result, DHCS has seen renewed interest in PACE and an increase in new/expansion applications submitted to DHCS for review. Therefore, DHCS is issuing revised guidance to clarify the Department's expectations with respect to the competitive nature of the review process.

The Centers for Medicare & Medicaid Services (CMS) releases annual updates to its PACE Application Guidance to address its electronic PACE application submission timelines, requirements, and review process. Applicants should review this guidance and be aware of CMS requirements for accessing HPMS. The downloadable PDF of the application and additional information can be found at:

<https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html>

State Application Review Process

All new and expansion PACE applications must go through an initial review process by DHCS in order to move forward with submission to CMS via HPMS. The initial submission components are detailed in this letter, which aims to provide DHCS with key organizational background and financial viability documentation. This information is

necessary for the State to complete/sign the State Assurance pages and authorize the submission of the full application to DHCS and CMS via HPMS.

Upon submission of the full application to CMS, the State will align its review of the remaining application with the CMS initial 45/90-day clock cycle, dependent on type of application, to create a concurrent review process. The initial CMS 45/90-day clock review begins upon receipt of the completed full application in HPMS, which must include the signed State Assurance pages.

DHCS will review the application according to state and federal laws and regulations. Prior to entering into a contract for the provision of Medi-Cal managed health care services, DHCS may consider any factor it determines to be necessary for consideration (Welfare & Institutions Code §§ 14095 and 14592(b)). This includes considering any information relevant to the issue of whether the application could result in unnecessary duplication of services or impair the financial or service viability of an existing program (42 USCA § 1395eee(e)(2)(B)).

Initial State Review

All new and expansion applications received by DHCS will follow the below initial state review timeframes for application submission:

Action	Due Date	Documents for Submission	Reviewer	Review Timeframe
Notification of Intent to DHCS	30 days prior to Initial Application Submission to DHCS	<ul style="list-style-type: none"> • Letter of Intent • Letter for Support from COHS (if applicable) 	DHCS	N/A
Initial Application Submission to DHCS	60 days prior to CMS application submission deadline	<ul style="list-style-type: none"> • Market Feasibility Study • Letters of Support • Application sections (see Attachment 1) 	DHCS	60 Calendar Days
Full Application Submission in HPMS	Align with CMS PACE Application Submission Deadline	<ul style="list-style-type: none"> • Remaining application sections • State Assurance Page 	DHCS/CMS	Align with CMS 45/90 day review clock

Concurrent Federal and State Review

The CMS review process of the PACE Application will include a series of attestations and uploads based on the type of application received, (Initial Application or Service Area Expansion).

Upon completion of the initial CMS 45/90-day clock review of the full application, CMS and/or DHCS may issue a Request for Additional Information (RAI) to the applicant. In the event a RAI is issued, the application is taken off the review clock during this period while the applicant responds to either the CMS and/or DHCS RAI. DHCS will align its remaining review and RAI (if necessary) with CMS timelines and ensure that any necessary changes are communicated to CMS. It is also during this period that DHCS conducts the Readiness Review (RR) onsite survey of the applicant PACE Center, as required. All initial applications and any Service Area Expansion (SAE) application that includes the addition of a new PACE center requires a RR of the new center. All deficiencies that may be identified during the DHCS Readiness Review onsite survey of the applicant PACE Center must be addressed through a corrective action plan submitted and accepted by DHCS.

Once CMS and/or DHCS have accepted the applicant's RAI response and the Readiness Review onsite survey has been completed by DHCS and the applicant and accepted by CMS, CMS will reinitiate the final 45/90-day clock review cycle. Conclusion of this cycle results in CMS notification to the applicant of final approval or denial.

PACE Growth and Expansion

All PACE growth and expansion falls into one of the below categories:

New PACE Organization – New entity applying to establish a PO

- Entity must identify specific zip codes to be served in one or more counties
- Entity must be able to serve all requested zip codes from PACE Center (subject to 60-minute one way travel time adult day health center (ADHC) requirement)
- Rate development required for each county requested

Existing PO Expansion (Existing County) – PO adding additional zip codes within existing county service area, opening a new PACE Center within existing county service area, or both

- Entity must be able to serve all requested zip codes from PACE Center(s) (subject to 60-minute one way travel time ADHC requirement)
- POs can add zip codes and use Alternative Care Settings (ACS) and Community-based physician waiver as an interim step before building new PACE Center
- Consider rate development/adjustment to account for expansion within the county and account for potential variance and/or changes in utilization
- Zip code only expansions subject to shorter CMS review period

Existing PO Expansion (New County) – PO adding zip codes in a new county of operation

- Usually requires a new PACE Center unless the zip codes requested fall within the required radius to be served by existing PACE Center and interdisciplinary team (IDT)
- Requires new rate development

Program Start Date

To align with state budget and rate development processes, all new PO applications and expansion applications requiring new rate development will only be able to begin operations on either January 1 or July 1 of a given year following receipt of final approval from CMS and DHCS. Prospective POs and expansion applicants requiring new rate development should take the available start dates into consideration when preparing to submit an application. Any delays in the application submission or review process may result in the program start getting pushed back to the next available program start date of either January 1 or July 1.

Initial Application Submission Components

Letter of Intent

All applicants must submit a Letter of Intent (LOI) to DHCS indicating their plans to submit a PACE application. The LOI should identify the applicant; the proposed service area, including a listing of proposed zip codes and a service area map; and the proposed site location for the applicant's PACE center. New applicants proposing to serve an area with an existing or pending PACE plan must identify the overlapping zip codes in their LOI. If an applicant has any questions about whether there is an existing or pending PO operating in its proposed service area it can refer to the DHCS PACE website for a listing of all zip codes by county that POs currently operate in at: <http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx>. Pending applications for new or expansion POs will also be posted to the DHCS website.

CMS application submission deadlines can be found under the application training guide here: <https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html>. The LOI to DHCS must be submitted at least 90 days prior to the proposed CMS submission date and the initial application must be submitted at least 60 days prior to the proposed CMS submission date.

Letters of Support

All PACE applicants must submit letters of support from local entities in the area that the applicant proposes to serve. These may include but are not limited to County Board of Supervisors, County Health and Human Services (HHS) Director, local hospitals, Medi-

Cal managed care plans, Independent Physician Associations (IPAs), Commission on Aging, Area Agencies on Aging (AAA), local Multipurpose Senior Services Program (MSSP) Waiver sites, etc. Letters of support should be attached to the LOI. The minimum requirements for letters of support in County Organized Health System counties is provided below.

Market Feasibility Study

All PACE applicants must submit a market analysis of the area that they propose to serve. The feasibility study should include the following:

- Estimate of the number of PACE-eligible individuals
- Description of the methodology/assumptions used to determine potential membership
- Identify all competitive factors impacting the market, such as:
 - Existing POs
 - Managed care plans (MCPs)
 - Demonstration County MCPs (Cal MediConnect and Managed Long-Term Services and Supports (LTSS))
 - Medi-Cal Waiver Programs
 - In-Home Supportive Services (IHSS)
- Identify projected market capture/saturation rates
- Demonstrate that there is an unmet need for PACE in the proposed service area
 - Please note that when multiple applications are received for the same county/zip code service area the order of submission and number of pre-existing plans may have an impact on the decision to approve / deny an application.

State Application Narrative

The following PACE application sections must be submitted to DHCS for initial review (see Attachment 1):

New PACE Application	Service Area Expansion (Existing and New County)
<ul style="list-style-type: none"> • 3.1 – Service Area • 3.2 – Legal Entity and Organization Structure • 3.3 – Governing Body • 3.4 – Fiscal Soundness 	<ul style="list-style-type: none"> • 3.1 – Service Area • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services

In addition to the attestations and documents required in the PACE application, DHCS requires detailed narrative in each of these sections to better understand the organizational background and financial standing of the applicant.

Additional Considerations and Limitations

Overlapping service area

New applicants proposing to enter an area already served by an existing PO must identify the overlapping zip codes in their LOI. DHCS will immediately notify any existing and/or pending POs of the new applicant's intent, and the existing and/or pending PO(s) will have an opportunity to submit their own market analysis in response. The counter-analysis must be submitted to DHCS by the initial application submission date. Overlapping service areas are determined at the zip code level. Therefore, if a PO is only servicing a portion of a county and a new or expansion application is requesting a zip code not in the POs service area, by zip code, then the new or expansion application would not trigger notification to the existing/pending PO for an overlapping service area competing market analysis.

DHCS will conduct its own analysis using Medi-Cal data to verify the market feasibility studies that applicants/POs submit. DHCS will evaluate actual numbers of Medi-Cal beneficiaries by age and aid code and will use historical trends of clinical eligibility and market capture to compare against market analyses submitted by applicants/existing POs.

DHCS, in consultation with other State Administering Agencies, has developed a review tool to assist in considering prospective PO applications and the overlapping service area they propose to enter. The review tool is included as Attachment II (Service Area Overlap Review Criteria) to this letter. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Restrictions on Delegation

DHCS is using this PACE Policy Letter to provide explicit clarification to its policy on the use of delegation in the PACE model. DHCS prohibits existing and applicant POs from delegating a separate entity to operate existing and/or additional (expansion) PACE Centers and IDTs. POs are responsible for coordinating and delivering the medical and long term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department has serious concerns with arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. DHCS intends to amend its PACE contracts to include this prohibition. The validity of the DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000, and was confirmed as “grandfathered” in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department’s prior written approval.

Please note that DHCS’ prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant’s home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

POs in County Organized Health System Counties

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code §14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a third party PO in a COHS county if the applicant includes a COHS’ letter of support that includes the following:

- The COHS’s support for the establishment of the independent PO in the county, and;
- The COHS request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county.

The COHS letter of support should be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. DHCS will ultimately decide whether to move forward with a PACE applicant in a COHS and recommend an 1115 Waiver amendment. Any recommendation from DHCS will be subject to CMS review and approval. In the instance that independent operation of a third party PO is approved, the third party PO must contract directly with the State (DHCS) and CMS as the PACE entity in the three-way program agreement. It is not acceptable for the COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement and delegate operation of the PO to a separate entity.

This policy reflects the process that was utilized to approve the operation of Redwood Coast PACE in Humboldt County. Redwood Coast PACE was approved to operate independently from the COHS because its PACE application was submitted and accepted prior to the launch of the rural Medi-Cal managed care expansion. The COHS (Partnership Health Plan) endorsed the Redwood Coast PACE application and the exception was made possible by an amendment to California's existing 1115(a)(1) Bridge to Reform Demonstration Waiver.

Licensing

PACE Centers must maintain both a Primary Care Clinic License and an ADHC License. POs must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. Assembly bills 847 (Chapter 315 of 2005) and 577 (Chapter 456 of 2009) established the authority for CDPH/DHCS to authorize exemptions to a PO from licensing and regulatory requirements applicable to clinics, adult day health care services, and home health agencies. If requesting exemption from licensure, a PO must maintain at least one of the PACE Center required licenses (Clinic or ADHC) for each PACE Center. Applicants should consult with the California Department of Public Health (CDPH) to verify licensing requirements. CMS will not accept State Readiness Review until all required licenses are secured. Licensure applications can be found at: <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx> .

Replacement PACE Centers

Existing POs may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a service area expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan, notification to participants, and details of any changes in staffing, policies and procedures, etc.

POs seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition. Replacement Centers are not subject to the January 1 or July 1 start dates.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care contract manager.

Sincerely,

ORIGINAL SIGNED BY

Sarah Eberhardt-Rios, Division Chief
Integrated System of Care Division

Enclosures

Attachment 1
Attachment 2

Attachment I - PACE Application Required Attestations and Uploads

Attestation Topic	Section #	Initial	SAE	Upload Required (Initial)	Upload Required (SAE)
Service Area	3.1	X	X	X	X
Legal Entity and Organizational	3.2	X	X	X	X
Governing Body	3.3	X	X	X	X
Fiscal Soundness	3.4	X	X	X	X
Marketing	3.5	X	X	X	X
Explanation of Rights	3.6	X	X	X	X
Grievance	3.7	X	X	X	X
Appeals	3.8	X	X	X	X
Enrollment	3.9	X	X	X	X
Disenrollment	3.10	X	X	X	X
Personnel Compliance	3.11	X	X		
Program Integrity	3.12	X	X		
Contracted Services	3.13	X	X		
Required Services	3.14	X	X		
Service Delivery	3.15	X	X		
Infection Control	3.16	X	X		
Interdisciplinary Team	3.17	X	X		
Participant Assessment	3.18	X	X		
Plan of Care	3.19	X	X		
Restraints	3.20	X	X		
Physical Environment	3.21	X	X		
Emergency and Disaster	3.22	X	X		
Transportation Services	3.23	X	X		
Dietary Services	3.24	X	X		
Termination	3.25	X	X	X	X
Maintenance of Records &	3.26	X	X		
Medical Records	3.27	X	X		
Quality Assessment Performance Improvement	3.28	X	X	X	X
State Attestations	3.29	X	X	X	X
Waivers	3.30	X	X	X (as applicable)	
Application Attestations	3.31	X	X	X	X
State Readiness Review	3.32	X	X (as applicable)	X	X (as applicable)

Attachment II: Service Area Overlap Review Criteria

This tool identifies criteria that DHCS will take into consideration when evaluating applications requesting overlap of existing PACE service areas. DHCS is not limited to the use of only this criteria and will take under consideration additional factors as it determines appropriate to fully assess the application. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Category	Subcategory	Criteria
Service Area Overlap with Existing PACE Operator	Service Area Overlap	Overlap includes less than 25% of potential participants in existing service area
		Overlap includes between 25% and 50% of potential participants in existing service area
		Overlap includes between 50% and 75% of potential participants in existing service area
		Overlap includes over 75% of potential participants in existing service area
	Facility Overlap	Proposed service area includes existing PACE facility or alternative care setting
		Proposed service area does not include existing PACE facility or alternative care setting
Level of Success & Investment of Existing PACE Operators/ Applicants	Market Penetration of Existing Operators in Proposed Service Area	Market penetration under 10%
		Market penetration between 10% and 30%
		Market penetration over 30%
	Recent Investments by Existing PACE Operator(s) and Recent Applicant(s) in Proposed Service Area	Facility investment over \$5M in the past year
		Facility investment over \$5M between 1 and 2 years
		Facility investment over \$5M between 2 and 3 years
No facility investments over \$5M in last 3 years		
Local Support	Local Government Support	Formal vote of city council or comparable body in support of new applicant
		Letter of support from city council member or comparable official
		No written support from local government official
	Local Service Provider Involvement	Lead applicant is a services provider in proposed service area
		Supporting applicant is a services provider in proposed service area
		No part of applying entity is services provider in proposed service area



PACE
CalOptima
Better. Together.

PACE Response to Regulatory Guidance

**Board of Directors Meeting
September 6, 2018**

Phil Tsunoda, Executive Director, Public Policy and Public Affairs

Current PACE Landscape

- Alternative and new methods of expansion are in line with the national PACE growth initiative, known as PACE 2.0
- CalOptima PACE has a variety of expansion strategies in place
 - Alternative Care Settings
 - Community-based physicians
 - Service area expansion to south Orange County
- DHCS Policy Letters create an opportunity for independent PACE centers to operate in County Organized Health System (COHS) counties

DHCS Policy Letters

- October 2017 and August 2018 letters outline the policies affecting the application review process and timelines, as well as restrictions on delegation
- Of note to CalOptima, the policy letters require a letter of support from the COHS health plan as part of an independent PACE Organization (PO) application

DHCS Policy Letters (Cont.)

“DHCS will only consider the operation of an independent PO in a COHS county if the applicant includes a letter of support from the COHS stating:

- The COHS’ support for the establishment of the independent PO in the county
- The COHS’ request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county”

Regulatory Approval

- CalOptima's *only role* with regard to an independent PO applying to operate in a COHS county is *at the beginning*, in considering whether to issue a letter of support and associated 1115 Waiver amendment request
- Lengthy application process follows this sequence:
 - 1) Independent PO requests from COHS a letter of support, which includes the 1115 Waiver amendment request
 - 2) If letter of support is provided, independent PO submits to DHCS a letter stating its intent to apply to operate a PACE center
 - 3) DHCS considers whether to submit to CMS the waiver amendment request
 - 4) If DHCS submits, CMS considers whether to approve the waiver amendment request
 - 5) If CMS approves the waiver amendment, DHCS evaluates the independent PO application
 - 6) If DHCS approves the application, CMS evaluates the independent PO application

Process for Consideration of Letter of Support

- CalOptima proposes a fair and objective evaluation process that includes, but is not limited to, certain elements:
- Application timeline window
 - Independent POs may submit letter of support requests during the period of November 1, 2018, to January 31, 2019
- Geographic ZIP code designation
 - Independent POs must include the specific ZIP codes the PO is interested in serving within Orange County

Process for Consideration of Letter of Support (Cont.)

- Threshold Criteria (20%)
 1. Operating experience
 2. Financial soundness
 3. Quality performance
 4. Demographic competence
- Primary Criteria (80%)
 5. Potential impact to CalOptima PACE program

Criterion 1: Operating Experience

- Show a minimum of five years of experience operating a PACE center
- Provide evidence of regulatory audits with no sanctions
- Submit operational policies and procedures
- Obtain reference letters from member advocates, providers and community stakeholders

Criterion 2: Financial Soundness

- Submit financial statements for the three most recent consecutive years
 - Income statements
 - Balance sheets
- Report important financial metrics
 - Liquidity
 - Debt ratio
 - Short-term viability
 - Delinquency
- Obtain third-party risk report via Dunn and Bradstreet where available

Criterion 3: Quality Performance

- Report performance against current CalPACE averages
 - Participants residing in nursing homes
 - Hospital admissions per 1,000
 - Hospital days per 1,000
 - Hospital readmission rate
 - Emergency room visits per 1,000
 - Participant satisfaction rating

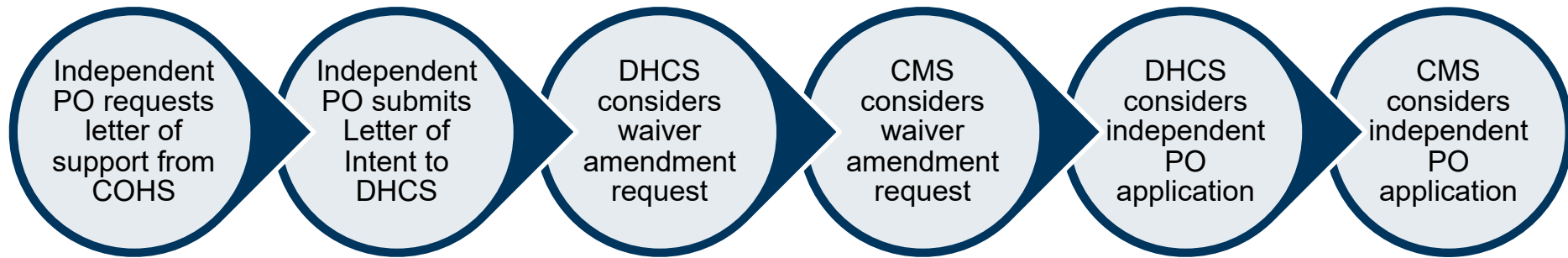
Criterion 4: Demographic Competence

- Provide a general PACE demographic profile of the ZIP code area of interest
- Demonstrate staff experience/understanding in serving PACE participants similar to the potential participants in the geographic area of interest
 - Training in cultural competency
 - Language diversity and capability
 - Accommodations for low literacy
 - Response to socioeconomic factors

Criterion 5: Impact to CalOptima PACE

- State potential impacts of an independent PO on CalOptima's existing PACE program

PACE Application Process



If the application is approved, the independent PO would contract directly with DHCS and CMS

Recommended Actions

- Approve CalOptima PACE expansion strategy in response to state regulatory guidance.
- Authorize the CEO to implement a process to consider letters of support for qualified organizations seeing to establish an independent PACE facility in Orange County.
 - Staff to bring back for Board approval any recommendation regarding a letter of support for an independent PO letter.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Authorize the expenditure for CalOptima's participation in the following events:
 - a. Up to \$10,000 and staff participation at the Vietnamese Cultural Center's 2018 Mid-Autumn Festival on Sunday, September 23, 2018 at Mile Square Park in Fountain Valley;
 - b. Up to \$3,000 and staff participation at the Vietnamese Physician Association of Southern California (VPASC) Foundation's Free Health Fair on Sunday, October 14, 2018 at the Westminster Rose Center in Westminster;
 - c. Up to \$1,500 and staff participation at the 2nd Annual Parkinson Interactive Conference for the Latino community on Saturday, October 20, 2018 at Downtown Anaheim Community Center in Anaheim;
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures.

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

Staff recommends the authorization of expenditures for participation in these community events to provide outreach and education about CalOptima's programs and services to our Vietnamese-speaking members, Spanish-speaking members and seniors. Participation in these events will provide

opportunities to increase access to health care services while strengthening relationships with our community partners.

- a. Vietnamese Cultural Center's 2018 Mid-Autumn Festival. The Vietnamese Cultural Center's 2018 Mid-Autumn Festival is a traditional festival for the Vietnamese community and also known as "Children's Day." The Mid-Autumn Festival celebrates three fundamental concepts: Gathering, Thanksgiving, and Praying. Children light lanterns and participate in a parade as part of the celebration. CalOptima has participated in the Mid-Autumn Festival for three years: 2015 at a \$5,720 sponsorship level, 2016 at a \$5,250 sponsorship level and 2017 at a \$6,000 sponsorship level.

Staff recommends CalOptima's continued support for this event at a \$10,000 level for 2018, which includes a \$10,000 financial commitment for the following: Opportunity for CalOptima's Chief Executive Officer to be a part of the event program, one (1) 10x10 exhibitor space, logo on promotional flyers and 1,500 lanterns to be distributed at the event, one (1) CalOptima banner on the stage at the festival. Employee time will be used to participate in this event. The anticipated number of attendees is more than 3,000 throughout the day. Staff will have an opportunity to share information about all CalOptima's programs and services with Vietnamese-speaking members and also outreach to potential members.

- b. VPASC Foundation's Free Health Fair. The VPASC Foundation's Free Health Fair will provide an opportunity to strengthen CalOptima's relationship with Vietnamese healthcare professionals and contracted providers including physicians, specialists and others serving our members. The VPASC is a non-profit organization established to improve the quality of health care to the underserved communities of Orange County by providing free public education seminars and free annual health fairs. The health fair brings together hundreds of healthcare professionals including doctors, dentists, pharmacists, nurses and dental assistants to provide free medical services. These services will include flu shots, screenings for blood pressure, blood glucose, vision, hepatitis B/C, and breast and colon cancer. Dental services will include dental exams, fillings, and extractions. Volunteer physicians will be on-site to provide health education on topics such as management of coronary artery disease, hypertension, strokes, high cholesterol, diabetes and hepatitis B. The event is open to the public and all services including medical, dental and health education will be provided at no cost. CalOptima has participated in the VPASC Foundation's Free Health Fair for two years: 2016 at a \$2,000 sponsorship level and 2017 at a \$3,000 sponsorship level.

Staff recommends CalOptima's continued support for this event at a \$3,000 sponsorship level for 2018, which includes a \$3,000 financial commitment for the following: one (1) exhibitor table, 5'x3' CalOptima banner display, and CalOptima brochures in each attendee's gift bag. Additional marketing benefits includes radio and newspaper recognition, CalOptima logo on the VPASC website, social media (Facebook, Instagram, Twitter), and e-mail blast. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services, potentially increasing awareness of programs, and utilization of primary and preventive care services. During last year's health fair, over one thousand two hundred

(1,200) individuals were served. VPASC is estimating that this year's event will serve over one thousand five hundred (1,500) hundred individuals.

- c. 2nd Annual Parkinson Interactive Conference. The 2nd Annual Parkinson Interactive Conference for the Latino Community provides an opportunity to highlight the PACE expansion and OneCare Connect programs and will provide staff an opportunity to provide outreach and education to CalOptima's Spanish-speaking members, who comprise approximately thirty percent of CalOptima's total membership, as well as outreach to potential members. This event provides information, resources and support to meet the needs of Spanish-speaking seniors and their caregivers through sharing information about Parkinson's disease, updates on current research and providing practical information about aging well and disease prevention. This event will take place simultaneously in Orange and Kern Counties, Chile and Mexico reaching over 6,000 attendees. Attendees will include individuals with Parkinson's disease, their care givers, family members and service providers. This conference is free to the public and continues to grow in participation. CalOptima participated in the inaugural Parkinson's Conference for the Latino Community last year at the \$500 level.

Staff recommends CalOptima's continued support for this event at a \$1,500 sponsorship level for 2018, which includes a \$1,500 financial commitment for the following: One (1) exhibitor table, CalOptima's logo displayed on all conference outreach materials, printed and electronic advertising materials, all printed materials on welcome package, during conference and event agenda, acknowledgement at conference and named nationally via live webcast through social media, on Give for a Smile webpage, and seating for sponsor representative at luncheon. Employee time will be used to participate in this event. Employees will have an opportunity to promote the PACE expansion and OneCare Connect programs with seniors and caregivers in the Latino community. Over five hundred (500) participants are anticipated to attend this event.

CalOptima staff has reviewed the request and it meets the consideration for participation as required in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability;
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations department. The Community Relations department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended action of up to \$14,500 is included as part of the Community Events budget under the CalOptima Fiscal Year 2018-19 Operating Budget approved by the CalOptima Board of Directors on June 7, 2018.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to support community and provider activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, or promote health and wellness.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. 2018 Vietnamese Cultural Center Mid-Autumn Festival Sponsorship Request Letter
2. 2018 VPASC Foundation Free Health Fair Sponsorship Request Letter
3. 2018 2nd Parkinson Interactive Conference for Latino Community Sponsorship Request Letter

/s/ Michael Schrader
Authorized Signature

8/29/2018
Date

August 14, 2018

Mr. Michael Schrader
CEO

CalOptima

505 City Parkway West
Orange, CA 92868

Re: Sponsorship for the 2018 Mid-Autumn Festival – Sunday, September 23, 2018

Dear Mr. Schrader:

On behalf of the Vietnamese Cultural Center, we would like to thank you for your support and participation in last year's Mid-Autumn Festival held at Mile Square Park in Fountain Valley. As you might remember the last event had approximately 3,000 attendees throughout the day and was a great success.

The Mid-Autumn Festival is a traditional festival for the Vietnamese community also known as "Children's Day." The Mid-Autumn Festival celebrates three fundamental concepts: Gathering, Thanksgiving and Praying. During this time various activities are held to celebrate, such as harvesting rice before the 15th of the eight lunar months, provide offerings to the God of Earth, setting up platforms with light lanterns during the evening. The Mid-Autumn Festival is a day where families gather and enjoy time with their children. The tradition of brightly lit lanterns leads to the legend that Cuoi floated to the moon on a banyan tree and was stranded there. Children light lanterns and participate in a procession to show Cuoi the way back to Earth.

This year, the 2018 Mid-Autumn Festival event will take place on Sunday, September 23, 2018 at Mile Square Park in Fountain Valley from 6:30 PM – 8:30 PM. We anticipate a greater attendance at the event this year, of which will consist of families with children and older adults.

We would like to ask for CalOptima's participation and sponsorship in the amount of estimate **\$10,000.00 for this year 2018 Mid-Autumn Festival.**

I also look forward to seeing you to be a part of the event program on stage. Should you have any questions regarding the event, please contact me at (714) 548-4845 or by e-mail at promath10@yahoo.com. The Vietnamese Cultural Center appreciates CalOptima's support.

Sincerely,

Pho Huynh

Pho Huynh
Program Director
Vietnamese Cultural Center





Vietnamese Physician Association of Southern California (VPASC) Foundation

a 501(c)(3) nonprofit organization
Tax ID # 45-3844398

18080 Beach Boulevard, Suite 105, Huntington Beach, CA 92648

E-mail: info@vpasc.org

August 4, 2018

Dear Business Leaders:

VPASC FOUNDATION BOARD

Phuong Nguyen, M.D.
President

Dinh Vu, M.D.
Treasurer

Hao Thai, M.D.
Secretary

Monique Le, M.D.
Board Member

Luan Nguyen, M.D.
Board Member

Hung Ong, M.D.
Board Member

Timothy Thien Bui, DDS
Board Member

Patrick Kha Le, DDS
Board Member

*"I can do things you cannot, you can do things I cannot;
together we can do great things."* Mother Teresa

Thank you for giving our group this opportunity to work with you. Together we can create a healthier community.

The Vietnamese Physician Association of Southern California (VPASC) Foundation is a California 501(c)(3) nonprofit organization originally incorporated in 2011. Our primary mission is to improve the quality of health care in the underserved communities of Orange County through free public education seminars and free annual health fairs.

Each year at our VPASC Free Health Fair, our group brings together hundreds of health care professionals (doctors, dentists, pharmacists, nurses, dental assistants), students, volunteers, and community businesses to provide much-needed medical screenings, dental treatments, and preventative health education free of charge to the medically underserved population.

This year, we have renamed our VPASC Free Health Fair to the "OC" Free Health Fair ... the "OC" stands for "One Community."

The 2018 "OC Free Health Fair" Presented by VPASC Foundation will be held on

Date: Sunday October 14, 2018

Time: 9 AM – 2 PM

Location: Westminster Rose Center
14140 All American Way
Westminster, CA 92683

Among the free medical services that will be available are free flu shots, blood pressure check for hypertension, blood glucose check for diabetes, vision check for glaucoma, and screenings for hepatitis B, breast cancer, and colon cancer.

[Back to Agenda](#)

Dental services will include dental exam, fillings, and extractions.

Health education lectures will be given by our volunteer physicians on important topics such as management of coronary artery disease, hypertension, strokes, high cholesterol, diabetes, and hepatitis B.

Our health fairs have always been very successful and well attended. The attendance has averaged around 1,100 patients per year for the last two years. This year, we hope to increase the attendance to 1,500 patients.

As always, our health fair is free and open to the public.

These public service activities are made possible only by the generous donation, sponsorship, and support of distinguished businesses in the community such as yours.

We hope that you are as passionate about bringing medical health services to the community as we are. We would appreciate if your institution will help us fund the 2018 "OC" Free Health Fair ... the "OC" stands for "One Community."

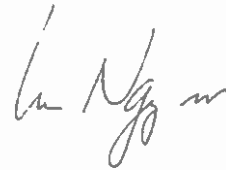
Attached you will find the preliminary health fair flyer and the sponsorship level proposal.

We thank you for your time and consideration.

Sincerely,



Phuong Trang Cao, PharmD
Chair of Health Fair Committee
VPASC Foundation
Cell: (714) 206-8226



Luan Nguyen, M.D.
President
VPASC
Cell: (714) 548-5337

TITLE SPONSORSHIP \$ 20,000

The ONLY Sponsor Name/Logo on 6 Major Banners (8' x 4.5') posted around Little Saigon

The ONLY Name/Logo display at the CENTER of all Health Fair Flyers

The ONLY Sponsor allowed to Cut Ribbon and Speak at Opening Ceremony

The ONLY Sponsor Name/Logo on Volunteer T-shirt

Television/Radio/Newspaper recognition as EXCLUSIVE TITLE SPONSOR

1 Display Table/Booth AT ENTRANCE of Health Fair / 1 Sponsor Banner (up to 12' x 3') display inside site

Business cards/brochures in attendee gift bag

Email Blast / Website / Social Media (FaceBook/Instagram/Twitter)

PLATINUM SPONSORSHIP \$ 5,000

Name on the bottom section of all Health Fair Flyers

Television/Radio/Newspaper Recognition

1 Display Table/Booth at site of Health Fair / 1 Sponsor Banner (up to 8' x 3') display inside site

Business cards/brochures in attendee gift bag

Email Blast / Website / Social Media (FaceBook/Instagram/Twitter)

DIAMOND SPONSORSHIP \$ 3,000

Name on the bottom section of all Health Fair Flyers

Radio/Newspaper Recognition

1 Display Table/Booth at site of Health Fair / 1 Sponsor Banner (up to 5' x 3') display inside site

Business cards/brochures in attendee gift bag

Email Blast / Website / Social Media (FaceBook/Instagram/Twitter)

BOOTH PARTICIPATION \$ 1,000

1 Display Table/Booth at site of Health Fair

Business cards/brochures in attendee gift bag

Blast / Website / Social Media (FaceBook/Instagram/Twitter)



Sponsors please provide own banners, business cards, and brochures to VPASC by October 5, 2018.

Please make checks payable to: VPASC Foundation - 501(c)(3) - Tax ID#: 45-3844398

Thank you for your time and generosity.

August 2, 2018

Cal-Optima

Tiffany Kaaiakamanu

505 City Parkway West, Orange, CA 92868

RE: Request to Sponsor 2nd Parkinson Interactive Conference for Latino Community

Dear Ms.Kaaiakamanu,

We are pleased to invite you to sponsor our 2nd Parkinson Interactive Conference for Latino Community /2da Conferencia Interactiva de Parkinson para la Comunidad Latina scheduled for October 20th , 2018 from 8:30 a.m. to 2:30 p.m. This event will take place simultaneously in California, Chile and Mexico.

This conference will have as purpose to raise the disease awareness among Spanish speaking Latino community. In addition, this will be the "kick off" Parkinson support group program in Orange and Kern County. Attendees will be people with Parkinson's disease, their care partners, and family members we will expecting around 500 people in two locations in Orange County at Downtown Anaheim Community Center 250 E Center St, Anaheim, CA 92805 and Kern County at Dignity Health Hospitals 1600 D St. Bakersfield CA. In addition to internet connected audience transmitting from these places to groups in USA, Mexico and Chile over all we expect to reach 6,000+ people

As a leader in our community, you without doubt, understand the pressing need for solutions to problems in local communities. This new, and more challenging event requires a larger participation from sponsor like you. Our efforts to connect families with information and resources for Parkinson's cannot take effect unless we have the support of everyone in our community.

If you have any questions about our conference or regarding the sponsorship levels listed below, feel free to contact me. Thank you for considering our request.

Cordially,



Adriana Jimenez,

Program Director

Give for a smile

(714)928-4988

ajimenez@giveforasmile.org www.giveforasmile.org "Changing one family's life at time"

Sponsorship levels:

Platinum Medal Sponsor \$5,000 Mentioned at national and international level

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Diploma from Parkinson Foundation <input type="checkbox"/> Logo identification on all conference outreach materials. Printed and electronic advertising materials <input type="checkbox"/> Logo on all printed materials on welcome package press materials <input type="checkbox"/> Full page display of logo in presentation during general sessions <input type="checkbox"/> Exhibition table in preferential place | <ul style="list-style-type: none"> <input type="checkbox"/> Acknowledgement at conference plenary and named nationally and international via the live webcast through YouTube and Facebook. <input type="checkbox"/> Sponsored on Give For A Smile webpage <input type="checkbox"/> Prominent display of corporate banner (banner to be provided by sponsor) <input type="checkbox"/> VIP seating for sponsor representative at plenary and luncheon |
|---|--|

Gold Medal Sponsor \$2,500 Mentioned at national level

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Diploma from Parkinson Foundation <input type="checkbox"/> Logo identification on all conference outreach materials. Printed and electronic advertising materials <input type="checkbox"/> Logo on all printed materials on welcome package press materials <input type="checkbox"/> Display of logo in presentation during general sessions <input type="checkbox"/> Exhibition space | <ul style="list-style-type: none"> <input type="checkbox"/> Acknowledgement at conference plenary and named nationally via the live webcast through YouTube and Facebook <input type="checkbox"/> Sponsored on Give For A Smile webpage <input type="checkbox"/> Display of corporate banner (banner to be provided by sponsor) <input type="checkbox"/> Seating for sponsor representative at luncheon's head table |
|---|--|

Silver Medal Sponsor \$1,500

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Logo on all printed materials on welcome package press materials <input type="checkbox"/> Sponsored on Give For A Smile webpage <input type="checkbox"/> Recognition in presentation during general sessions | <ul style="list-style-type: none"> <input type="checkbox"/> Exhibition space <input type="checkbox"/> Seating for sponsor representative at luncheon's head table |
|---|---|

Bronze Medal Sponsor \$500

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Listing in all printed materials on welcome package press materials | <ul style="list-style-type: none"> <input type="checkbox"/> Sponsored on Give For A Smile webpage |
|--|--|

SPONSORSHIP AMOUNT \$ _____

- Make check payable to: **Give for a Smile**
- Note on the check: **2nd Parkinson Interactive Conference for Latino Community**
- Please Mail this form and your check by **August 31, 2018** to:
Give For a Smile P.O. Box 600, Stanton, CA 90680-0600
- Employer Identification No. 45-2454983

NO ACTION TAKEN
CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

17. Consider Ratification of Contract for Legal Services

Contact

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

Recommended Action

Ratify a contract with Richards, Watson and Gershon for the provision of legal services in support of performance review process in an amount not to exceed \$18,000.

Background/Discussion

At its April 5, 2012 meeting, the Board took action to require all new contracts for legal services to be approved by the Board of Directors.

Consistent with CalOptima Policy GA.5002: Purchasing, staff conducted an informal bid process, and obtained quotations from a number of qualified sources to provide advice on performance review process. In August 2018, an evaluation team reviewed the proposals. The criteria for evaluating the proposals included qualifications of the firm, related experience, capabilities and price. Based on the results of the evaluation, staff recommends CalOptima retain Richards, Watson and Gershon for such legal services.

The recommended firm, Richards, Watson and Gershon, is based in Brea, California, and has extensive experience with public agency and employment law. The proposed primary attorney is Roy Clarke.

Fiscal Impact

The fiscal impact for the recommended action is expected not to exceed \$18,000. This is an unbudgeted item; however, management expects these proposed expenses to be covered by the current year's budgeted operating surplus, reducing the surplus by up to the recommended amount.

Rationale for Recommendation

Contracting for legal services is recommended to provide support for performance review process.

Concurrence

Diana Hoffman, Deputy Chief Counsel

Attachment

None

/s/ Michael Schrader
Authorized Signature

8/29/2018
Date

AGENDA ITEM 18 TO FOLLOW CLOSED SESSION

Consider Chief Executive Officer and Chief Counsel
Performance Reviews and Compensation

Board of Directors Meeting August 2, 2018

Provider Advisory Committee (PAC) Update

August 9, 2018 PAC Meeting

Eleven (11) PAC members were in attendance at the June PAC meeting.

PAC received a CEO update from Michael Schrader that included recuperative care, the California Children Services (CCS) transition to the Whole Child Model (WCM) with the other County Organized Health Systems that began in July 2018. Mr. Schrader noted that several stakeholder meetings had been held and that they would continue to be held on a regular basis.

Emily Fonda, M.D., Medical Director gave the Chief Medical Officer update on behalf of Dr. Helmer. She updated the members on the National Committee for Quality Assurance (NCQA) audit that CalOptima had undergone in July 2018. She noted that it would take several months to get the results back but noted that lots of compliments had been given during the audit process. Dr. Fonda also gave a brief update on the PACE expansion. Dr. Fonda thanked Member Flood for his help in developing the Long-Term Services and Support (LTSS) Plan that would be instrumental in helping reduce admissions to the hospital.

Cheryl Meronk, Director, Strategic Development provided an update on Intergovernmental Transfer (IGT) Funds 5, 6 and 7 and also discussed years 8 and 9.

Kelly Rex-Kimmet, Director, Quality Analytics provided the annual Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) update. She noted that the results were similar to years past, but that there had been some improvement from last year's report.

PAC also received an overview of the June Financial Report from Greg Hamblin, Chief Financial Officer and update on contracting initiatives from Michelle Laughlin, Executive Director, Network Operations.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's current activities.



Board of Directors Meeting September 6, 2018

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

At the August 23, 2018 OneCare Connect Member Advisory Committee (OCC MAC) meeting, members welcomed Keiko Gamez as a new member/family member representative.

OCC MAC also received the following informational presentations: Cheryl Meronk, Director Strategic Development, provided a verbal update, followed by a handout on the Intergovernmental Transfer (IGT) Funds. Ms. Meronk reviewed IGT 5, 6, and 7. She also discussed the possible funding for IGT 8 and 9. Candice Gomez, Executive Director, Program Implementation, presented an update on the Health Homes Program, which is due to go live at CalOptima on July 1, 2019. Irma Munoz, Lead Project Manager Quality Analytics, provided the 2018 Healthcare Effectiveness Data and Information Set (HEDIS) results which were based on 2017 performance. Marsha Choo, Manager Quality Analytics, provided information on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) update. Both updates reflected improvement in scores as they relate to OneCare Connect members.

OCC MAC members received updates from CalOptima's executive staff, including the Chief Executive Officer update from Michael Schrader, and a Chief Medical Officer update from Emily Fonda, M.D., Medical Director.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.



CalOptima
Better. Together.

CalOptima Delivery System Review

**Board of Directors Meeting
September 6, 2018**

Greg Hamblin, Chief Financial Officer

Overview

- Background: Provider Network
- Comparable Health Plans
- Last CalOptima Network RFP
- Delivery System Metrics
 - Medi-Cal Membership by Network
 - Contracted Medi-Cal Providers by Network
 - Contracted Hospitals by Network
- Quality/ HEDIS Metrics
- Financial Metrics
- Health Network Requirements
- Summary/ Considerations

Background: Provider Network

History of Health Networks – Year First Contracted with CalOptima

1995 (23 years)	2003 (15 years)	2004 (14 years)	2006 (12 years)	2015 (3 years)
<ul style="list-style-type: none">• CHOC Health Alliance• Kaiser Permanente• Prospect Medical Group• United Care Medical Network	<ul style="list-style-type: none">• Arta Western*• Family Choice Health Network*• Noble*	<ul style="list-style-type: none">• Monarch Family Healthcare• Talbert Medical Group	<ul style="list-style-type: none">• AMVI Care Health Network• Alta Med Health Services	<ul style="list-style-type: none">• OC Advantage**#• Heritage – Regal Medical Group**

* Health networks have been contracted since at least January 1, 2003

** Health networks were added as part of the network expansion related to Medi-Cal Expansion and OneCare Connect (OCC) program implementation

Health network has not been able to meet minimum membership requirement of 5,000 members after three years

Background: Provider Network (cont.)

- CalOptima non-delegated responsibilities (for all members)
 - Grievances and appeals (except Kaiser)
 - Health education (except Kaiser)
 - Long term services & supports (except Kaiser)
 - Managed care plan – Provider screening for Medi-Cal
 - Member and provider communications
 - Model of Care
 - Oversight of health networks and delegates
 - Provider data management/ Provider directory
 - Quality improvement
- Health network delegated key responsibilities
 - Claims
 - Credentialing
 - Provider contracting
 - Utilization management
- CalOptima performs all health network functions for CCN/COD

Comparable Health Plans

- Queried two of the largest Medi-Cal plans in California: LA Care and Inland Empire Health Plan (IEHP)
 - Consistent responses between the two plans
 - Have not performed a request for proposal (RFP) for re-procurement related to core health network providers
 - Any substantial changes to the provider network would be disruptive to existing members
 - Most all provider contracts are evergreen (no annual renewal)
 - Contract amendments are made, as required

Comparable Health Plans (cont.)

	CalOptima	Inland Empire	LA Care
Issuance of RFP	RFP issued for significant increase in MCE population growth and Medicare/ Medi-Cal providers for OCC	Has not issued RFP or re-procurement of core Medi-Cal network	Has not issued RFP or re-procurement of core Medi-Cal network
Medi-Cal Membership (June 2018)	Orange: 756,881	Total: 1,222,350 Riverside: 604,614 San Bernardino: 617,736	Los Angeles: 2,066,390
Delegated Entities	HMO/IPAs: 13	IPAs: 17	IPAs: 28
Global Sub-capitated arrangements (100% full risk)	One health plan: <ul style="list-style-type: none"> • Kaiser 	One health plan: <ul style="list-style-type: none"> • Kaiser 	3 health plans: <ul style="list-style-type: none"> • Kaiser • Anthem • Care First
Contracted Hospitals	30	30	40
Direct Provider Network (Y/N)	Y	Y	Y
Contract Period	Generally, 1 year period – Renewed on an annual basis	Evergreen (no specific end date) – Rates and other contract changes made as needed through amendments	Evergreen (no specific end date) – Rates and other contract changes made as needed through amendments

Last CalOptima Network RFP

- March 2013: Released RFP to modify or add health networks
 - Reason for RFP
 - New members: Medi-Cal Expansion expected to increase membership by over 45%
 - Need for Providers: OCC implementation to begin July 2014; need to add providers who serve Medicare members
 - Evaluated medical groups and health plans based on their ability to meet the minimum quality, administrative and financial participation criteria
 - Developed formal scoring criteria to evaluate RFP responses
 - Used Board-approved criteria to select medical groups and health plans
- At the same time, CalOptima explored direct contracting with independent providers through CCN to maintain provider-patient relationships through OCC implementation
 - Any willing and qualified provider
 - Providers had to agree to CalOptima contract terms and requirements in order to contract

Last CalOptima Network RFP (cont.)

- RFP submission and results
 - 17 proposals submitted
 - 5 proposals from existing health networks proposing to change their current contract model (e.g., SRG to full risk HMO)
 - 12 proposals from new health networks

	Total Number
Total number of new health networks assessed	12
Number of health networks that met the RFP minimum requirements	5
Number of health networks that chose not to contract due to readiness review, contract terms, or other business decisions	3
Number of health networks that proceeded with contracting	2

Last CalOptima Network RFP (cont.)

- Lessons Learned

- Last RFP for additional health networks resulted in only 2 out of 12 respondents being added through the RFP and contracting process
 - However, one of the two contracted health networks has not met the minimum membership requirement of 5,000 members after three years
 - Since the health network has failed to meet this requirement, a termination notice is anticipated
- Significant administrative workload to process all RFP responses
 - Very low execution rate from RFP to sustainable network contract
 - Low membership after 3 years for the 2 new health networks
- Unlikely that any new health network could reach the minimum membership requirement (5,000) without adding new member population
 - Members would have to transfer from other health networks or CCN
 - By member choice only
 - Auto-assignment could be minimal as performance measures may not exist for the first year

Delivery System Metrics

Medi-Cal Membership by Network – July 2018

Health Network	Model	Enrollment	% Total
CHOC Health Alliance	PHC	146,549	19.4%
COD – CalOptima	FFS	104,533	13.8%
Monarch Family Healthcare	HMO	81,235	10.7%
CCN – CalOptima	FFS	75,618	10.0%
Arta Western	SRG	65,592	8.7%
Alta Med Health Services	SRG	46,335	6.1%
Family Choice Health Network	PHC	46,227	6.1%
Kaiser Permanente	HMO	45,659	6.0%
Prospect Medical Group	HMO	33,989	4.5%
United Care Medical Network	SRG	32,334	4.3%
Noble	SRG	24,798	3.3%
Talbert Medical Group	SRG	23,889	3.2%
AMVI Care Health Network	PHC	22,386	3.0%
Heritage – Regal Medical Group	HMO	5,863	0.8%
OC Advantage	PHC	2,126	0.3%
Total Medi-Cal Enrollment Only		757,133	100.0%

Delivery System Metrics (cont.)

Contracted Medi-Cal Providers by Network

Health Network	Orange County PCPs	Network Unique PCPs		Overlap with Other Networks	
		Count	%	Count	%
Alta Med Health Services	110	7	6.4%	103	93.6%
AMVI Care Health Network	79	2	2.5%	77	97.5%
Arta Western	255	6	2.4%	249	97.6%
CHOC Health Alliance	425	33	7.8%	392	92.2%
CCN – CalOptima	598	107	17.9%	491	82.1%
Family Choice Health Network	174	11	6.3%	163	93.7%
Heritage – Regal Medical Group	332	40	12.0%	292	88.0%
Monarch Family Healthcare	315	56	17.8%	259	82.2%
Noble	116	6	5.2%	110	94.8%
OC Advantage	75	4	5.3%	71	94.7%
Prospect Medical Group	236	21	8.9%	215	91.1%
Talbert Medical Group	234	36	15.4%	198	84.6%
United Care Medical Network	186	49	26.3%	137	73.7%
Total PCP's		1,068			

Notes: Each PCP count represents unique PCP physicians; a PCP may be affiliated with one or more networks

Kaiser is excluded from the data

Overlap – PCP is available for selection from at least two entities at minimum

Delivery System Metrics (cont.)

Contracted Hospitals by Network – Summary

Health Network	Model	Total Hospital Affiliations
CCN/COD/SRGs	FFS	30*
Monarch Family Healthcare	HMO	14
Heritage – Regal Medical Group	HMO	8
CHOC Health Alliance	PHC	6
Prospect Medical Group	HMO	5
Family Choice Health Network	PHC	1
AMVI Care Health Network	PHC	1
OC Advantage	PHC	1

* 9 of the 30 total hospitals are only affiliated with CCN/COD/SRG
CalOptima is at risk for hospital costs related to CCN/COD/SRGs. SRGs are not contracted directly with these hospitals for CalOptima members.

Delivery System Metrics (cont.)

Contracted Hospitals by Network – Detail

Hospital	CCN/COD	Monarch	Heritage	CHOC	Prospect	Family	AMVI	OC Ad-	Total
	SRG	HMO	Regal	PHC	HMO	Choice	PHC	vantage	
	FFS		HMO			PHC		PHC	
Anaheim Global Medical Center	1								1
Anaheim Regional Medical Center	1	1			1				3
Chapman Global Medical Center	1	1							2
Children's Hospital of Orange County	1			1					2
CHOC Children's at Mission Hospital	1	1		1					3
College Hospital – Cerritos	1								1
College Hospital Costa Mesa	1		1						2
Foothill Regional Medical Center	1				1				2
Fountain Valley Regional Hospital & Medical Center	1	1	1		1	1	1	1	7
Garden Grove Hospital and Medical Center	1								1
Healthbridge Children's Hospital – Orange	1								1
Hoag Memorial Hospital Presbyterian	1			1					2
Huntington Beach Hospital	1	1							2
Kindred Hospital – Brea	1								1
Kindred Hospital – Santa Ana	1		1						2
Kindred Hospital – Westminster	1		1						2
Long Beach Memorial Medical Center	1	1							2

Delivery System Metrics (cont.)

Contracted Hospitals by Network – Detail (cont.)

Hospital	CCN/COD SRG	Monarch	Heritage Regal	CHOC	Prospect	Family Choice	AMVI	OC Ad- vantage	Total
	FFS	HMO	HMO	PHC	HMO	PHC	PHC	PHC	
Long Beach Memorial Medical Center Miller Children's	1	1							2
Los Alamitos Medical Center	1	1	1		1				4
Mission Hospital Regional Medical Center	1	1		1					3
Orange County Global Medical Center	1	1	1						3
Placentia Linda Hospital	1	1	1		1				4
Prime HealthCare La Palma Intercommunity Hospital	1	1							2
Promise Hospital of East Los Angeles LP	1								1
South Coast Global Medical Center	1	1	1	1					4
St. Joseph Hospital	1			1					2
St. Jude Medical Center	1								1
UCI Medical Center	1								1
West Anaheim Medical Center	1	1							2
Whittier Hospital Medical Center	1								1
Total	30	14	8	6	5	1	1	1	

Quality/ HEDIS Metrics

Raw Scores by Measure

	Adult Access to Preventive Care Services	Adolescent Well Care Visits	Breast Cancer Screening	Children's Access to Primary Care Physician	Cervical Cancer Screening	Diabetes Care: Eye Exam
CCN	71%	37%	55%	78%	53%	49%
Health Network 1	58%	59%		90%		67%
Health Network 2	69%	45%	66%	86%	59%	62%
Health Network 3	72%	48%	64%	88%	58%	56%
Health Network 4	60%	72%	69%	91%	63%	59%
Health Network 5	67%	49%	66%	80%	57%	59%
Health Network 6	62%	41%	63%	82%	51%	65%
Health Network 7	71%	53%	65%	87%	60%	52%
Health Network 8	68%	24%		75%	47%	62%
Health Network 9	57%	49%	64%	82%	55%	72%
Health Network 10	63%	52%	64%	88%	52%	57%
Health Network 11	66%	26%			48%	59%
Health Network 12	51%	44%	49%	81%	42%	55%

Based on 2017 measurement results

Quality/ HEDIS Metrics (cont.)

Raw Scores by Measure (cont.)

	Diabetes Care: HbA1c Screening	Childhood Immunizations Combo 10	Appropriate Treatment for Children with Pharyngitis	Medication Management for People with Asthma	Appropriate Treatment for Children with URI	Well Child Visits 3-6 years
CCN	84%	27%	58%	42%	94%	64%
Health Network 1	92%	31%	57%	34%	94%	80%
Health Network 2	87%	20%	51%	56%	93%	76%
Health Network 3	86%	21%	54%	46%	90%	79%
Health Network 4	87%	22%	19%	39%	91%	84%
Health Network 5	87%	39%	33%	42%	94%	75%
Health Network 6	87%	17%	74%	44%	92%	69%
Health Network 7	88%	26%	37%	35%	92%	74%
Health Network 8	88%				76%	50%
Health Network 9	88%	28%	41%	35%	91%	70%
Health Network 10	85%	20%	46%	40%	93%	73%
Health Network 11	90%					
Health Network 12	80%	27%	53%	49%	93%	69%

Based on 2017 measurement results

Financial Metrics

Medi-Cal MLR Audit Results – Summary

	Combined 3-year Average (CY 2014-2016)
Total Health Networks	13
Health Networks <85% MLR	3

- Medical Loss Ratio (MLR) is only applicable to capitation
 - Contract requirement – to ensure at least 85% of their capitation payment is spent on medical care
 - Capitation rates are risk adjusted by CalOptima to account for member acuity/cost variation
- CCN is not a capitated health network
 - However, health networks are capitated based on the FFS rates that CCN pays providers
 - In addition, health networks are given a 10-15% administrative load in their capitation rates

Financial Metrics (cont.)

Medi-Cal MLR Audit Results by Network

Health Network	Combined 3-year Average (CY 2014-16)
Health Network 1	75%*
Health Network 2	89%
Health Network 3	88%
Health Network 4	85%
Health Network 5	94%
Health Network 6	86%
Health Network 7	117%
Health Network 8	89%
Health Network 9	85%
Health Network 10	72%*
Health Network 11	79%*
Health Network 12	96%
Health Network 13	85%
Average	91%

* Health network is under corrective action for not meeting 85% minimum MLR requirement

Health Network Requirements – 2015 RFP

- Minimum New Health Network Requirements
 - Physician network requirements
 - 95% of primary care physicians must practice in Orange County
 - 50% of physicians must be specialists
 - 20% of physicians are not currently affiliated with any existing CalOptima delegated health network
 - Participate in all CalOptima programs
 - Medi-Cal, OneCare and OneCare Connect
 - Qualify to participate in an established health delivery model
 - SRG: Shared Risk Group
 - PHC: Physician and Hospital risk sharing partnership
 - HMO: Full risk health network and Knox-Keene licensed medical groups
 - Demonstrate medical, quality, administrative, operational and financial readiness as described in the Statement of Work (SOW)

Health Network Requirements – Contract

- Fulfill and comply with all requirements of:
 - CalOptima Readiness Assessment
 - CalOptima Policies and Procedures
 - CMS, DHCS and NCQA
- Agree to:
 - CalOptima contractual terms
 - CalOptima reimbursement methodology and capitation rates
 - Divisions of financial responsibility (DOFRs)
 - Participate in all state and federal audits and corrective action plans
 - Participate in CalOptima's Quality, Utilization Management and oversight programs
 - Requirements of the Delegation and Business Associate Agreements

Summary/ Considerations

- Market

- New health networks must share auto-assignments with other existing health networks which makes growth very slow
- New health networks may also add members if existing members in other health networks choose to move; also a slow growth process
- The addition of new health network will not add new Medi-Cal members to CalOptima

- Member

- New health network would receive members by choice or through the auto-assignment process
 - Auto assignment would be minimal the first year, as performance measures might not exist or qualify to be measurable
 - Difficult for health network to meet minimum membership – either by member choice or by auto-assignment
- Member always has the choice to select a different health network or CCN each month
- Changes in health networks could create significant member disruption

Summary/ Considerations (cont.)

- Provider

- CalOptima has 100% of providers who want to participate in Medi-Cal
- All health networks willing to contract with new providers based on need
- CCN/COD network accepts any willing and qualified provider as long as they meet and agree to the contract standards and requirements
- Result: Providers have opportunity through health networks and CCN/COD to participate in CalOptima

- Financial

- CalOptima sets the payments rates
- CalOptima sets the performance standards and completes periodic reviews and audits to ensure compliance and enforce contract terms
- Result: CalOptima ensures the delegation of risk to a health network is appropriate

- Regulatory

- DHCS contract requires written approval prior to making any substantial changes in the availability or location of covered services



A Public Agency

CalOptima
Better. Together.

Financial Summary

July 2018

Board of Directors Meeting
September 6, 2018

Greg Hamblin
Chief Financial Officer

FY 2018-19: Consolidated Enrollment

- July 2018 MTD:
 - Overall enrollment was 778,534 member months
 - Actual lower than budget by 6,633 or 0.8%
 - Medi-Cal: unfavorable variance of 8,177 members
 - Temporary Assistance for Needy Families (TANF) unfavorable variance of 4,771 members
 - Senior Persons with Disabilities (SPD) unfavorable variance of 102 members
 - Medi-Cal Expansion (MCE) unfavorable variance of 3,237
 - Long-Term Care (LTC) unfavorable variance of 67
 - OneCare Connect: favorable variance of 1,476 members due to retro adjustments
 - 1,743 decrease from prior month
 - Medi-Cal: decrease of 3,352 from June
 - OneCare Connect: increase of 1,631 from June
 - OneCare: decrease of 28 from June
 - PACE: increase of 6 from June

FY 2018-19: Consolidated Revenues

- July 2018 MTD:
 - Actual lower than budget by \$5.1 million or 1.9%
 - Medi-Cal: unfavorable to budget by \$7.1 million or 2.9%
 - Unfavorable volume variance of \$2.6 million
 - Unfavorable price variance of \$4.5 million due to:
 - \$3.6 million of Proposition 56 revenue budgeted but not recognized in July
 - \$1.9 million due of Non-LTC revenue
 - \$1.4 million of Coordinated Care Initiative (CCI) revenue, offset by:
 - \$2.8 million of prior year (PY) revenue
 - OneCare Connect: favorable to budget by \$2.1 million or 8.4%
 - Favorable volume variance of \$2.5 million
 - Unfavorable price variance of \$0.4 million

FY 2018-19: Consolidated Revenues (cont.)

- July 2018 MTD:
 - OneCare: unfavorable to budget by \$221.0 thousand or 14.4%
 - Favorable volume variance of \$76.6 thousand
 - Unfavorable price variance of \$297.5 thousand due to PY retro adjustments
 - PACE: favorable to budget by \$112.8 thousand or 5.7%
 - Favorable volume variance of \$14.5 thousand
 - Favorable price variance of \$98.3 thousand

FY 2018-19: Consolidated Medical Expenses

- July 2018 MTD:
 - Actual lower than budget by \$5.8 million or 2.2%
 - Medi-Cal: favorable variance of \$5.3 million
 - Favorable volume variance of \$2.5 million
 - Favorable price variance of \$2.8 million
 - Professional Claims favorable variance of \$1.6 million due to Proposition 56 expense of \$3.2 million, offset by Child Health and Disability Prevention (CHDP)
 - Prescription Drug favorable variance of \$1.2 million
 - Managed Long Term Services and Supports (MLTSS) favorable variance of \$1.1 million due to LTC expense
 - Facilities favorable variance of \$0.6 million
 - Provider Capitation unfavorable variance of \$2.3 million due to CHDP

FY 2018-19: Consolidated Medical Expenses (cont.)

- July 2018 MTD:

- OneCare Connect: favorable variance of \$0.2 million or 0.7%
 - Unfavorable volume variance of \$2.4 million
 - Favorable price variance of \$2.5 million
- OneCare: favorable variance of \$0.1 million
- PACE: favorable variance of \$0.2 million

- Medical Loss Ratio (MLR):

➤ July 2018: Actual: 95.0% Budget: 95.3%

FY 2018-19: Consolidated Administrative Expenses

- July 2018 MTD:

- Actual lower than budget by \$2.2 million or 17.1%
 - Salaries, wages and benefits: favorable variance of \$1.0 million
 - Purchased Services: favorable variance of \$0.4 million
 - Professional Fees: favorable variance of \$0.3 million
 - Other categories: favorable variance of \$0.5 million

- Administrative Loss Ratio (ALR):

- July 2018 MTD: Actual: 3.9% Budget: 4.6%

FY 2018-19: Change in Net Assets

- July 2018 MTD:
 - \$5.0 million surplus
 - \$4.3 million favorable to budget
 - Lower than budgeted revenue of \$5.1 million
 - Lower than budgeted medical expenses of \$5.8 million
 - Lower than budgeted administrative expenses of \$2.2 million
 - Higher than budgeted investment and other income of \$1.5 million

Enrollment Summary: July 2018

Month-to-Date				Enrollment (By Aid Category)	Year-to-Date			
Actual	Budget	Variance	%		Actual	Budget	Variance	%
63,642	63,771	(129)	(0.2%)	Aged	63,642	63,771	(129)	(0.2%)
630	620	10	1.6%	BCCTP	630	620	10	1.6%
47,121	47,104	17	0.0%	Disabled	47,121	47,104	17	0.0%
313,231	316,710	(3,479)	(1.1%)	TANF Child	313,231	316,710	(3,479)	(1.1%)
94,529	95,821	(1,292)	(1.3%)	TANF Adult	94,529	95,821	(1,292)	(1.3%)
3,382	3,449	(67)	(1.9%)	LTC	3,382	3,449	(67)	(1.9%)
237,937	241,174	(3,237)	(1.3%)	MCE	237,937	241,174	(3,237)	(1.3%)
760,472	768,649	(8,177)	(1.1%)	Medi-Cal	760,472	768,649	(8,177)	(1.1%)
16,399	14,923	1,476	9.9%	OneCare Connect	16,399	14,923	1,476	9.9%
273	271	2	0.7%	PACE	273	271	2	0.7%
1,390	1,324	66	5.0%	OneCare	1,390	1,324	66	5.0%
778,534	785,167	(6,633)	(0.8%)	CalOptima Total	778,534	785,167	(6,633)	(0.8%)

Financial Highlights: July 2018

Month-to-Date

Actual	Budget	\$ Budget	% Budget
778,534	785,167	(6,633)	(0.8%)
269,548,271	274,683,454	(5,135,183)	(1.9%)
256,028,551	261,837,231	5,808,680	2.2%
10,431,606	12,581,739	2,150,133	17.1%
3,088,114	264,484	2,823,630	1067.6%
1,927,999	416,667	1,511,333	362.7%
5,016,113	681,151	4,334,963	636.4%
95.0%	95.3%	0.3%	
3.9%	4.6%	0.7%	
<u>1.1%</u>	<u>0.1%</u>	1.0%	
100.0%	100.0%		

Year-to-Date

Actual	Budget	\$ Budget	% Budget
778,534	785,167	(6,633)	(0.8%)
269,548,271	274,683,454	(5,135,183)	(1.9%)
256,028,551	261,837,231	5,808,680	2.2%
10,431,606	12,581,739	2,150,133	17.1%
3,088,114	264,484	2,823,630	1067.6%
1,927,999	416,667	1,511,333	362.7%
5,016,113	681,151	4,334,963	636.4%
95.0%	95.3%	0.3%	
3.9%	4.6%	0.7%	
<u>1.1%</u>	<u>0.1%</u>	1.0%	
100.0%	100.0%		

Member Months

Revenues

Medical Expenses

Administrative Expenses

Operating Margin

Non Operating Income (Loss)

Change in Net Assets

Medical Loss Ratio

Administrative Loss Ratio

Operating Margin Ratio

Total Operating

Consolidated Performance Actual vs. Budget: July (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
<u>Actual</u>	<u>Budget</u>	<u>Variance</u>		<u>Actual</u>	<u>Budget</u>	<u>Variance</u>
1.4	1.4	(0.0)	Medi-Cal	1.4	1.4	(0.0)
1.4	(1.1)	2.5	OCC	1.4	(1.1)	2.5
(0.1)	(0.1)	(0.0)	OneCare	(0.1)	(0.1)	(0.0)
<u>0.4</u>	<u>0.1</u>	<u>0.4</u>	<u>PACE</u>	<u>0.4</u>	<u>0.1</u>	<u>0.4</u>
3.1	0.3	2.8	Operating	3.1	0.3	2.8
<u>1.9</u>	<u>0.4</u>	<u>1.5</u>	<u>Inv./Rental Inc, MCO tax</u>	<u>1.9</u>	<u>0.4</u>	<u>1.5</u>
1.9	0.4	1.5	Non-Operating	1.9	0.4	1.5
5.0	0.7	4.3	TOTAL	5.0	0.7	4.3

Consolidated Revenue & Expense:

July 2018 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	522,535	237,937	760,472	16,399	1,390	273	778,534
REVENUES							
Capitation Revenue	\$ 131,250,748	\$ 107,924,941	\$ 239,175,689	\$ 26,980,106	\$ 1,315,478	\$ 2,076,997	\$ 269,548,271
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	<u>131,250,748</u>	<u>107,924,941</u>	<u>239,175,689</u>	<u>26,980,106</u>	<u>1,315,478</u>	<u>2,076,997</u>	<u>269,548,271</u>
MEDICAL EXPENSES							
Provider Capitation	35,633,445	49,066,161	84,699,605	11,881,315	353,536	-	96,934,457
Facilities	21,612,139	21,084,824	42,696,962	3,143,970	424,557	312,576	46,578,065
Ancillary	-	-	-	523,844	12,835	-	536,678
Professional Claims	16,889,054	8,077,416	24,966,470	-	-	394,291	25,360,761
Prescription Drugs	17,590,273	19,518,193	37,108,466	5,605,707	454,148	148,525	43,316,846
MLTSS	32,196,494	2,849,076	35,045,571	1,131,427	74,707	(1,746)	36,249,959
Medical Management	1,886,851	927,274	2,814,125	1,046,181	77,067	521,098	4,458,470
Quality Incentives	773,330	405,248	1,178,578	280,840	-	2,730	1,462,148
Reinsurance & Other	469,824	200,097	669,921	281,905	6,500	172,841	1,131,166
Total Medical Expenses	<u>127,051,409</u>	<u>102,128,289</u>	<u>229,179,698</u>	<u>23,895,188</u>	<u>1,403,350</u>	<u>1,550,315</u>	<u>256,028,551</u>
Medical Loss Ratio	96.8%	94.6%	95.8%	88.6%	106.7%	74.6%	95.0%
GROSS MARGIN	4,199,339	5,796,653	9,995,991	3,084,918	(87,871)	526,683	13,519,720
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			6,115,005	826,170	0	90,762	7,031,938
Professional fees			109,466	4,168	14,667	2,800	131,101
Purchased services			681,659	171,215	7,193	2,815	862,882
Printing & Postage			362,091	39,719	3,692	-	405,503
Depreciation & Amortization			413,694	-	-	2,074	415,768
Other expenses			1,175,088	45,429	60	5,547	1,226,123
Indirect cost allocation & Occupancy			(237,168)	557,394	34,965	3,100	358,291
Total Administrative Expenses			<u>8,619,835</u>	<u>1,644,095</u>	<u>60,578</u>	<u>107,098</u>	<u>10,431,606</u>
Admin Loss Ratio			3.6%	6.1%	4.6%	5.2%	3.9%
INCOME (LOSS) FROM OPERATIONS			1,376,156	1,440,822	(148,449)	419,584	3,088,114
INVESTMENT INCOME							1,947,905
TOTAL GRANT INCOME			(20,066)				(20,066)
OTHER INCOME			160				160
CHANGE IN NET ASSETS			<u>\$ 1,356,250</u>	<u>\$ 1,440,822</u>	<u>\$ (148,449)</u>	<u>\$ 419,584</u>	<u>\$ 5,016,113</u>

Balance Sheet: As of July 2018

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	260,361,586	Accounts Payable	17,304,582
Investments	437,006,305	Medical Claims liability	842,502,823
Capitation receivable	557,852,509	Accrued Payroll Liabilities	11,662,536
Receivables - Other	22,751,343	Deferred Revenue	88,080,026
Prepaid expenses	6,585,498	Deferred Lease Obligations	114,458
		Capitation and Withholds	105,349,942
Total Current Assets	<u>1,284,557,241</u>	Total Current Liabilities	<u>1,065,014,368</u>
Capital Assets			
Furniture & Equipment	34,328,849		
Building/Leasehold Improvements	7,732,113		
505 City Parkway West	49,743,943		
	<u>91,804,904</u>		
Less: accumulated depreciation	<u>(41,516,685)</u>		
Capital assets, net	<u>50,288,219</u>	Other (than pensions) post	
		employment benefits liability	24,691,270
Other Assets		Net Pension Liabilities	25,192,066
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	100,000
Board-designated assets			
Cash and Cash Equivalents	15,040,319	TOTAL LIABILITIES	<u>1,114,997,704</u>
Long-term Investments	<u>523,655,935</u>		
Total Board-designated Assets	538,696,254	Deferred Inflows	
		Excess Earnings	-
Total Other Assets	<u>538,996,254</u>	Change in Assumptions	3,329,380
TOTAL ASSETS	<u>1,873,841,715</u>	TNE	81,663,334
Deferred Outflows		Funds in Excess of TNE	684,984,346
Pension Contributions	393,907		
Difference in Experience	1,365,903	Net Assets	<u>766,647,680</u>
Excess Earnings	1,017,387		
Changes in Assumptions	8,355,853		
TOTAL ASSETS & DEFERRED OUTFLOWS	<u>1,884,974,765</u>	TOTAL LIABILITIES & FUND BALANCES	<u>1,884,974,765</u>

Board Designated Reserve and TNE Analysis As of July 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	147,430,499				
	Tier 1 - Logan Circle	147,337,640				
	Tier 1 - Wells Capital	146,701,566				
Board-designated Reserve						
		441,469,705	320,553,484	492,932,120	120,916,221	(51,462,415)
TNE Requirement	Tier 2 - Logan Circle	97,226,548	81,663,334	81,663,334	15,563,214	15,563,214
Consolidated:		538,696,253	402,216,818	574,595,454	136,479,435	(35,899,201)
<i>Current reserve level</i>		<i>1.88</i>	<i>1.40</i>	<i>2.00</i>		



UNAUDITED FINANCIAL STATEMENTS

July 2018

[Back to Agenda](#)

Table of Contents

Financial Highlights.....	3
Financial Dashboard.....	4
Statement of Revenues and Expenses – Consolidated Month to Date.....	5
Statement of Revenues and Expenses – Consolidated LOB Month to Date.....	6
Highlights – Overall.....	7
Enrollment Summary.....	8
Enrollment Trended by Network Type.....	9
Highlights – Enrollment.....	10
Statement of Revenues and Expenses – Medi-Cal.....	11
Highlights – Medi-Cal.....	12
Statement of Revenues and Expenses – OneCare Connect.....	13
Highlights – OneCare Connect.....	14
Statement of Revenues and Expenses – OneCare.....	15
Statement of Revenues and Expenses – PACE.....	16
Statement of Revenues and Expenses – Building: 505 City Parkway.....	17
Highlights – OneCare, PACE & 505 City Parkway.....	18
Balance Sheet.....	19
Board Designated Reserve & TNE Analysis.....	20
Statement of Cash Flow.....	21
Highlights – Balance Sheet & Statement of Cash Flow.....	22
Statement of Revenues and Expenses – CalOptima Foundation.....	23
Balance Sheet – CalOptima Foundation.....	24
Highlights – CalOptima Foundation.....	25
Budget Allocation Changes.....	26

**CalOptima - Consolidated
Financial Highlights
For the One Month Ended July 31, 2018**

Month-to-Date				Year-to-Date				
Actual	Budget	\$ Budget	% Budget		Actual	Budget	\$ Budget	% Budget
778,534	785,167	(6,633)	(0.8%)	Member Months	778,534	785,167	(6,633)	(0.8%)
269,548,271	274,683,454	(5,135,183)	(1.9%)	Revenues	269,548,271	274,683,454	(5,135,183)	(1.9%)
256,028,551	261,837,231	5,808,680	2.2%	Medical Expenses	256,028,551	261,837,231	5,808,680	2.2%
10,431,606	12,581,739	2,150,133	17.1%	Administrative Expenses	10,431,606	12,581,739	2,150,133	17.1%
3,088,114	264,484	2,823,630	1067.6%	Operating Margin	3,088,114	264,484	2,823,630	1067.6%
1,927,999	416,667	1,511,333	362.7%	Non Operating Income (Loss)	1,927,999	416,667	1,511,333	362.7%
5,016,113	681,151	4,334,963	636.4%	Change in Net Assets	5,016,113	681,151	4,334,963	636.4%
95.0%	95.3%	0.3%		Medical Loss Ratio	95.0%	95.3%	0.3%	
3.9%	4.6%	0.7%		Administrative Loss Ratio	3.9%	4.6%	0.7%	
<u>1.1%</u>	<u>0.1%</u>	1.0%		Operating Margin Ratio	<u>1.1%</u>	<u>0.1%</u>	1.0%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

CalOptima
Financial Dashboard
For the One Month Ended July 31, 2018

MONTH - TO - DATE

Enrollment				
	Actual	Budget	Fav / (Unfav)	
Medi-Cal	760,472	768,649	↓	(8,177) (1 1%)
OneCare Connect	16,399	14,923	↑	1,476 9 9%
OneCare	1,390	1,324	↑	66 5 0%
PACE	273	271	↑	2 0 7%
Total	778,534	785,167	↓	(6,633) (0 8%)

Change in Net Assets (000)				
	Actual	Budget	Fav / (Unfav)	
Medi-Cal	\$ 1,356	\$ 1,363	↓	\$ (7) (0 5%)
OneCare Connect	1,441	(1,064)	↑	2,505 235 4%
OneCare	(148)	(101)	↓	(47) (46 5%)
PACE	420	67	↑	353 526 9%
505 Bldg	-	-	↑	- 0 0%
Investment Income & Other	1,948	417	↑	1,531 367 1%
Total	\$ 5,017	\$ 682	↑	\$ 4,335 635 6%

MLR			
	Actual	Budget	% Point Var
Medi-Cal	95 8%	95 2%	↓ (0 6)
OneCare Connect	88 6%	96 7%	↑ 8 1
OneCare	106 7%	98 0%	↓ (8 7)

Administrative Cost (000)				
	Actual	Budget	Fav / (Unfav)	
Medi-Cal	\$ 8,620	\$ 10,412	↑	\$ 1,792 17 2%
OneCare Connect	1,644	1,896	↑	252 13 3%
OneCare	61	132	↑	72 54 2%
PACE	107	141	↑	34 24 3%
Total	\$ 10,432	\$ 12,582	↑	\$ 2,150 17 1%

Total FTE's Month			
	Actual	Budget	Fav / (Unfav)
Medi-Cal	931	1,026	96
OneCare Connect	219	234	15
OneCare	3	6	3
PACE	59	67	7
Total	1,212	1,333	121

MM per FTE			
	Actual	Budget	Fav / (Unfav)
Medi-Cal	817	749	68
OneCare Connect	75	64	11
OneCare	467	221	246
PACE	5	4	1
Total	1,363	1,037	326

YEAR - TO - DATE

Year To Date Enrollment				
	Actual	Budget	Fav / (Unfav)	
Medi-Cal	760,472	768,649	↓	(8,177) (1 1%)
OneCare Connect	16,399	14,923	↑	1,476 9 9%
OneCare	1,390	1,324	↑	66 5 0%
PACE	273	271	↑	2 0 7%
Total	778,534	785,167	↓	(6,633) (0 8%)

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OneCare	(148)	(101)	↓	(47) (46 5%)
PACE	420	67	↑	353 526 9%
505 Bldg	-	-	↑	- 0 0%
Investment Income & Other	1,948	417	↑	1,531 367 1%
Total	\$ 5,017	\$ 682	↑	\$ 4,335 635 6%

MLR			
	Actual	Budget	% Point Var
Medi-Cal	95 8%	95 2%	↓ (0 6)
OneCare Connect	88 6%	96 7%	↑ 8 1
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Administrative Cost (000)				
	Actual	Budget	Fav / (Unfav)	
Medi-Cal	\$ 8,620	\$ 10,412	↑	\$ 1,792 17 2%
OneCare Connect	1,644	1,896	↑	252 13 3%
OneCare	61	132	↑	72 54 2%
PACE	107	141	↑	34 24 3%
Total	\$ 10,432	\$ 12,582	↑	\$ 2,150 17 1%

Total FTE's YTD			
	Actual	Budget	Fav / (Unfav)
Medi-Cal	931	1,026	96
OneCare Connect	219	234	15
OneCare	3	6	3
PACE	59	67	7
Total	1,212	1,333	121

MM per FTE			
	Actual	Budget	Fav / (Unfav)
Medi-Cal	817	749	68
OneCare Connect	75	64	11
OneCare	467	221	246
PACE	5	4	1
Total	1,363	1,037	326

**CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended July 31, 2018**

	Actual		Budget		Variance	
	\$	PMPM	\$	PMPM	\$	PMPM
MEMBER MONTHS	778,534		785,167		(6,633)	
REVENUE						
Medi-Cal	\$ 239,175,689	\$ 314 51	\$ 246,287,677	\$ 320 42	\$ (7,111,988)	\$ (5 91)
OneCare Connect	26,980,106	1,645 23	24,895,094	1,668 24	2,085,012	(23 01)
OneCare	1,315,478	946 39	1,536,436	1,160 45	(220,958)	(214 06)
PACE	2,076,997	7,608 05	1,964,246	7,248 14	112,751	359 91
Total Operating Revenue	<u>269,548,271</u>	<u>346 23</u>	<u>274,683,454</u>	<u>349 84</u>	<u>(5,135,183)</u>	<u>(3 61)</u>
MEDICAL EXPENSES						
Medi-Cal	229,179,698	301 37	234,512,542	305 10	5,332,844	3 73
OneCare Connect	23,895,188	1,457 11	24,062,981	1,612 48	167,793	155 37
OneCare	1,403,350	1,009 60	1,505,608	1,137 17	102,258	127 57
PACE	1,550,315	5,678 81	1,756,100	6,480 07	205,785	801 26
Total Medical Expenses	<u>256,028,551</u>	<u>328 86</u>	<u>261,837,231</u>	<u>333 48</u>	<u>5,808,680</u>	<u>4 62</u>
GROSS MARGIN	13,519,720	17 37	12,846,223	16 36	673,497	1 01
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,031,938	9 03	7,982,855	10 17	950,917	1 14
Professional fees	131,101	0 17	412,333	0 53	281,232	0 36
Purchased services	862,882	1 11	1,237,509	1 58	374,627	0 47
Printing & Postage	405,503	0 52	533,146	0 68	127,643	0 16
Depreciation & Amortization	415,768	0 53	464,167	0 59	48,398	0 06
Other expenses	1,226,123	1 57	1,579,497	2 01	353,373	0 44
Indirect cost allocation & Occupancy expense	358,291	0 46	372,233	0 47	13,942	0 01
Total Administrative Expenses	<u>10,431,606</u>	<u>13 40</u>	<u>12,581,739</u>	<u>16 02</u>	<u>2,150,133</u>	<u>2 62</u>
INCOME (LOSS) FROM OPERATIONS	3,088,114	3 97	264,484	0 34	2,823,630	3 63
INVESTMENT INCOME						
Interest income	2,397,437	3 08	416,667	0 53	1,980,771	2 55
Realized gain/(loss) on investments	(228,733)	(0 29)	-	-	(228,733)	(0 29)
Unrealized gain/(loss) on investments	(220,799)	(0 28)	-	-	(220,799)	(0 28)
Total Investment Income	<u>1,947,905</u>	<u>2 50</u>	<u>416,667</u>	<u>0 53</u>	<u>1,531,239</u>	<u>1 97</u>
TOTAL GRANT INCOME	(20,066)	(0 03)	-	-	(20,066)	(0 03)
OTHER INCOME	160	-	-	-	160	-
CHANGE IN NET ASSETS	<u>5,016,113</u>	<u>6.44</u>	<u>681,151</u>	<u>0.87</u>	<u>4,334,963</u>	<u>5.57</u>
MEDICAL LOSS RATIO	95.0%		95.3%		0.3%	
ADMINISTRATIVE LOSS RATIO	3.9%		4.6%		0.7%	

**CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended July 31, 2018**

	<u>Medi-Cal Classic</u>	<u>Medi-Cal Expansion</u>	<u>Total Medi-Cal</u>	<u>OneCare Connect</u>	<u>OneCare</u>	<u>PACE</u>	<u>Consolidated</u>
MEMBER MONTHS	522,535	237,937	760,472	16,399	1,390	273	778,534
REVENUES							
Capitation Revenue	\$ 131,250,748	\$ 107,924,941	\$ 239,175,689	\$ 26,980,106	\$ 1,315,478	\$ 2,076,997	\$ 269,548,271
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	<u>131,250,748</u>	<u>107,924,941</u>	<u>239,175,689</u>	<u>26,980,106</u>	<u>1,315,478</u>	<u>2,076,997</u>	<u>269,548,271</u>
MEDICAL EXPENSES							
Provider Capitation	35,633,445	49,066,161	84,699,605	11,881,315	353,536		96,934,457
Facilities	21,612,139	21,084,824	42,696,962	3,143,970	424,557	312,576	46,578,065
Ancillary	-	-	-	523,844	12,835	-	536,678
Professional Claims	16,889,054	8,077,416	24,966,470	-	-	394,291	25,360,761
Prescription Drugs	17,590,273	19,518,193	37,108,466	5,605,707	454,148	148,525	43,316,846
MLTSS	32,196,494	2,849,076	35,045,571	1,131,427	74,707	(1,746)	36,249,959
Medical Management	1,886,851	927,274	2,814,125	1,046,181	77,067	521,098	4,458,470
Quality Incentives	773,330	405,248	1,178,578	280,840		2,730	1,462,148
Reinsurance & Other	469,824	200,097	669,921	281,905	6,500	172,841	1,131,166
Total Medical Expenses	<u>127,051,409</u>	<u>102,128,289</u>	<u>229,179,698</u>	<u>23,895,188</u>	<u>1,403,350</u>	<u>1,550,315</u>	<u>256,028,551</u>
Medical Loss Ratio	96.8%	94.6%	95.8%	88.6%	106.7%	74.6%	95.0%
GROSS MARGIN	4,199,339	5,796,653	9,995,991	3,084,918	(87,871)	526,683	13,519,720
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			6,115,005	826,170	0	90,762	7,031,938
Professional fees			109,466	4,168	14,667	2,800	131,101
Purchased services			681,659	171,215	7,193	2,815	862,882
Printing & Postage			362,091	39,719	3,692		405,503
Depreciation & Amortization			413,694			2,074	415,768
Other expenses			1,175,088	45,429	60	5,547	1,226,123
Indirect cost allocation & Occupancy			(237,168)	557,394	34,965	3,100	358,291
Total Administrative Expenses			<u>8,619,835</u>	<u>1,644,095</u>	<u>60,578</u>	<u>107,098</u>	<u>10,431,606</u>
Admin Loss Ratio			3.6%	6.1%	4.6%	5.2%	3.9%
INCOME (LOSS) FROM OPERATIONS			1,376,156	1,440,822	(148,449)	419,584	3,088,114
INVESTMENT INCOME							1,947,905
TOTAL GRANT INCOME			(20,066)				(20,066)
OTHER INCOME			160				160
CHANGE IN NET ASSETS			<u>\$ 1,356,250</u>	<u>\$ 1,440,822</u>	<u>\$ (148,449)</u>	<u>\$ 419,584</u>	<u>\$ 5,016,113</u>
BUDGETED CHANGE IN NET ASSETS			1,363,384	(1,064,219)	(101,419)	66,739	681,151
VARIANCE TO BUDGET - FAV (UNFAV)			<u>\$ (7,133)</u>	<u>\$ 2,505,041</u>	<u>\$ (47,030)</u>	<u>\$ 352,846</u>	<u>\$ 4,334,963</u>

July 31, 2018 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is \$5.0 million, \$4.3 million favorable to budget
- Operating surplus is \$3.1 million with a surplus in non-operating of \$1.9 million

Change in Net Assets by LOB (\$millions)

MONTH-TO-DATE			
<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	
1.4	1.4	(0.0)	Medi-Cal
1.4	(1.1)	2.5	OCC
(0.1)	(0.1)	(0.0)	OneCare
<u>0.4</u>	<u>0.1</u>	<u>0.4</u>	<u>PACE</u>
3.1	0.3	2.8	Operating
<u>1.9</u>	<u>0.4</u>	<u>1.5</u>	<u>Inv./Rental Inc, MCO tax</u>
1.9	0.4	1.5	Non-Operating
5.0	0.7	4.3	TOTAL

**CalOptima
Enrollment Summary
For the One Month Ended July 31, 2018**

Month-to-Date				Enrollment (By Aid Category)	Year-to-Date			
Actual	Budget	Variance	%		Actual	Budget	Variance	%
63,642	63,771	(129)	(0.2%)	Aged	63,642	63,771	(129)	(0.2%)
630	620	10	1.6%	BCCTP	630	620	10	1.6%
47,121	47,104	17	0.0%	Disabled	47,121	47,104	17	0.0%
313,231	316,710	(3,479)	(1.1%)	TANF Child	313,231	316,710	(3,479)	(1.1%)
94,529	95,821	(1,292)	(1.3%)	TANF Adult	94,529	95,821	(1,292)	(1.3%)
3,382	3,449	(67)	(1.9%)	LTC	3,382	3,449	(67)	(1.9%)
237,937	241,174	(3,237)	(1.3%)	MCE	237,937	241,174	(3,237)	(1.3%)
760,472	768,649	(8,177)	(1.1%)	Medi-Cal	760,472	768,649	(8,177)	(1.1%)
16,399	14,923	1,476	9.9%	OneCare Connect	16,399	14,923	1,476	9.9%
273	271	2	0.7%	PACE	273	271	2	0.7%
1,390	1,324	66	5.0%	OneCare	1,390	1,324	66	5.0%
778,534	785,167	(6,633)	(0.8%)	CalOptima Total	778,534	785,167	(6,633)	(0.8%)

Enrollment (By Network)								
167,096	168,520	(1,424)	(0.8%)	HMO	167,096	168,520	(1,424)	(0.8%)
217,791	222,367	(4,576)	(2.1%)	PHC	217,791	222,367	(4,576)	(2.1%)
193,182	194,150	(968)	(0.5%)	Shared Risk Group	193,182	194,150	(968)	(0.5%)
182,403	183,612	(1,209)	(0.7%)	Fee for Service	182,403	183,612	(1,209)	(0.7%)
760,472	768,649	(8,177)	(1.1%)	Medi-Cal	760,472	768,649	(8,177)	(1.1%)
16,399	14,923	1,476	9.9%	OneCare Connect	16,399	14,923	1,476	9.9%
273	271	2	0.7%	PACE	273	271	2	0.7%
1,390	1,324	66	5.0%	OneCare	1,390	1,324	66	5.0%
778,534	785,167	(6,633)	(0.8%)	CalOptima Total	778,534	785,167	(6,633)	(0.8%)

CalOptima
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	MMs
HMO													
Aged	3,844												3,844
BCCTP	1												1
Disabled	6,744												6,744
TANF Child	58,435												58,435
TANF Adult	29,473												29,473
LTC	2												2
MCE	68,597												68,597
	<u>167,096</u>												<u>167,096</u>
PHC													
Aged	1,600												1,600
BCCTP	-												-
Disabled	7,243												7,243
TANF Child	157,157												157,157
TANF Adult	12,731												12,731
LTC	-												-
MCE	39,060												39,060
	<u>217,791</u>												<u>217,791</u>
Shared Risk Group													
Aged	3,593												3,593
BCCTP	-												-
Disabled	7,626												7,626
TANF Child	67,471												67,471
TANF Adult	30,936												30,936
LTC	2												2
MCE	83,554												83,554
	<u>193,182</u>												<u>193,182</u>
Fee for Service (Dual)													
Aged	49,903												49,903
BCCTP	16												16
Disabled	20,706												20,706
TANF Child	2												2
TANF Adult	1,081												1,081
LTC	3,025												3,025
MCE	2,327												2,327
	<u>77,060</u>												<u>77,060</u>
Fee for Service (Non-Dual)													
Aged	4,702												4,702
BCCTP	613												613
Disabled	4,802												4,802
TANF Child	30,166												30,166
TANF Adult	20,308												20,308
LTC	353												353
MCE	44,399												44,399
	<u>105,343</u>												<u>105,343</u>
MEDI-CAL TOTAL													
Aged	63,642												63,642
BCCTP	630												630
Disabled	47,121												47,121
TANF Child	313,231												313,231
TANF Adult	94,529												94,529
LTC	3,382												3,382
MCE	237,937												237,937
	<u>760,472</u>												<u>760,472</u>
PACE	273												273
OneCare	1,390												1,390
OneCare Connect	16,399												16,399
TOTAL	<u>778,534</u>												<u>778,534</u>

ENROLLMENT:

Overall MTD enrollment was 778,534

- Unfavorable to budget by 6,633 or 0.8%
- Decreased 1,743 or 0.2% from prior month (June 2018)
- Decreased 9,152 or 1.2% from prior year (July 2017)

Medi-Cal enrollment was 760,472

- Unfavorable to budget by 8,177
 - Temporary Assistance for Needy Families (TANF) unfavorable by 4,771
 - Senior Persons with Disabilities (SPD) unfavorable by 102
 - Medi-Cal Expansion (MCE) unfavorable by 3,237
 - Long-Term Care (LTC) unfavorable by 67
- Decreased 3,352 from prior month

OneCare Connect enrollment was 16,399

- Favorable to budget by 1,476
- Increased 1,631 from prior month

OneCare enrollment was 1,390

- Favorable to budget by 66
- Decreased 28 from prior month

PACE enrollment was 273

- Favorable to budget by 2
- Increased 6 from prior month

**CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the One Month Ending July, 31, 2018**

Month				Year to Date				
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
760,472	768,649	(8,177)	(1.1%)	Member Months	760,472	768,649	(8,177)	(1.1%)
				Revenues				
239,175,689	246,287,677	(7,111,988)	(2.9%)	Capitation revenue	239,175,689	246,287,677	(7,111,988)	(2.9%)
-	-	-	0.0%	Grant & other income	-	-	-	0.0%
239,175,689	246,287,677	(7,111,988)	(2.9%)	Total Operating Revenue	239,175,689	246,287,677	(7,111,988)	(2.9%)
				Medical Expenses				
85,878,183	84,468,845	(1,409,338)	(1.7%)	Provider capitation	85,878,183	84,468,845	(1,409,338)	(1.7%)
42,696,962	43,789,730	1,092,767	2.5%	Facilities	42,696,962	43,789,730	1,092,767	2.5%
24,966,470	26,868,395	1,901,925	7.1%	Professional Claims	24,966,470	26,868,395	1,901,925	7.1%
37,108,466	38,756,487	1,648,020	4.3%	Prescription drugs	37,108,466	38,756,487	1,648,020	4.3%
35,045,571	36,509,870	1,464,299	4.0%	MLTSS	35,045,571	36,509,870	1,464,299	4.0%
2,814,125	3,588,582	774,457	21.6%	Medical management	2,814,125	3,588,582	774,457	21.6%
669,921	530,634	(139,287)	(26.2%)	Reinsurance & other	669,921	530,634	(139,287)	(26.2%)
229,179,698	234,512,542	5,332,844	2.3%	Total Medical Expenses	229,179,698	234,512,542	5,332,844	2.3%
9,995,991	11,775,136	(1,779,144)	(15.1%)	Gross Margin	9,995,991	11,775,136	(1,779,144)	(15.1%)
				Administrative Expenses	-	-	-	
6,115,005	6,960,948	845,943	12.2%	Salaries, wages & employee benefits	6,115,005	6,960,948	845,943	12.2%
109,466	349,650	240,184	68.7%	Professional fees	109,466	349,650	240,184	68.7%
681,659	947,642	265,983	28.1%	Purchased services	681,659	947,642	265,983	28.1%
362,091	423,310	61,218	14.5%	Printing and postage	362,091	423,310	61,218	14.5%
-	-	-	0.0%	Occupancy expenses	-	-	-	0.0%
413,694	462,076	48,382	10.5%	Depreciation and amortization	413,694	462,076	48,382	10.5%
1,175,088	1,491,718	316,630	21.2%	Other operating expenses	1,175,088	1,491,718	316,630	21.2%
(237,168)	(223,592)	13,576	6.1%	Indirect cost allocation, Occupancy Expense	(237,168)	(223,592)	13,576	6.1%
8,619,835	10,411,752	1,791,917	17.2%	Total Administrative Expenses	8,619,835	10,411,752	1,791,917	17.2%
				Grant Income				
23,998	249,874	(225,876)	(90.4%)	Grant Revenue	23,998	249,874	(225,876)	(90.4%)
12,750	223,107	210,357	94.3%	Grant expense - Service Partner	12,750	223,107	210,357	(94.3%)
31,314	26,767	(4,547)	(17.0%)	Grant expense - Administrative	31,314	26,767	(4,547)	17.0%
(20,066)	-	(20,066)	0.0%	Total Grant Income	(20,066)	-	(20,066)	0.0%
160	-	160	0.0%	Other income	160	-	160	0.0%
1,356,250	1,363,384	(7,133)	(0.5%)	Change in Net Assets	1,356,250	1,363,384	(7,133)	(0.5%)
95.8%	95.2%	(0.6%)	(0.6%)	Medical Loss Ratio	95.8%	95.2%	(0.6%)	(0.6%)
3.6%	4.2%	0.6%	14.7%	Admin Loss Ratio	3.6%	4.2%	0.6%	14.7%

MEDI-CAL INCOME STATEMENT – JULY MONTH:

REVENUES of \$239.2 million are unfavorable to budget by \$7.1 million, driven by:

- Unfavorable volume related variance of \$2.6 million
- Unfavorable price related variance of \$4.5 million due to:
 - \$3.6 million of Proposition 56 revenue
 - \$1.9 million of Non-LTC revenue
 - \$1.4 million of Coordinated Care Initiative (CCI) revenue, offset by:
 - \$2.8 million prior year (PY) revenue

MEDICAL EXPENSES: Overall \$229.2 million, favorable to budget by \$5.3 million due to:

- **Professional Claims** expense is favorable to budget \$1.9 million due to Proposition 56 expense of \$3.2 million, offset by Child Health and Disability Prevention (CHDP)
- **Prescription Drug** expenses are favorable to budget by \$1.6 million
- **Managed Long Term Services and Supports (MLTSS)** expense is favorable to budget \$1.5 million due to LTC expense
- **Facilities** favorable variance of \$1.1 million
- **Provider Capitation** is unfavorable to budget by \$1.4 million due to CHDP, offset by favorable volume variance

ADMINISTRATIVE EXPENSES are \$8.6 million, favorable to budget \$1.8 million, driven by:

- **Salary & Benefits:** \$0.8 million favorable to budget driven by open positions (102)
- **Purchased Services:** \$0.3 million favorable to budget
- **Other Non-Salary:** \$0.7 million favorable to budget

CHANGE IN NET ASSETS is \$1.4 million for the month, in line with budget

**CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the One Month Ending July 31, 2018**

Month				Year to Date				
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
16,399	14,923	1,476	9.9%	Member Months	16,399	14,923	1,476	9.9%
				Revenues				
2,550,282	3,380,360	(830,078)	(24.6%)	Medi-Cal Capitation revenue	2,550,282	3,380,360	(830,078)	(24.6%)
18,829,511	16,809,068	2,020,443	12.0%	Medicare Part C revenue	18,829,511	16,809,068	2,020,443	12.0%
5,600,313	4,705,666	894,647	19.0%	Medicare Part D revenue	5,600,313	4,705,666	894,647	19.0%
26,980,106	24,895,094	2,085,012	8.4%	Total Operating Revenue	26,980,106	24,895,094	2,085,012	8.4%
				Medical Expenses				
12,162,155	11,278,993	(883,162)	(7.8%)	Provider capitation	12,162,155	11,278,993	(883,162)	(7.8%)
3,143,970	3,590,807	446,837	12.4%	Facilities	3,143,970	3,590,807	446,837	12.4%
523,844	650,671	126,827	19.5%	Ancillary	523,844	650,671	126,827	19.5%
1,131,427	1,735,927	604,500	34.8%	Long Term Care	1,131,427	1,735,927	604,500	34.8%
5,605,707	5,342,559	(263,148)	(4.9%)	Prescription drugs	5,605,707	5,342,559	(263,148)	(4.9%)
1,046,181	1,315,008	268,827	20.4%	Medical management	1,046,181	1,315,008	268,827	20.4%
281,905	149,016	(132,889)	(89.2%)	Other medical expenses	281,905	149,016	(132,889)	(89.2%)
23,895,188	24,062,981	167,793	0.7%	Total Medical Expenses	23,895,188	24,062,981	167,793	0.7%
3,084,918	832,113	2,252,805	270.7%	Gross Margin	3,084,918	832,113	2,252,805	270.7%
				Administrative Expenses				
826,170	881,368	55,198	6.3%	Salaries, wages & employee benefits	826,170	881,368	55,198	6.3%
4,168	42,917	38,749	90.3%	Professional fees	4,168	42,917	38,749	90.3%
171,215	251,415	80,200	31.9%	Purchased services	171,215	251,415	80,200	31.9%
39,719	86,202	46,482	53.9%	Printing and postage	39,719	86,202	46,482	53.9%
-	-	-	0.0%	Occupancy expenses	-	-	-	0.0%
-	-	-	0.0%	Depreciation & amortization	-	-	-	0.0%
45,429	77,036	31,608	41.0%	Other operating expenses	45,429	77,036	31,608	41.0%
557,394	557,394	-	0.0%	Indirect cost allocation	557,394	557,394	-	0.0%
1,644,095	1,896,332	252,237	13.3%	Total Administrative Expenses	1,644,095	1,896,332	252,237	13.3%
1,440,822	(1,064,219)	2,505,041	235.4%	Change in Net Assets	1,440,822	(1,064,219)	2,505,041	235.4%
88.6%	96.7%	8.1%	8.4%	Medical Loss Ratio	88.6%	96.7%	8.1%	8.4%
6.1%	7.6%	1.5%	20.0%	Admin Loss Ratio	6.1%	7.6%	1.5%	20.0%

ONECARE CONNECT INCOME STATEMENT – JULY MONTH:

REVENUES of \$27.0 million are favorable to budget by \$2.1 million driven by:

- Favorable volume related variance of \$2.5 million due to enrollment
- Unfavorable price related variance of \$0.4 million

MEDICAL EXPENSES of \$23.9 million are favorable to budget \$0.2 million due to:

- Unfavorable volume related variance of \$2.4 million
- Favorable price related variance of \$2.5 million

ADMINISTRATIVE EXPENSES of \$1.6 million are favorable to budget \$0.3 million

CHANGE IN NET ASSETS is \$1.4 million, \$2.5 million favorable to budget

**CalOptima
OneCare - 60
Statement of Revenues and Expenses
For the One Month Ending July 31, 2018**

Month				Year to Date				
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
1,390	1,324	66	5.0%	Member Months	1,390	1,324	66	5.0%
				Revenues				
819,743	1,035,290	(215,547)	(20.8%)	Medicare Part C revenue	819,743	1,035,290	(215,547)	(20.8%)
495,736	501,147	(5,411)	(1.1%)	Medicare Part D revenue	495,736	501,147	(5,411)	(1.1%)
1,315,478	1,536,436	(220,958)	(14.4%)	Total Operating Revenue	1,315,478	1,536,436	(220,958)	(14.4%)
				Medical Expenses				
353,536	426,321	72,785	17.1%	Provider capitation	353,536	426,321	72,785	17.1%
424,557	513,165	88,608	17.3%	Inpatient	424,557	513,165	88,608	17.3%
12,835	54,472	41,638	76.4%	Ancillary	12,835	54,472	41,638	76.4%
74,707	26,857	(47,850)	(178.2%)	Skilled nursing facilities	74,707	26,857	(47,850)	(178.2%)
454,148	443,983	(10,165)	(2.3%)	Prescription drugs	454,148	443,983	(10,165)	(2.3%)
77,067	34,252	(42,815)	(125.0%)	Medical management	77,067	34,252	(42,815)	(125.0%)
6,500	6,558	58	0.9%	Other medical expenses	6,500	6,558	58	0.9%
1,403,350	1,505,608	102,258	6.8%	Total Medical Expenses	1,403,350	1,505,608	102,258	6.8%
(87,871)	30,828	(118,700)	(385.0%)	Gross Margin	(87,871)	30,828	(118,700)	(385.0%)
				Administrative Expenses				
0	40,168	40,168	100.0%	Salaries, wages & employee benefits	0	40,168	40,168	100.0%
14,667	19,600	4,933	25.2%	Professional fees	14,667	19,600	4,933	25.2%
7,193	17,425	10,232	58.7%	Purchased services	7,193	17,425	10,232	58.7%
3,692	13,206	9,514	72.0%	Printing and postage	3,692	13,206	9,514	72.0%
60	6,883	6,823	99.1%	Other operating expenses	60	6,883	6,823	99.1%
34,965	34,965	-	0.0%	Indirect cost allocation, occupancy expense	34,965	34,965	-	0.0%
60,578	132,248	71,670	54.2%	Total Administrative Expenses	60,578	132,248	71,670	54.2%
(148,449)	(101,419)	(47,030)	(46.4%)	Change in Net Assets	(148,449)	(101,419)	(47,030)	(46.4%)
106.7%	98.0%	(8.7%)	(8.9%)	Medical Loss Ratio	106.7%	98.0%	(8.7%)	(8.9%)
4.6%	8.6%	4.0%	46.5%	Admin Loss Ratio	4.6%	8.6%	4.0%	46.5%

CalOptima
PACE
Statement of Revenues and Expenses
For the One Month Ending July 31, 2018

Month				Year to Date				
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
273	271	2	0.7%	Member Months	273	271	2	0.7%
				Revenues				
1,512,798	1,517,392	(4,594)	(0.3%)	Medi-Cal Capitaion revenue	1,512,798	1,517,392	(4,594)	(0.3%)
419,771	359,877	59,894	16.6%	Medicare Part C revenue	419,771	359,877	59,894	16.6%
144,428	86,977	57,451	66.1%	Medicare Part D revenue	144,428	86,977	57,451	66.1%
2,076,997	1,964,246	112,751	5.7%	Total Operating Revenue	2,076,997	1,964,246	112,751	5.7%
				Medical Expenses				
521,098	637,862	116,764	18.3%	Medical management	521,098	637,862	116,764	18.3%
312,576	400,164	87,588	21.9%	Claims payments to hospitals	312,576	400,164	87,588	21.9%
394,291	431,848	37,557	8.7%	Professional claims	394,291	431,848	37,557	8.7%
172,841	120,809	(52,032)	(43.1%)	Patient transportation	172,841	120,809	(52,032)	(43.1%)
148,525	155,325	6,800	4.4%	Prescription drugs	148,525	155,325	6,800	4.4%
(1,746)	7,392	9,138	123.6%	Long-term care facility payments	(1,746)	7,392	9,138	123.6%
2,730	2,700	(30)	(1.1%)	Other expenses	2,730	2,700	(30)	(1.1%)
1,550,315	1,756,100	205,785	11.7%	Total Medical Expenses	1,550,315	1,756,100	205,785	11.7%
526,683	208,146	318,537	153.0%	Gross Margin	526,683	208,146	318,537	153.0%
				Administrative Expenses				
90,762	100,371	9,608	9.6%	Salaries, wages & employee benefits	90,762	100,371	9,608	9.6%
2,800	167	(2,633)	(1580.0%)	Professional fees	2,800	167	(2,633)	(1580.0%)
2,815	21,027	18,212	86.6%	Purchased services	2,815	21,027	18,212	86.6%
-	10,428	10,428	100.0%	Printing and postage	-	10,428	10,428	100.0%
2,074	2,091	17	0.8%	Depreciation & amortization	2,074	2,091	17	0.8%
5,547	3,859	(1,688)	(43.7%)	Other operating expenses	5,547	3,859	(1,688)	(43.7%)
3,100	3,466	366	10.6%	Indirect cost allocation, Occupancy expenses	3,100	3,466	366	10.6%
107,098	141,407	34,309	24.3%	Total Administrative Expenses	107,098	141,407	34,309	24.3%
				Operating Tax				
3,811	-	3,811	0.0%	Tax revenue	3,811	-	3,811	0.0%
3,811	-	(3,811)	0.0%	Premium tax expense	3,811	-	(3,811)	0.0%
-	-	-	0.0%	Total Net Operating Tax	-	-	-	0.0%
419,584	66,739	352,846	528.7%	Change in Net Assets	419,584	66,739	352,846	528.7%
74.6%	89.4%	14.8%	16.5%	Medical Loss Ratio	74.6%	89.4%	14.8%	16.5%
5.2%	7.2%	2.0%	28.4%	Admin Loss Ratio	5.2%	7.2%	2.0%	28.4%

CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the One Month Ending July 31, 2018

Month				Year to Date			
Actual	Budget	\$ Variance	% Variance	Actual	Budget	\$ Variance	% Variance
				Revenues			
-	-	-	0.0%	-	-	-	0.0%
-	-	-	0.0%	-	-	-	0.0%
				Administrative Expenses			
33,562	22,981	(10,581)	(46.0%)	33,562	22,981	(10,581)	(46.0%)
161,416	162,935	1,519	0.9%	161,416	162,935	1,519	0.9%
15,816	15,917	101	0.6%	15,816	15,917	101	0.6%
81,361	173,136	91,775	53.0%	81,361	173,136	91,775	53.0%
60,237	1,635	(58,602)	(3,584.2%)	60,237	1,635	(58,602)	(3,584.2%)
(352,392)	(376,604)	(24,212)	(6.4%)	(352,392)	(376,604)	(24,212)	(6.4%)
-	-	-	0.0%	-	-	-	0.0%
				Change in Net Assets			
-	-	-	0.0%	-	-	-	0.0%

OTHER STATEMENTS – JULY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is (\$148.4) thousand, \$47.0 thousand unfavorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is \$419.6 thousand, \$352.8 thousand favorable to budget

**CalOptima
Balance Sheet
July 31, 2018**

ASSETS

Current Assets

Operating Cash	260,361,586
Investments	437,006,305
Capitation receivable	557,852,509
Receivables - Other	22,751,343
Prepaid expenses	6,585,498

Total Current Assets 1,284,557,241

Capital Assets

Furniture & Equipment	34,328,849
Building/Leasehold Improvements	7,732,113
505 City Parkway West	49,743,943
	<u>91,804,904</u>
Less: accumulated depreciation	(41,516,685)
Capital assets, net	<u>50,288,219</u>

Other Assets

Restricted Deposit & Other	300,000
Board-designated assets	
Cash and Cash Equivalents	15,040,319
Long-term Investments	<u>523,655,935</u>
Total Board-designated Assets	<u>538,696,254</u>
Total Other Assets	<u>538,996,254</u>

TOTAL ASSETS 1,873,841,715

Deferred Outflows

Pension Contributions	393,907
Difference in Experience	1,365,903
Excess Earnings	1,017,387
Changes in Assumptions	8,355,853

TOTAL ASSETS & DEFERRED OUTFLOWS 1,884,974,765

LIABILITIES & FUND BALANCES

Current Liabilities

Accounts Payable	17,304,582
Medical Claims liability	842,502,823
Accrued Payroll Liabilities	11,662,536
Deferred Revenue	88,080,026
Deferred Lease Obligations	114,458
Capitation and Withholds	105,349,942

Total Current Liabilities 1,065,014,368

Other (than pensions) post employment benefits liability	24,691,270
Net Pension Liabilities	25,192,066
Bldg 505 Development Rights	100,000

TOTAL LIABILITIES 1,114,997,704

Deferred Inflows

Excess Earnings	-
Change in Assumptions	3,329,380

TNE 81,663,334

Funds in Excess of TNE 684,984,346

Net Assets 766,647,680

TOTAL LIABILITIES & FUND BALANCES 1,884,974,765

CalOptima
Board Designated Reserve and TNE Analysis
as of July 31, 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	147,430,499				
	Tier 1 - Logan Circle	147,337,640				
	Tier 1 - Wells Capital	146,701,566				
Board-designated Reserve						
		441,469,705	320,553,484	492,932,120	120,916,221	(51,462,415)
TNE Requirement	Tier 2 - Logan Circle	97,226,548	81,663,334	81,663,334	15,563,214	15,563,214
Consolidated:		538,696,253	402,216,818	574,595,454	136,479,435	(35,899,201)
	<i>Current reserve level</i>	<i>1.88</i>	<i>1.40</i>	<i>2.00</i>		

**CalOptima
Statement of Cash Flows
July 31, 2018**

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	5,016,113	5,016,113
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	577,185	577,185
Changes in assets and liabilities:		
Prepaid expenses and other	(288,151)	(288,151)
Catastrophic reserves		
Capitation receivable	(259,452,836)	(259,452,836)
Medical claims liability	9,883,210	9,883,210
Deferred revenue	(25,622,923)	(25,622,923)
Payable to providers	8,901,051	8,901,051
Accounts payable	10,310,026	10,310,026
Other accrued liabilities	211,157	211,157
Net cash provided by/(used in) operating activities	(250,465,167)	(250,465,167)
 GASB 68 CalPERS Adjustments	-	-
 CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Investments	143,292,643	143,292,643
Purchase of property and equipment	(107,154)	(107,154)
Change in Board designated reserves	(448,582)	(448,582)
Net cash provided by/(used in) investing activities	142,736,907	142,736,907
 NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(107,728,261)	(107,728,261)
 CASH AND CASH EQUIVALENTS, beginning of period	\$368,089,847	368,089,847
 CASH AND CASH EQUIVALENTS, end of period	260,361,586	260,361,586

BALANCE SHEET:

ASSETS increased \$8.7 million from June or 0.5%

- **Cash and Cash Equivalents** decreased by \$107.7 million due payment for Proposition 56 of \$22.0 million and no capitation payment received in the month
- **Investments** decreased \$143.3 million due to fund operations as no capitation payments were received
- **Net Capitation Receivables** increased \$261.6 million due to timing of payments

LIABILITIES increased \$3.7 million from June or 0.3%

- **Medical Claims Liability** by line of business increased \$9.9 million due to overpayment reclassification from receivables
- **Deferred Revenue** decreased \$25.6 million due to recognition of prior month's overpayment
- **Capitation Payable** increased \$8.9 million due increase in capitation and shared risk pool
- **Accrued Expenses** increased \$9.4 million

NET ASSETS are \$766.6 million, an increase of \$5.0 million from June

CalOptima Foundation
Statement of Revenues and Expenses
For the One Month Ended July 31, 2018
Consolidated

Month				Year - To - Date			
Actual	Budget	\$ Variance	% Variance	Actual	Budget	\$ Variance	% Variance
Revenues				Revenues			
0	0	0	0.0%	0	0	0	0.0%
-----				-----			
Operating Expenditures				Operating Expenditures			
0	6,184	6,184	100.0%	0	6,184	6,184	100.0%
0	2,985	2,985	100.0%	0	2,985	2,985	100.0%
0	0	0	0.0%	0	0	0	0.0%
0	0	0	0.0%	0	0	0	0.0%
0	0	0	0.0%	0	0	0	0.0%
917	229,840	228,923	99.6%	917	229,840	228,923	99.6%
-----				-----			
917	239,009	238,092	99.6%	917	239,009	238,092	99.6%
-----				-----			
0	0	0	0.0%	0	0	0	0.0%
-----				-----			
(917)	(239,009)	(238,092)	(99.6%)	(917)	(239,009)	(238,092)	(99.6%)
=====				=====			

**CalOptima Foundation
Balance Sheet
July 18, 2018**

<u>ASSETS</u>		<u>LIABILITIES & NET ASSETS</u>	
Operating cash	2,843,139	Accounts payable-Current	917
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	<u>0</u>	Payable to CalOptima	0
Total Current Assets	<u>2,843,139</u>	Grants-Foundation	0
		Total Current Liabilities	<u>917</u>
		Total Liabilities	<u>917</u>
		Net Assets	<u>2,842,222</u>
 TOTAL ASSETS	 <u><u>2,843,139</u></u>	 TOTAL LIABILITIES & NET ASSE	 <u><u>2,843,139</u></u>

CALOPTIMA FOUNDATION - JULY MONTH

INCOME STATEMENT:

OPERATING REVENUE

- No activity

OPERATING EXPENSES

- Audit Fees \$0.9 thousand

BALANCE SHEET:

ASSETS

- Cash--\$2.8 million remains from the FY14 \$3.0 million transferred by CalOptima for grants and programs in support of providers and community

LIABILITIES

- \$0.9 thousand

NET INCOME is (\$0.9) thousand

**Budget Allocation Changes
Reporting Changes for July 2018**

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
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No Activity for July

This report summarizes budget transfers between general ledger classes that are greater than \$10,000 and less than \$100,000. This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting September 6, 2018

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

- 2016 One-Third Financial Audit:

On July 3, 2018, CalOptima received the final report for CMS' contract year (CY) 2016 One-Third Financial Audit, which outlined two (2) findings and five (5) observations. CalOptima's corrective action plan responses will be due to CMS within ninety (90) days or by October 1, 2018.

2. OneCare Connect

- Performance Measure Validation (PMV) Audit for Medicare-Medicaid Plans (MMPs):

On May 21, 2018, CMS notified MMPs of upcoming efforts to validate that MMPs' reported data on performance measures are reliable, valid, complete, and comparable. The following elements will be validated for the 2017 measurement year for select core and state-specific performance measures:

- MMP Core 2.1: Members with an assessment completed within 90 days of enrollment.
- MMP CA 1.2: High-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA).
- MMP CA 1.4: Low-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA).

Validation activities will focus on enrollment and eligibility data processes, assessment and care plan completion processes, performance measure production, and primary source verification. CalOptima's PMV audit is scheduled for September 17, 2018.

- 2018 Data Integrity Testing (applicable to OneCare Connect and OneCare):

As part of its audit readiness efforts, CalOptima has engaged an independent auditing consultant to perform validation of its universes for completeness and accuracy for select Part C core operational areas based on the final 2017 CMS Medicare Parts C and D Program Audit Protocols and the 2017 CMS Program Audit Protocols for Medicare-Medicaid Plans (MMPs). The data integrity testing takes place from early August through September 2018.

- Compliance Program Effectiveness (CPE) Audit (applicable to OneCare Connect and OneCare):

CalOptima is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis, and to share the results with its governing body. As such, CalOptima has engaged an independent consultant to conduct the audit to ensure that its Compliance Program is being administered effectively. The audit is taking place from August through November 2018. CalOptima's Office of Compliance is currently preparing documents for the onsite audit scheduled for the week of September 24, 2018.

3. Medi-Cal

- 2018 Medi-Cal Audit:

The Department of Health Care Services (DHCS) conducted its annual audit of CalOptima's Medi-Cal program from February 26, 2018 through March 9, 2018. The audit covered the period from February 1, 2017 through January 31, 2018. The audit consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, organization and administration of CalOptima, facility site reviews, and medical records review. DHCS issued its draft audit report on August 27, 2018. DHCS has scheduled the exit conference for August 30, 2018. The draft report contained only one (1) finding in the area of case management and care coordination. Upon completion of the exit conference, CalOptima will have fifteen (15) days to dispute the content of the draft report, if necessary. DHCS is expected to finalize its report and request a Corrective Action Plan (CAP) from CalOptima by October 1, 2018. CalOptima will have thirty (30) calendar days from the date of receipt, or no later than October 30, 2018, to respond to the CAP request.

B. Regulatory Notices of Non-Compliance

1. CalOptima did not receive any notices of non-compliance from its regulators for the month of July 2018.

C. Updates on Internal and Health Network Audits

1. Internal Audits: Medi-Cal, OneCare, OneCare Connect, and PACE

- For the months of June through August 2018 (based on data from May through July 2018), monthly file reviews for internal departments were suspended due to the annual audits in progress. In lieu of the monthly file reviews, CalOptima's Audit & Oversight Department conducted a validation audit, including a desk review of applicable policies and procedures, to ensure that deficiencies identified throughout the year have been remediated.

2. Health Network Audits: Medi-Cal ^{a\}

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
March 2018	74%	73%	85%	62%	78%	85%	90%	77%	92%	96%	53%	75%	73%
April 2018	86%	94%	92%	76%	78%	85%	89%	94%	94%	96%	78%	78%	98%
May 2018	75%	78%	79%	85%	78%	91%	88%	88%	88%	88%	33%	50%	72%

- The lower scores for timeliness were due to the following reasons:
 - Failure to meet timeframe for decision (Urgent – 72 hours, Routine – 5 business days, Deferral – 14 business days)
 - 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)
 - Failure to meet timeframe for member delay notification (5 business days)
 - Failure to meet timeframe for provider delay notification (5 business days)
- The lower scores for clinical decision making were due to the following reasons:
 - Failure to cite criteria for decision
 - Failure to obtain adequate clinical information
 - Failure to have appropriate professional make decision

3 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.

- The lower letter scores were due to the following reasons:
 - Failure to describe why the request did not meet criteria in lay language
 - Failure to provide language assistance program (LAP) insert in approved threshold languages
 - Failure to provide member with information on how to file a grievance
 - Failure to provide letter in member’s primary language
 - Failure to provide letter with description of services in lay language
 - Failure to provide peer-to-peer discussion of the decision with medical reviewer
 - 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

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2018	89%	99%	96%	81%
April 2018	95%	97%	96%	86%
May 2018	98%	99%	98%	85%

- The compliance rate for denied claims accuracy decreased from 86% in April 2018 to 85% in May 2018 due to multiple family planning claims incorrectly denied.

- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2018	100%	95%	100%	100%
April 2018	76%	100%	100%	100%
May 2018	100%	100%	100%	100%

- No significant trends to report.

3. Health Network Audits: OneCare ^{a\}

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
March 2018	77%	N/A	83%	89%	80%	80%	68%	87%
April 2018	100%	100%	80%	88%	63%	100%	83%	94%
May 2018	80%	67%	81%	89%	84%	100%	75%	89%

- The lower scores for timeliness were due to the following reasons:
 - Failure to meet timeframe for member oral notification (Expedited – 72 hours)
 - Failure to meet timeframe for provider notification (Expedited – 24 hours)
 - Failure to meet timeframe for decision (Expedited – 24 hours)
- The lower scores for clinical decision making were due to the following reasons:
 - Failure to cite criteria for decision
 - Failure to have appropriate professional make decision
- The lower letter scores were due to the following reasons:
 - Failure to describe why the request did not meet criteria in lay language
 - Failure to provide letter with description of services in lay language
 - Failure to provide peer-to-peer discussion of the decision with medical reviewer

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2018	99%	86%	100%	95%
April 2018	96%	91%	100%	99%
May 2018	98%	100%	100%	99%

- No significant trends to report.

5 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.

4. Health Network Audits: OneCare Connect ^{a\}

- 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
March 2018	78%	53%	71%	70%	73%	43%	87%	77%	63%	61%	69%
April 2018	82%	82%	87%	80%	84%	100%	73%	95%	70%	84%	93%
May 2018	83%	50%	70%	85%	71%	63%	81%	85%	80%	66%	74%

- The lower scores for timeliness were due to the following reasons:
 - Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days)
 - Failure to meet timeframe for member notification (2 business days)
 - Failure to meet timeframe for 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 cite criteria for decision
 - Failure to obtain adequate clinical information
 - Failure to have appropriate professional make decision
- The lower letter scores were due to the following reasons:
 - Failure to provide language assistance program (LAP) insert in approved threshold languages
 - Failure to provide member with information on how to file a grievance
 - Failure to provide letter in member’s primary language
 - Failure to provide letter with description of services in lay language
 - Failure to provide peer-to-peer discussion of the decision with medical reviewer
 - 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

6 | a\ “N/A” indicates that the category is not applicable to that file type. “Nothing to Report” indicates that there were no files submitted for review for that file type.

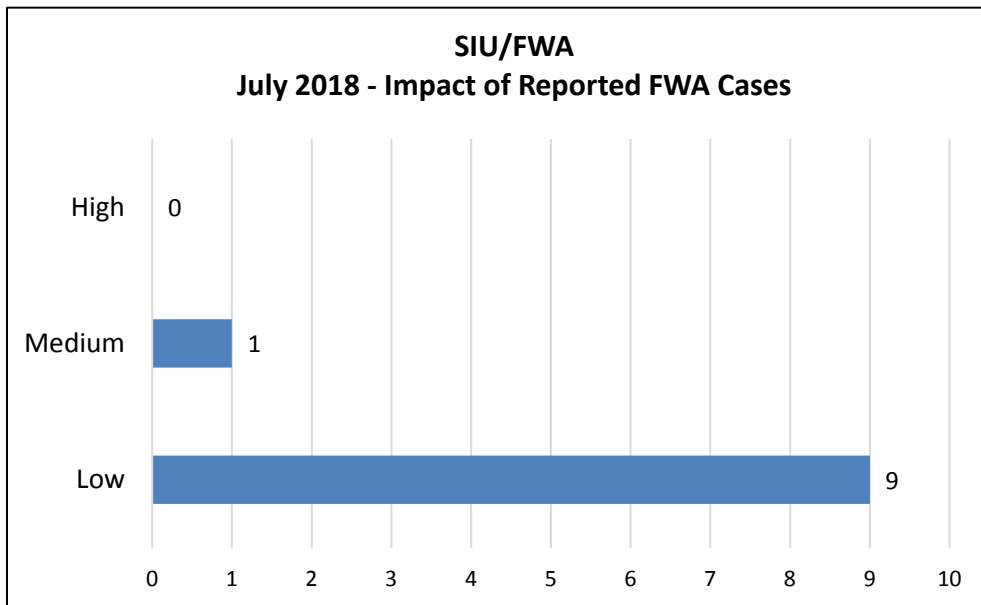
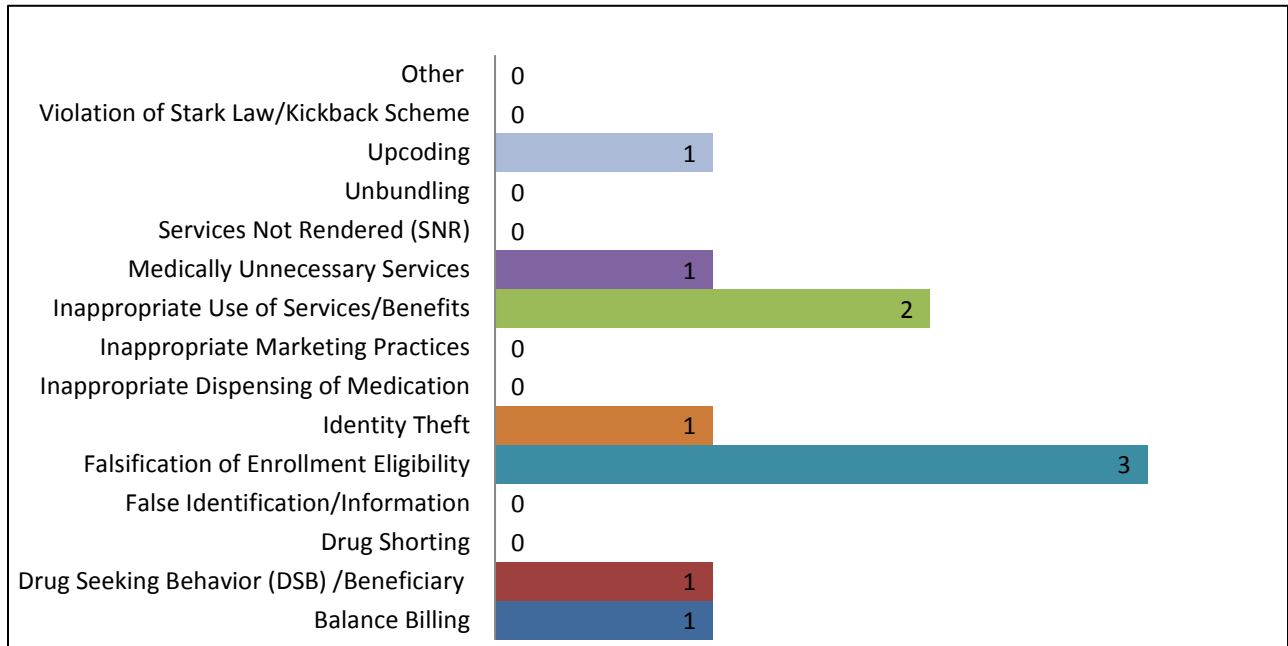
- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2018	91%	95%	98%	97%
April 2018	90%	92%	98%	87%
May 2018	96%	97%	100%	79%

- The compliance rate for denied claims accuracy decreased from 87% in April 2018 to 79% in May 2018 due to missing dual logo on denial notices to member.

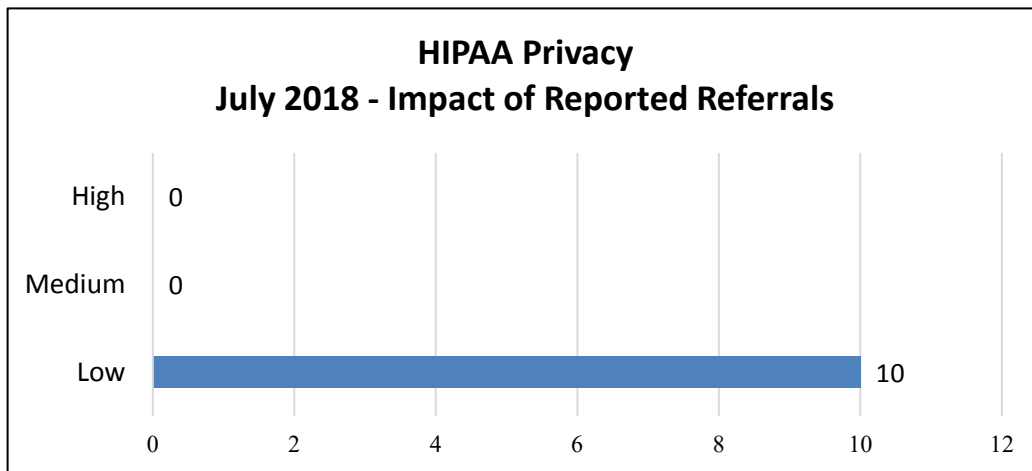
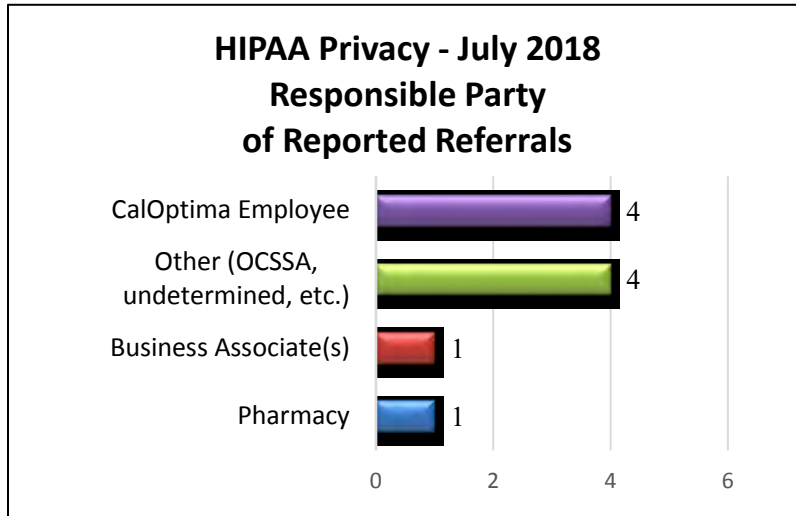
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in July 2018)



8 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.

E. Privacy Update (July 2018)



PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	10
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	10

9 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.



CalOptima
Better. Together.

Federal & State Legislative Advocate Reports

**Board of Directors Meeting
September 6, 2018**

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

M E M O R A N D U M

August 8, 2018

To: CalOptima
From: Akin Gump Strauss Hauer & Feld, LLP
Re: August Board of Directors Report

While the House will be on recess through the end of August, the Senate is cutting its summer break short and will return August 15 to tackle a number of issues on the pre-election agenda, including appropriations and nominations. Meanwhile, work continues in the Senate on crafting comprehensive opioid legislation. This report provides an update on legislative activity through August 8, 2018.

Appropriations

After several delays, the House Appropriations Committee approved its Fiscal Year 2019 Labor-HHS spending bill on a 30-22 vote after a 13-hour session on July 11. The Committee adopted a bipartisan manager's amendment that shifted funds around within the Department of Health and Human Services (HHS), providing an additional \$75 million for Substance Abuse and Mental Health Services Administration (SAMHSA) programs and an additional \$50 million for the Centers for Disease Control and Prevention (CDC). Democrats offered more than a dozen amendments related to migrant family separations, and many were adopted by voice vote. The Committee also adopted 26-25 an amendment from Rep. Marcy Kaptur (D-OH) that would require HHS to report on drug spending in Medicare and Medicaid. House Labor-HHS Subcommittee Chairman Tom Cole (R-OK) stated that he was hopeful that the Labor-HHS bill will be combined with the House Defense appropriations bill (H.R. 6157).

In the Senate, leaders plan to combine the Defense spending bill (S. 3159) with the Labor-HHS appropriations measure (S. 3158), taking up the package after the chamber returns on August 15. Republicans hope pairing the bills will ease passage of the Labor-HHS measure. Still, fights over family planning grants and abortion funding restrictions for global health programs are likely to complicate negotiations over the bill.

Meanwhile, President Trump on July 29 threatened a government shutdown if Democrats fail to support his border security proposals, including funding for a wall on the southern border. Members face a September 30 deadline to pass funding legislation to keep the government open into the next fiscal year. House and Senate leaders have already acknowledged they will need at least a partial continuing resolution to finish work on appropriations.

CalOptima
August 8, 2018
Page 2

Opioid Legislation

Senate Republicans continue to negotiate comprehensive opioid response legislation after the House passed a sweeping package on June 22. With appropriations and nominations on the agenda, it appears unlikely that a final bill will be sent to the President before the midterm elections. In addition, it may be politically advantageous for Senate Republicans to delay action, denying a legislative victory for Democratic incumbents in states hit hard by the crisis. Ultimately, a conference committee will likely be appointed to resolve difference between the House and Senate packages.

Committee Activity

The House Ways and Means Committee advanced 11 bills related to health savings accounts (HSAs) and related issues on July 11; most of the proposals were packaged into two bills the House passed on July 25. H.R. 6199, which passed 277-142, allows additional products and services to count as qualified medical expenses for HSAs and permits additional contributions to a spouse's flexible spending account. H.R. 6311, which passed 242-176, would increase the maximum contribution limit for HSAs and further delay the ACA's health insurance tax until 2022, among other changes.

The House on July 24 also voted 283-132 to pass H.R. 184, which would permanently eliminate the ACA's medical device tax, which is currently suspended through 2019. Fifty-seven Democrats voted for the legislation, one Republican voted against it.

On July 25, the Senate Health, Education, Labor and Pensions (HELP) Committee advanced S. 2554, the Patient Right to Know Drug Prices Act, by voice vote. The bill prohibits pharmacy "gag clauses" that prevent pharmacists from telling a patient if a prescription drug would be more affordable without insurance. CMS warned Part D plans against such contracts following the release of the Administration's drug pricing blueprint.



**CalOptima Legislative Report
By Don Gilbert and Trent Smith
August 13, 2018**

The Legislature returned on August 6 from Summer Recess to conclude their final month of work before adjourning at midnight on August 31. The first order of business is to push hundreds of bills through the Appropriations Committee process. The Appropriations Committees in each house are responsible for evaluating the fiscal impact bills have on the state. Any bill deemed to have a cost to the state of more than \$150,000 is moved to the Suspense File. This low fiscal threshold means a vast majority of bills are placed on the Suspense File. On August 16 both the Senate and Assembly Appropriations Committees will have hearings to announce which bills from the Suspense File will be passed and which will be held. Bills held on the Suspense File are considered dead for the year.

The Governor's Department of Finance (DOF) provides analyses on Suspense File bills, which usually is the first-time authors learn if the Governor is likely to sign or veto their bills. Opposition from the DOF is usually not a good sign and the Appropriations Committees will often, but not always, hold these bills. The capitol community eagerly anticipates the Suspense File hearings as many bills die a "quiet death" at this juncture of the legislative process. This is very good news for bills you may oppose, but devastating if your sponsored legislations are held.

We will be watching closely to see if AB 2275 by Assemblyman Arambula passes off the Senate Appropriations Suspense File. This bill requires the Department of Health Care Services (DHCS) to establish a quality assessment and performance improvement program for all Medi-Cal managed care plans, which requires plans to meet a minimum performance level, effective January 1, 2021, that improves quality of care and reduces health disparities for beneficiaries. While most County Organized Health Systems (COHS), such as CalOptima, usually provide very good quality of care, this bill could be administratively burdensome and costly without any clear benefit to improving care. Furthermore, COHS regularly work with their local communities and DHCS to ensure enrollees receive timely quality care. The Local Health Plans of California (LHPC), of which CalOptima is a member, decided to formally oppose AB 2275 after negotiations with the author to make the bill more manageable failed.

Another bill we are watching closely is AB 2299 by Assemblyman Kansen Chu. This bill requires DHCS to ensure that all written health education and informing materials developed by Medi-Cal managed care plans in English or translated into threshold languages are at or below the equivalent of sixth grade reading level. This measure is opposed by DHCS, which is usually a signal that the Governor could veto the bill should it make it to the Governor's desk. AB 2299 will be heard in the Senate Appropriations Committee on August 13.

AB 2472 is another bill that we have previously reported on. This bill requires Covered California to prepare a feasibility analysis of a public health insurance plan option. In addition, AB 2472 requires a health plan that has a contract with DHCS to negotiate with Covered California to offer coverage in service areas with two or fewer health plan's offering products. Initially, we were concerned that this bill could ultimately force some public Medi-Cal managed care plans to participate in the health benefits exchange. However, the bill now only applies commercial health plans.

Meanwhile, the DHCS negotiations with health plans, clinics, and hospitals intended to reform the 340B drug program appear to have stalled. After months of talks, DHCS seems ready to adopt their own policy, which could be imposed in the form of an "All Plan Letter" imposing new reporting and reimbursement requirements on health plans. The new requirements could take money from clinics, hospitals and contract pharmacies and put it into the pockets of DHCS. Stay tuned.

2017–18 Legislative Tracking Matrix

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H.R. 6 Walden	Opioids – Prescription Controls, Education/Prevention, and Provider Incentives: The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act is a bipartisan effort in response to the national opioid crisis. The bill includes a broad range of provisions from multiple bills that were previously advanced through the House Energy and Commerce and Ways and Means Committees. There are several provisions relevant to the Medicaid and Medicare programs, including proposals to implement controls on pharmaceuticals to prevent inappropriate dispensation of opioids, expand access to effective addiction treatment, increase opioid misuse education and prevention efforts, and provide incentives to discourage physicians from over prescribing opioids.	06/26/2018 Read in the Senate and placed on the Senate Legislative Calendar 06/22/2018 Passed the House 06/13/2018 Introduced	Watch
H.R. 6082 Mullin	Confidentiality Regulations: Would align the federal Confidentiality of Substance Use Disorder Patient Records regulations (42 USC 290dd-2 and 42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) as they relate to the disclosure of substance use disorder (SUD) treatment. This bill would authorize the disclosure of SUD patient records to a covered entity, such as CalOptima, for treatment, payment, and health care operations without a patient’s written consent, which is required under current law. This change would simplify the process of coordinating behavioral and physical health services by allowing health plans and providers treating the same patient to access their member’s SUD treatment information.	06/21/2018 Referred to the Senate Committee on Health, Education, Labor, and Pensions 06/13/2018 Introduced	Watch CalOptima provided feedback to members of OC congressional delegation
H.R. 4957 Sanchez	Improving Alzheimer’s Care: Among other provisions, would establish Alzheimer’s models of care based on a comprehensive continuum of care, similar to care delivery in the Program of All-Inclusive Care for the Elderly (PACE).	02/13/2018 Referred to House Committee on Ways and Means Subcommittee on Health 02/07/2018 Introduced in the House	Watch
H.R. 1625 Royce	FY 2018 Federal Budget/Omnibus Spending Bill: Funds the federal government for the remainder of the 2018 budget year, through September 30. The bill includes: <ul style="list-style-type: none"> • \$1.3 trillion in overall spending • \$403 billion in Medicaid spending (an increase of \$25 billion or 7 percent, accounting for 1.8 million more Medicaid beneficiaries and an increase in opioid related funding, among other factors) • \$3.6 billion for opioid-addiction and mental health services (an increase of \$2.55 billion or 244 percent) <p>Of note, the bill did not include any stabilization measures for the individual market, such as the cost-sharing reduction payments or a federal reinsurance program.</p>	03/22/2018 Signed into law	Watch

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H.R. 1892 Larson	FY 2018 Federal Budget/Previous Spending Levels Continued: <ul style="list-style-type: none"> Establishes a two-year budget framework and continues current federal spending levels until March 23, 2018. Permanently reauthorizes Dual Eligible Special Needs Plans (including CalOptima's OneCare program). Extends reauthorization for the Children's Health Insurance Program (CHIP) until 2027. Extends the Community Health Center Fund (CHCF) for two years. 	02/09/2018 Signed into law	CalOptima sent letter of support for CHIP, D-SNP and CHCF
H.R. 195 Russell	FY 2018 Federal Budget/Previous Spending Levels Continued: Extends current federal discretionary spending until February 8, 2018. Also authorizes CHIP funding for six years, until 2023, and gradually phases down the enhanced federal matching rate – 88/12 federal/state, to the regular CHIP rate – 65/35 federal/state in FY 2021.	01/22/2018 Signed into law	CalOptima sent letter of support for CHIP
H.R. 1 Brady	Tax Cuts and Jobs Act: Amends portions of the Internal Revenue Code that address corporate and individual tax rates and deductions. It also eliminates the Affordable Care Act's (ACA) individual mandate, effective December 31, 2018.	12/22/2017 Signed into law	Watch
H.R. 3922 Walden	Five Year CHIP Re-authorization: Would have extended federal CHIP funding, which expired on September 30, 2017, for five years. Would have retained the current ACA mandated state/federal CHIP matching rate (88/12 for California) for two years, reduced it by 11.5 percent for one year (76.5/23.5), and reverted to pre-ACA levels for two years (65/35). Also included spending offsets such as increasing Medicare premiums for beneficiaries who make more than \$500,000 annually, requiring Medicaid beneficiaries to report lottery winnings as income, and decreasing funding for the ACA-enacted Prevention and Public Health Fund. Of note, H.R. 1892, referenced above, extends federal CHIP funding until 2027, and was signed into law on 02/09/2018.	11/03/2017 Passed House, ordered to Senate 02/09/2018 10-year reauthorization of CHIP funding included as part of H.R. 1892 (Larson)	CalOptima sent letter of support for CHIP
H. Concurrent Resolution 71 Black	FY 2018 Budget Resolution: The annual budget resolution sets the budgetary framework for the upcoming fiscal year and allows Congress to pass reconciliation legislation, which requires 51 votes to pass the Senate rather than the normal 60-vote threshold. While the budget resolution is non-binding and does not appropriate federal dollars, it does outline spending priorities for the remainder of the unfunded fiscal year (December 9, 2017 - September 30, 2018).	10/26/2017 Passed House and Senate (Budget resolutions do not require a Presidential signature)	Watch
H.R. 601 Lowey	FY 2018 Federal Budget/Previous Spending Levels Continued: Extends current federal discretionary spending (\$1.24 trillion overall) and raises the debt ceiling through December 8, 2017. Ensures funding for federal agencies such as the U.S. Department of Health and Human Services (HHS) continues at approximately \$65 billion per year. Mandatory spending (\$2.54 trillion overall) for programs such as Medicare and Medicaid continues at previous levels, less a small percentage, as required by the terms of the Budget Control Act of 2011.	09/08/2017 Signed into law	Watch

2017–18 Legislative Tracking Matrix *(continued)*

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
Bipartisan Health Care Stabilization Act of 2017 Alexander/Murray	<p>Marketplace Stabilization: Would fund cost-sharing reductions (CSRs) – federal payments to marketplace insurers to reduce deductibles and co-pays for consumers earning between 139-250 percent of the federal poverty level (FPL) who have a “silver” level plan – through 2019. Also, would increase flexibility and streamline the state waiver approval process, among other changes.</p> <p>While this bill does not impact Medicaid directly, it is of interest to CalOptima because of its impact on the health care system, and, because it is common for Medicaid members to “churn” between Medicaid and the individual market.</p>	<p>10/19/2017 Draft bill text released</p>	Watch
S. 1804 Sanders	<p>Medicare for All: Would replace the current U.S. health care system with a single-payer system, known as “Medicare for All.” This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs, as well as most forms of private insurance, and enroll all eligible individuals into the new universal plan.</p>	<p>09/13/2017 Referred to Senate Committee on Finance</p>	Watch
H.R. 676 Ellison	<p>Medicare for All: Similar to S. 1804, would replace the current U.S. health care system with a single-payer system, known as “Medicare for All.” This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs as well as most forms of private insurance. The program would be funded via existing sources of government revenues for health care and by increasing personal income taxes on the top five percent of income earners, among other measures.</p>	<p>01/24/2018 Referred to House Committee on Energy and Commerce, House Committee on Ways and Means, and the House Committee on Natural Resources</p>	Watch

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 840 Mitchell	<p>Budget Act of 2018: Funds the state government for the 2018-2019 fiscal year. The Medi-Cal allocation is \$104.4 billion, including \$23 billion general fund. The following allocations impact the Medi-Cal program:</p> <ul style="list-style-type: none"> • Medi-Cal Expansion Population: \$18.7 billion (\$1.7 billion GF) • Coverage for children regardless of immigration status: \$365.2 million (\$287.7 million GF) • Breast and Cervical Cancer Treatment Coverage: \$8.4 million GF • Supplemental Provider Payment: \$710 million (from Proposition 56) <p><i>The Budget Act is the predominant method by which appropriations are made to fund the state government. A budget bill is introduced by January 10 and the Legislature is required to pass the budget bill by June 15. The Budget Bill becomes the Budget Act upon the Governor's signature.</i></p>	<p>06/27/2018 Signed into law by the Governor</p>	Watch
SB 856 Senate Budget Committee	<p>Junior Budget Bill: Makes changes and corrections to the Budget Act of 2018, such as appropriating Proposition 56 tobacco tax revenue and related federal funds for Medi-Cal, among other provisions. This bill allocates up to \$500 million for supplemental payments for physician services and directs the Department of Health Care Services (DHCS) to develop the methodology for distributing these payments as well as post the proposed payment structure on its website by September 30, 2018.</p> <p><i>The Junior Budget Bill is the method by which amendments are made to the chaptered Budget Act.</i></p>	<p>06/27/2018 Signed into law by the Governor</p>	Watch
SB 849 Senate Budget Committee	<p>Medi-Cal Trailer Bill: Budget trailer bill that makes appropriations related to Proposition 56 supplemental payments (in conjunction with SB 856) and creates a dental integration pilot program in San Mateo County (carving dental into managed care), among other provisions.</p> <p><i>When budget changes proposed by the Governor require changes to existing law, the legislation introduces separate legislation, referred to as "trailer bills," which are heard concurrently with the Budget Bill.</i></p>	<p>06/27/2018 Signed into law by the Governor</p>	Watch
SB 850 Senate Budget Committee	<p>Homeless Emergency Aid program and Orange County Shelter: Would establish the Homeless Emergency Aid program to provide local governments with one-time flexible block grant funds to address their immediate homelessness challenges. The bill would require the Business, Consumer Services, and Housing Agency to allocate a total of \$500 million among local governments, with funding allocated according to homeless point-in-time counts, proportionate share of total homeless population, as well as direct allocations to cities and counties with populations over 330,000. This bill would also require DHCS to allocate \$5 million to the Bridges at Kraemer Place emergency shelter in Orange County to create a homeless navigation center.</p>	<p>06/27/2018 Signed into law by the Governor</p>	Watch

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
RN 1802014 Trailer Bill – 340B Drug Program	<p>340B Drug Purchasing Program: Would prohibit the use of 340B discounted drugs in Medi-Cal starting July 1, 2019, pending approval from CMS. Section 340B of the Public Health Service Act allows certain hospitals and clinics to purchase pharmaceuticals at discounted prices.</p> <p>Federal and state agencies have found inconsistencies with the program’s implementation. According to DHCS, these inconsistencies create a substantial administrative burden on the state. As such, the Department’s proposed trailer bill language seeks to prohibit the use of 340B drugs in Medi-Cal. In the event that CMS does not grant the state permission to entirely exclude 340B drugs from Medi-Cal, the state will seek CMS approval for limiting the use of 340B drugs in Medi-Cal.</p> <p>Although this trailer bill language was not included in the final Budget deal, DHCS is likely to continue efforts to reform the 340B program through the regulatory process.</p>	<p>05/15/2018 Heard in Senate Budget Subcommittee No. 3: Health and Human Services</p> <p>01/16/2018 Trailer bill language published on the Department of Finance website</p>	<p>Watch</p> <p>CalOptima provided feedback as part of the CAHP and LHPC comment letters to DHCS</p>
AB 2331 Weber	<p>Medi-Cal Eligibility Redetermination: Would allow developmentally disabled individuals receiving services at regional centers to remain continuously eligible for Medi-Cal. Rather than the beneficiary being responsible for ensuring that annual redetermination is performed, counties will use information provided by the California Department of Developmental Services (DDS) and DHCS to ensure that they meet Medi-Cal eligibility criteria.</p>	<p>05/25/2018 Held under submission in Assembly Appropriations Committee</p> <p>02/13/2018 Introduced</p>	<p>CalOptima sent letter of support</p> <p>LHPC: Support</p>
AB 1963 Waldron	<p>Opioids – Treatment: Would increase provider reimbursement rates for Medication-Assisted Treatments (MAT). MAT requires that patients receive counseling, behavioral therapies, and recovery support services in combination with prescribed medication, such as buprenorphine/naloxone, methadone, buprenorphine, and naltrexone. These therapies have proven to be very effective in treating opioid addiction. There is a significant shortage of providers certified to administer MAT treatments. Depending on how the reimbursement structure is constructed, a rate increase could potentially help CalOptima expand access to MAT services in Orange County.</p>	<p>05/25/2018 Held under submission in Assembly Appropriations Committee</p> <p>01/30/2018 Introduced</p>	<p>Watch</p> <p>CalOptima provided feedback to the bill author</p>
AB 2741 Burke	<p>Opioids – Supply Limit: Would prohibit providers from prescribing more than a five-day opioid supply to a minor, except in the case of pain associated with cancer, palliative or hospice care, chronic pain, and emergency services and care; and require parental consent for opioid prescriptions.</p>	<p>06/18/2018 Held in the Senate Business, Professions and Economic Development Committee at the request of the author</p> <p>05/07/2018 Passed Assembly Floor and ordered to the Senate</p> <p>02/16/2018 Introduced</p>	<p>Watch</p> <p>CalOptima provided feedback to the bill author</p>

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 1998 Rodriguez	<p>Opioids – Prescription Controls: Would institute more stringent prescription controls related to opioids, including limiting opioid prescriptions to amounts sufficient for not more than three days.</p> <p><i>Bills which are determined to exceed a cost impact of \$150,000 are placed on "suspense file" to be heard by the Appropriations Committees at the suspense file hearing towards the end of the legislative cycle. If the bill moves out of the suspense file, it proceeds to the floor for a vote while bills held on suspense die.</i></p>	<p>08/16/2018 Held in Senate Appropriations Committee Suspense File</p> <p>05/30/2018 Passed Assembly Floor and ordered to the Senate</p> <p>02/01/2018 Introduced</p>	<p>Watch</p>
AB 2430 Arambula	<p>Medi-Cal Eligibility for Seniors: Would adjust the income threshold for seniors eligible for Medi-Cal under the Aged and Disabled Federal Poverty Level Program from 123 percent FPL to 138 percent FPL, bringing it in line with other Medi-Cal programs for adult beneficiaries. Currently, seniors with income levels above 123 percent FPL are only eligible for Medi-Cal if they pay an added out of pocket expense known as "share of cost." Under share of cost, beneficiaries must take full responsibility for health care expenses up to a predetermined amount (share of cost) for the month in which they receive services. Once they meet their share of cost, Medi-Cal pays for any additional covered services for that month. This bill aims to ensure that low-income seniors have access to Medi-Cal at the same income level as most other adult beneficiaries, without incurring extra financial burdens.</p>	<p>08/16/2018 Held in Senate Appropriations Committee Suspense File</p> <p>05/29/2018 Passed Assembly Floor and ordered to the Senate</p> <p>02/14/2018 Introduced</p>	<p>Watch</p> <p>CAHP: Support</p> <p>LHPC: Support</p>
SB 945 Atkins	<p>Breast and Cervical Cancer Treatment Program (BCCTP): Would remove the 18 to 24-month cap on coverage under the state Breast and Cervical Cancer Treatment Program (BCCTP), which would allow members to remain in the program and CalOptima to continue receiving adequate reimbursement for the duration of their treatment. Currently, DHCS administers BCCTP, which provides cancer treatment coverage to individuals diagnosed with breast and/or cervical cancer that meet certain screening and income eligibility criteria. Currently, for individuals enrolled in the state BCCTP program, treatment coverage is limited to 18 months for breast cancer and 24 months for cervical cancer.</p> <p>Provisions from SB 945 were included as trailer bill language in AB 1810 (Committee on Budget, Assembly) which was signed into law eliminating the treatment term limits. The Budget includes \$8.4 million General Fund allocation for this purpose.</p>	<p>06/26/2018 Held in the Assembly Health Committee at the request of the author</p> <p>05/29/2018 Passed Senate Floor and ordered to the Assembly</p> <p>01/29/2018 Introduced</p>	<p>Watch</p> <p>LHPC: Support</p>

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2275 Arambula	Medi-Cal Quality Requirements: Would create new quality requirements for Medi-Cal managed care plans, which would be a significant departure from the state’s current quality assurance and performance improvement program. Amended language allows National Committee for Quality Assurance (NCQA) accredited plans, like CalOptima, to submit survey data collected annually as part of the NCQA accreditation.	08/22/2018 Passed Senate Floor and ordered back to the Assembly for concurrence in Senate amendments 05/30/2018 Passed Assembly Floor and ordered to the Senate 02/13/2018 Introduced	Watch CAHP: Oppose LHPC: Oppose CalOptima provided feedback to the bill author
AB 2299 Chu	Materials for Medi-Cal Members: Requires all Medi-Cal managed care plans’ (MCPs) written health education and informational materials to meet a readability and suitability checklist established by DHCS. Informational materials would also be required to go through a “community review” process prior to submission to DHCS. Under current state policy, MCPs are already required to meet readability and suitability standards for all written materials. Currently, CalOptima’s Health Education and Cultural Linguistic Services departments already review all informational materials released to members in all threshold languages. This bill would add an additional step – the community review – to the current process. This additional step could delay the release of member materials for an additional 45 days. According to analysis conducted by staff, while the intent of the bill appears to benefit members, these added requirements would create unnecessary delays in releasing information to members.	08/22/2018 Passed Senate Floor and ordered back to the Assembly for concurrence in Senate amendments 05/29/2018 Passed Assembly Floor and ordered to the Senate 02/13/2018 Introduced	Watch CAHP: Oppose LHPC: Oppose CalOptima provided feedback to the bill author
AB 2579 Burke	WIC to Medi-Cal Express Lane: Would establish an “express lane” eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to Medi-Cal. WIC is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program.	08/16/2018 Held in Senate Appropriations Committee Suspense File 05/30/2018 Passed Assembly Floor and ordered to the Senate 02/15/2018 Introduced	Watch CAHP: Support LHPC: Support
AB 2193 Maienschein	Maternal Mental Health Clinical Case Management Program: Would require health plans to develop a maternal mental health clinical case management program to address mental health conditions that occur during pregnancy or postpartum period. Upon analysis by staff, CalOptima’s Comprehensive Perinatal Services Program (CPSP) appears to comply with the requirements of the bill, as currently written, as these overlap with existing standards and requirements in Medi-Cal managed care contracts.	08/16/2018 Passed Senate Appropriations Committee and ordered to the Senate Floor	Watch CalOptima provided feedback to LHPC

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 1125 Atkins	Access to Mental Health at FQHCs: Would allow a Federally Qualified Health Center (FQHC) to be reimbursed by the state for a mental health visit that occurs on the same day as a medical face-to-face visit. Currently, a patient must seek mental health treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would give members access to both primary care and on-site mental health care on the same day, while ensuring that clinics are appropriately reimbursed for both services. Currently, approximately 138,000 CalOptima members receive care at FQHCs.	<p>08/16/2018 Passed Assembly Appropriations Committee and ordered to the Assembly Floor</p> <p>05/30/2018 Passed Senate Floor and ordered to the Assembly</p> <p>02/13/2018 Introduced</p>	<p>CalOptima sent letter of support</p> <p>LHPC: Support</p>
AB 2029 Garcia	Billable Visits for Service Outside the FQHC's Four Walls: Among other provisions, this bill would align state and federal regulations to allow FQHCs to bill for services provided to CalOptima members outside the FQHC's four walls. Current federal law allows FQHCs to provide services to patients at temporary shelters, a beneficiary's residence, a location of another provider, or any location approved by the U.S. Health Resources and Services Administration (HRSA). Allowing FQHCs to bill for services outside their four walls would expand access to care for CalOptima members who are homebound, require specialized transportation or reside in temporary shelters.	<p>08/16/2018 Held in Senate Appropriations Committee Suspend File</p> <p>02/05/2018 Introduced</p>	<p>Watch</p> <p>CalOptima provided feedback as part of LHPC comment letter to the bill author</p>
AB 2965 Arambula	Medi-Cal Eligibility: Extends full scope Medi-Cal coverage to eligible individuals who are under 26 years of age, regardless of immigration status.	<p>08/16/2018 Held in Senate Appropriations Committee Suspend File</p> <p>05/30/2018 Passed Assembly Floor and ordered to the Senate</p> <p>02/16/2018 Introduced</p>	<p>Watch</p> <p>CAHP: Support</p> <p>LHPC: Support</p>
SB 974 Lara	Medi-Cal Eligibility: Extends full scope Medi-Cal coverage to eligible individuals who are 65 years of age or older, regardless of immigration status.	<p>08/16/2018 Held in Assembly Appropriations Committee Suspend File</p> <p>05/30/2018 Passed Senate Floor and ordered to the Assembly</p> <p>02/01/2018 Introduced</p>	<p>Watch</p> <p>LHPC: Support</p>

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2718 Friedman	Transitional Medi-Cal Eligibility for CalWORKs Recipients: Extends Medi-Cal eligibility from six months to twelve months for families transitioning off the California Work Opportunity and Responsibility to Kids program (CalWORKs). Current state policy allows for a six-month extension of coverage after a family exits the program, and an additional six months if their income remains at or below 185 percent FPL. This bill would allow families to retain access to Medi-Cal coverage for twelve months, regardless of income, by requiring the state to implement the federally allowable twelve-month period option.	08/16/2018 Held in Senate Appropriations Committee Suspend File 05/30/2018 Passed Assembly Floor and ordered to the Senate 02/15/2018 Introduced	Watch
AB 2203 Gray	Medi-Cal Provider Rates: Beginning July 1, 2019, would require DHCS to increase Medi-Cal primary care provider rates to the rate paid for those services under the federal Medicare program.	05/25/2018 Held under submission in Assembly Appropriations Committee 02/12/2018 Introduced	Watch
AB 2122 Reyes	Pediatric Blood Lead Testing: Would require DHCS to notify parents of children enrolled in Medi-Cal of lead testing requirements and inform them when their children have missed the test. Under current law, children are to be tested at 12 months of age and again at 24 months. This bill would require DHCS to report its progress in meeting the lead testing requirements on an annual basis. Medi-Cal managed care plans would be required to notify and educate health care providers that fail to blood test at least eighty percent of enrolled children. According to the bill language, a disproportionate number of children who test positive for lead-poisoning are enrolled in Medi-Cal.	08/23/2018 Passed Senate Floor and ordered back to the Assembly for concurrence in Senate amendments 06/14/2018 Amended to include provider notification and education and re-referred to Senate Health Committee 05/31/2018 Passed Assembly Floor and ordered to the Senate 02/08/2018 Introduced	Watch CalOptima provided feedback to the bill author

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2472 Wood	Medi-Cal Public Option Feasibility Study: Would require Covered California to prepare a feasibility study to assess the possibility of establishing a public health insurance plan. The plan would permit individuals whose income is greater than 138 percent of the federal poverty level to purchase Medi-Cal coverage. Among other requirements, the study would explore the feasibility of allowing Medi-Cal managed care plans to negotiate with Covered California regarding offering products on the California Health Benefit Exchange in counties where only two or fewer plans are available for purchase through the Exchange.	08/22/2018 Passed Senate Floor and ordered back to the Assembly for concurrence in Senate amendments 06/07/18 Amended to merge AB 2416 language regarding requirement for Medi-Cal managed care plans to negotiate with the Exchange Re-referred to Senate Health Committee 02/14/2018 Introduced	Watch
AB 3175 Rubio	Child Life Specialist: Would require that services provided by certified child life specialists be covered under the California Children's Services (CCS) program. CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with specialized health care conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, among others. CCS-eligible children living in select counties, including Orange County, will transition from fee-for-service to Medi-Cal managed care as part of the Whole Child Model (WCM), established as part of SB 586 (Chapter 625, Statutes of 2016). In Orange County, the CCS WCM transition is scheduled to take place in January 2019. Certified child life specialists are allied health care professionals that support children and families coping with the stress and uncertainty of life altering healthcare crises.	05/25/2018 Held under submission in Assembly Appropriations Committee 02/16/2018 Introduced	Watch
SB 906 Beall	Medi-Cal Mental Health Services Peer Certification: Would require DHCS to establish a statewide certification program for peer and family support specialists and to include as a service to be reimbursed under the Medi-Cal program. Among other responsibilities, a peer and family support specialist would provide individualized support services to members with mental health care needs and substance use disorders.	08/16/2018 Passed Assembly Appropriations Committee and ordered to the Assembly Floor 05/30/2018 Passed Assembly Floor and ordered to the Assembly 01/17/2018 Introduced	Watch

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 399 Portantino	Autism Spectrum Disorder Treatment: Would make changes to current law related to the treatment of Autism Spectrum Disorder, such that managed care plans would be required to cover certain treatment protocols that are not currently covered, such as the Developmental Individual-difference Relationship (DIR) model and “Floortime.” These therapies are intended to be spontaneous play sessions between a child with autism and an adult. Also, this bill would reduce the required educational levels of autism service paraprofessionals.	08/16/2018 Passed Assembly Appropriations Committee and ordered to the Assembly Floor 01/29/2018 Passed Senate Floor and ordered to the Assembly 02/15/2017 Introduced	Watch CAHP: Oppose LHPC: Oppose
AB 2565 Chiu	Covered California Premium Assistance: Would require Covered California to offer enhanced premium assistance to individuals between 200 percent and 400 percent FPL who enroll in health care coverage through the Exchange. The enhanced premium assistance would be in addition to the current federal subsidies. According to the bill author, the cost to the state would be \$300 million, and would increase financial assistance to approximately 550,000 people enrolled in Covered California. While this bill does not impact Medi-Cal directly, it is of interest to CalOptima because individuals often “churn” between Medi-Cal and the individual market.	08/16/2018 Held in Senate Appropriations Committee Suspend File 05/30/2018 Passed Assembly Floor and ordered to the Senate 02/15/2018 Introduced	Watch
SB 171 Hernandez	Medicaid Managed Care Final Rule (“Mega Reg”): Implements certain provisions of the Mega Reg by making changes at the state level regarding Medi-Cal managed care plans. Specifically, this bill changes the way public hospitals receive supplemental payments and creates a new, across-the-board Medical Loss Ratio (MLR) standard for Medi-Cal managed care plans. DHCS received federal approval for the new public hospitals directed payment structure, comprised of the Enhanced Payment Program (EPP) and the Quality Incentive Program (QIP), in April 2018.	10/13/2017 Signed into law	Watch
SB 608 Hernandez	Hospital Quality Assurance Fee (QAF): Would modify the QAF to bring it into compliance with CMS Medicaid Managed Care Final Rule requirements. The current language of the bill only reflects a portion of the California Hospital Association’s proposal to reform the QAF. DHCS received federal approval for the new Private Hospital Directed Payment (PHDP) structure in March 2018. The new structure begins a 10-year phase out of the current QAF structure and phase in of the PHDP.	09/01/2017 Held under submission	Watch

CAHP: California Association of Health Plans
LHPC: Local Health Plans of California

Last Updated: August 23, 2018

2017–18 Legislative Tracking Matrix (continued)

2018 Federal Legislative Dates

January 3	116 th Congress convenes 1st session
March 26–April 9	Spring recess
July 27–September 3	Summer recess
November 6	General Election

2018 State Legislative Dates

January 3	Legislature reconvenes
February 16	Last day for legislation to be introduced
April 27	Last day for policy committees to hear and report bills to fiscal committees
May 11	Last day for policy committees to hear and report non-fiscal bills to the floor
May 25	Last day for fiscal committees to report fiscal bills to the floor
May 29–June 1	Floor session only
June 1	Last day to pass bills out of their house of origin
June 5	Statewide Primary Election
June 15	Budget bill must be passed by midnight
June 28	Last day for a legislative measure to qualify for the Nov. 6 General Election ballot
July 6–August 5	Summer recess
August 7	Special Election for CA Senate District 32
August 17	Last day for fiscal committees to report bills to the floor
August 20 – 31	Floor session only
August 31	Last day for bills to be passed. Final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature
November 6	General Election
November 30	Adjournment <i>Sine Die</i> at midnight
December 3	Convening of the 2019-20 session

Sources: 2018 State Legislative Deadlines, California State Assembly: <http://assembly.ca.gov/legislativedeadlines>



CalOptima
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Federal & State Legislative Advocate Reports

**Board of Directors Meeting
September 6, 2018**

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

M E M O R A N D U M

August 8, 2018

To: CalOptima
From: Akin Gump Strauss Hauer & Feld, LLP
Re: August Board of Directors Report

While the House will be on recess through the end of August, the Senate is cutting its summer break short and will return August 15 to tackle a number of issues on the pre-election agenda, including appropriations and nominations. Meanwhile, work continues in the Senate on crafting comprehensive opioid legislation. This report provides an update on legislative activity through August 8, 2018.

Appropriations

After several delays, the House Appropriations Committee approved its Fiscal Year 2019 Labor-HHS spending bill on a 30-22 vote after a 13-hour session on July 11. The Committee adopted a bipartisan manager's amendment that shifted funds around within the Department of Health and Human Services (HHS), providing an additional \$75 million for Substance Abuse and Mental Health Services Administration (SAMHSA) programs and an additional \$50 million for the Centers for Disease Control and Prevention (CDC). Democrats offered more than a dozen amendments related to migrant family separations, and many were adopted by voice vote. The Committee also adopted 26-25 an amendment from Rep. Marcy Kaptur (D-OH) that would require HHS to report on drug spending in Medicare and Medicaid. House Labor-HHS Subcommittee Chairman Tom Cole (R-OK) stated that he was hopeful that the Labor-HHS bill will be combined with the House Defense appropriations bill (H.R. 6157).

In the Senate, leaders plan to combine the Defense spending bill (S. 3159) with the Labor-HHS appropriations measure (S. 3158), taking up the package after the chamber returns on August 15. Republicans hope pairing the bills will ease passage of the Labor-HHS measure. Still, fights over family planning grants and abortion funding restrictions for global health programs are likely to complicate negotiations over the bill.

Meanwhile, President Trump on July 29 threatened a government shutdown if Democrats fail to support his border security proposals, including funding for a wall on the southern border. Members face a September 30 deadline to pass funding legislation to keep the government open into the next fiscal year. House and Senate leaders have already acknowledged they will need at least a partial continuing resolution to finish work on appropriations.

CalOptima
August 8, 2018
Page 2

Opioid Legislation

Senate Republicans continue to negotiate comprehensive opioid response legislation after the House passed a sweeping package on June 22. With appropriations and nominations on the agenda, it appears unlikely that a final bill will be sent to the President before the midterm elections. In addition, it may be politically advantageous for Senate Republicans to delay action, denying a legislative victory for Democratic incumbents in states hit hard by the crisis. Ultimately, a conference committee will likely be appointed to resolve difference between the House and Senate packages.

Committee Activity

The House Ways and Means Committee advanced 11 bills related to health savings accounts (HSAs) and related issues on July 11; most of the proposals were packaged into two bills the House passed on July 25. H.R. 6199, which passed 277-142, allows additional products and services to count as qualified medical expenses for HSAs and permits additional contributions to a spouse's flexible spending account. H.R. 6311, which passed 242-176, would increase the maximum contribution limit for HSAs and further delay the ACA's health insurance tax until 2022, among other changes.

The House on July 24 also voted 283-132 to pass H.R. 184, which would permanently eliminate the ACA's medical device tax, which is currently suspended through 2019. Fifty-seven Democrats voted for the legislation, one Republican voted against it.

On July 25, the Senate Health, Education, Labor and Pensions (HELP) Committee advanced S. 2554, the Patient Right to Know Drug Prices Act, by voice vote. The bill prohibits pharmacy "gag clauses" that prevent pharmacists from telling a patient if a prescription drug would be more affordable without insurance. CMS warned Part D plans against such contracts following the release of the Administration's drug pricing blueprint.



**CalOptima Legislative Report
By Don Gilbert and Trent Smith
August 13, 2018**

The Legislature returned on August 6 from Summer Recess to conclude their final month of work before adjourning at midnight on August 31. The first order of business is to push hundreds of bills through the Appropriations Committee process. The Appropriations Committees in each house are responsible for evaluating the fiscal impact bills have on the state. Any bill deemed to have a cost to the state of more than \$150,000 is moved to the Suspense File. This low fiscal threshold means a vast majority of bills are placed on the Suspense File. On August 16 both the Senate and Assembly Appropriations Committees will have hearings to announce which bills from the Suspense File will be passed and which will be held. Bills held on the Suspense File are considered dead for the year.

The Governor's Department of Finance (DOF) provides analyses on Suspense File bills, which usually is the first-time authors learn if the Governor is likely to sign or veto their bills. Opposition from the DOF is usually not a good sign and the Appropriations Committees will often, but not always, hold these bills. The capitol community eagerly anticipates the Suspense File hearings as many bills die a "quiet death" at this juncture of the legislative process. This is very good news for bills you may oppose, but devastating if your sponsored legislations are held.

We will be watching closely to see if AB 2275 by Assemblyman Arambula passes off the Senate Appropriations Suspense File. This bill requires the Department of Health Care Services (DHCS) to establish a quality assessment and performance improvement program for all Medi-Cal managed care plans, which requires plans to meet a minimum performance level, effective January 1, 2021, that improves quality of care and reduces health disparities for beneficiaries. While most County Organized Health Systems (COHS), such as CalOptima, usually provide very good quality of care, this bill could be administratively burdensome and costly without any clear benefit to improving care. Furthermore, COHS regularly work with their local communities and DHCS to ensure enrollees receive timely quality care. The Local Health Plans of California (LHPC), of which CalOptima is a member, decided to formally oppose AB 2275 after negotiations with the author to make the bill more manageable failed.

Another bill we are watching closely is AB 2299 by Assemblyman Kansen Chu. This bill requires DHCS to ensure that all written health education and informing materials developed by Medi-Cal managed care plans in English or translated into threshold languages are at or below the equivalent of sixth grade reading level. This measure is opposed by DHCS, which is usually a signal that the Governor could veto the bill should it make it to the Governor's desk. AB 2299 will be heard in the Senate Appropriations Committee on August 13.

AB 2472 is another bill that we have previously reported on. This bill requires Covered California to prepare a feasibility analysis of a public health insurance plan option. In addition, AB 2472 requires a health plan that has a contract with DHCS to negotiate with Covered California to offer coverage in service areas with two or fewer health plan's offering products. Initially, we were concerned that this bill could ultimately force some public Medi-Cal managed care plans to participate in the health benefits exchange. However, the bill now only applies commercial health plans.

Meanwhile, the DHCS negotiations with health plans, clinics, and hospitals intended to reform the 340B drug program appear to have stalled. After months of talks, DHCS seems ready to adopt their own policy, which could be imposed in the form of an "All Plan Letter" imposing new reporting and reimbursement requirements on health plans. The new requirements could take money from clinics, hospitals and contract pharmacies and put it into the pockets of DHCS. Stay tuned.

2017–18 Legislative Tracking Matrix

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H.R. 6 Walden	Opioids – Prescription Controls, Education/Prevention, and Provider Incentives: The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act is a bipartisan effort in response to the national opioid crisis. The bill includes a broad range of provisions from multiple bills that were previously advanced through the House Energy and Commerce and Ways and Means Committees. There are several provisions relevant to the Medicaid and Medicare programs, including proposals to implement controls on pharmaceuticals to prevent inappropriate dispensation of opioids, expand access to effective addiction treatment, increase opioid misuse education and prevention efforts, and provide incentives to discourage physicians from over prescribing opioids.	<p>06/26/2018 Read in the Senate and placed on the Senate Legislative Calendar</p> <p>06/22/2018 Passed the House</p> <p>06/13/2018 Introduced</p>	Watch
H.R. 6082 Mullin	Confidentiality Regulations: Would align the federal Confidentiality of Substance Use Disorder Patient Records regulations (42 USC 290dd-2 and 42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) as they relate to the disclosure of substance use disorder (SUD) treatment. This bill would authorize the disclosure of SUD patient records to a covered entity, such as CalOptima, for treatment, payment, and health care operations without a patient’s written consent, which is required under current law. This change would simplify the process of coordinating behavioral and physical health services by allowing health plans and providers treating the same patient to access their member’s SUD treatment information.	<p>06/21/2018 Referred to the Senate Committee on Health, Education, Labor, and Pensions</p> <p>06/13/2018 Introduced</p>	<p>Watch</p> <p>CalOptima provided feedback to members of OC congressional delegation</p>
H.R. 4957 Sanchez	Improving Alzheimer’s Care: Among other provisions, would establish Alzheimer’s models of care based on a comprehensive continuum of care, similar to care delivery in the Program of All-Inclusive Care for the Elderly (PACE).	<p>02/13/2018 Referred to House Committee on Ways and Means Subcommittee on Health</p> <p>02/07/2018 Introduced in the House</p>	Watch
H.R. 1625 Royce	FY 2018 Federal Budget/Omnibus Spending Bill: Funds the federal government for the remainder of the 2018 budget year, through September 30. The bill includes: <ul style="list-style-type: none"> • \$1.3 trillion in overall spending • \$403 billion in Medicaid spending (an increase of \$25 billion or 7 percent, accounting for 1.8 million more Medicaid beneficiaries and an increase in opioid related funding, among other factors) • \$3.6 billion for opioid-addiction and mental health services (an increase of \$2.55 billion or 244 percent) <p>Of note, the bill did not include any stabilization measures for the individual market, such as the cost-sharing reduction payments or a federal reinsurance program.</p>	<p>03/22/2018 Signed into law</p>	Watch

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H.R. 1892 Larson	FY 2018 Federal Budget/Previous Spending Levels Continued: <ul style="list-style-type: none"> Establishes a two-year budget framework and continues current federal spending levels until March 23, 2018. Permanently reauthorizes Dual Eligible Special Needs Plans (including CalOptima's OneCare program). Extends reauthorization for the Children's Health Insurance Program (CHIP) until 2027. Extends the Community Health Center Fund (CHCF) for two years. 	02/09/2018 Signed into law	CalOptima sent letter of support for CHIP, D-SNP and CHCF
H.R. 195 Russell	FY 2018 Federal Budget/Previous Spending Levels Continued: Extends current federal discretionary spending until February 8, 2018. Also authorizes CHIP funding for six years, until 2023, and gradually phases down the enhanced federal matching rate – 88/12 federal/state, to the regular CHIP rate – 65/35 federal/state in FY 2021.	01/22/2018 Signed into law	CalOptima sent letter of support for CHIP
H.R. 1 Brady	Tax Cuts and Jobs Act: Amends portions of the Internal Revenue Code that address corporate and individual tax rates and deductions. It also eliminates the Affordable Care Act's (ACA) individual mandate, effective December 31, 2018.	12/22/2017 Signed into law	Watch
H.R. 3922 Walden	Five Year CHIP Re-authorization: Would have extended federal CHIP funding, which expired on September 30, 2017, for five years. Would have retained the current ACA mandated state/federal CHIP matching rate (88/12 for California) for two years, reduced it by 11.5 percent for one year (76.5/23.5), and reverted to pre-ACA levels for two years (65/35). Also included spending offsets such as increasing Medicare premiums for beneficiaries who make more than \$500,000 annually, requiring Medicaid beneficiaries to report lottery winnings as income, and decreasing funding for the ACA-enacted Prevention and Public Health Fund. Of note, H.R. 1892, referenced above, extends federal CHIP funding until 2027, and was signed into law on 02/09/2018.	11/03/2017 Passed House, ordered to Senate 02/09/2018 10-year reauthorization of CHIP funding included as part of H.R. 1892 (Larson)	CalOptima sent letter of support for CHIP
H. Concurrent Resolution 71 Black	FY 2018 Budget Resolution: The annual budget resolution sets the budgetary framework for the upcoming fiscal year and allows Congress to pass reconciliation legislation, which requires 51 votes to pass the Senate rather than the normal 60-vote threshold. While the budget resolution is non-binding and does not appropriate federal dollars, it does outline spending priorities for the remainder of the unfunded fiscal year (December 9, 2017 - September 30, 2018).	10/26/2017 Passed House and Senate (Budget resolutions do not require a Presidential signature)	Watch
H.R. 601 Lowey	FY 2018 Federal Budget/Previous Spending Levels Continued: Extends current federal discretionary spending (\$1.24 trillion overall) and raises the debt ceiling through December 8, 2017. Ensures funding for federal agencies such as the U.S. Department of Health and Human Services (HHS) continues at approximately \$65 billion per year. Mandatory spending (\$2.54 trillion overall) for programs such as Medicare and Medicaid continues at previous levels, less a small percentage, as required by the terms of the Budget Control Act of 2011.	09/08/2017 Signed into law	Watch

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
Bipartisan Health Care Stabilization Act of 2017 Alexander/Murray	<p>Marketplace Stabilization: Would fund cost-sharing reductions (CSRs) – federal payments to marketplace insurers to reduce deductibles and co-pays for consumers earning between 139-250 percent of the federal poverty level (FPL) who have a “silver” level plan – through 2019. Also, would increase flexibility and streamline the state waiver approval process, among other changes.</p> <p>While this bill does not impact Medicaid directly, it is of interest to CalOptima because of its impact on the health care system, and, because it is common for Medicaid members to “churn” between Medicaid and the individual market.</p>	<p>10/19/2017 Draft bill text released</p>	<p>Watch</p>
S. 1804 Sanders	<p>Medicare for All: Would replace the current U.S. health care system with a single-payer system, known as “Medicare for All.” This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs, as well as most forms of private insurance, and enroll all eligible individuals into the new universal plan.</p>	<p>09/13/2017 Referred to Senate Committee on Finance</p>	<p>Watch</p>
H.R. 676 Ellison	<p>Medicare for All: Similar to S. 1804, would replace the current U.S. health care system with a single-payer system, known as “Medicare for All.” This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs as well as most forms of private insurance. The program would be funded via existing sources of government revenues for health care and by increasing personal income taxes on the top five percent of income earners, among other measures.</p>	<p>01/24/2018 Referred to House Committee on Energy and Commerce, House Committee on Ways and Means, and the House Committee on Natural Resources</p>	<p>Watch</p>

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 840 Mitchell	<p>Budget Act of 2018: Funds the state government for the 2018-2019 fiscal year. The Medi-Cal allocation is \$104.4 billion, including \$23 billion general fund. The following allocations impact the Medi-Cal program:</p> <ul style="list-style-type: none"> • Medi-Cal Expansion Population: \$18.7 billion (\$1.7 billion GF) • Coverage for children regardless of immigration status: \$365.2 million (\$287.7 million GF) • Breast and Cervical Cancer Treatment Coverage: \$8.4 million GF • Supplemental Provider Payment: \$710 million (from Proposition 56) <p><i>The Budget Act is the predominant method by which appropriations are made to fund the state government. A budget bill is introduced by January 10 and the Legislature is required to pass the budget bill by June 15. The Budget Bill becomes the Budget Act upon the Governor's signature.</i></p>	<p>06/27/2018 Signed into law by the Governor</p>	<p>Watch</p>
SB 856 Senate Budget Committee	<p>Junior Budget Bill: Makes changes and corrections to the Budget Act of 2018, such as appropriating Proposition 56 tobacco tax revenue and related federal funds for Medi-Cal, among other provisions. This bill allocates up to \$500 million for supplemental payments for physician services and directs the Department of Health Care Services (DHCS) to develop the methodology for distributing these payments as well as post the proposed payment structure on its website by September 30, 2018.</p> <p><i>The Junior Budget Bill is the method by which amendments are made to the chaptered Budget Act.</i></p>	<p>06/27/2018 Signed into law by the Governor</p>	<p>Watch</p>
SB 849 Senate Budget Committee	<p>Medi-Cal Trailer Bill: Budget trailer bill that makes appropriations related to Proposition 56 supplemental payments (in conjunction with SB 856) and creates a dental integration pilot program in San Mateo County (carving dental into managed care), among other provisions.</p> <p><i>When budget changes proposed by the Governor require changes to existing law, the legislation introduces separate legislation, referred to as "trailer bills," which are heard concurrently with the Budget Bill.</i></p>	<p>06/27/2018 Signed into law by the Governor</p>	<p>Watch</p>
SB 850 Senate Budget Committee	<p>Homeless Emergency Aid program and Orange County Shelter: Would establish the Homeless Emergency Aid program to provide local governments with one-time flexible block grant funds to address their immediate homelessness challenges. The bill would require the Business, Consumer Services, and Housing Agency to allocate a total of \$500 million among local governments, with funding allocated according to homeless point-in-time counts, proportionate share of total homeless population, as well as direct allocations to cities and counties with populations over 330,000. This bill would also require DHCS to allocate \$5 million to the Bridges at Kraemer Place emergency shelter in Orange County to create a homeless navigation center.</p>	<p>06/27/2018 Signed into law by the Governor</p>	<p>Watch</p>

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
RN 1802014 Trailer Bill – 340B Drug Program	<p>340B Drug Purchasing Program: Would prohibit the use of 340B discounted drugs in Medi-Cal starting July 1, 2019, pending approval from CMS. Section 340B of the Public Health Service Act allows certain hospitals and clinics to purchase pharmaceuticals at discounted prices.</p> <p>Federal and state agencies have found inconsistencies with the program’s implementation. According to DHCS, these inconsistencies create a substantial administrative burden on the state. As such, the Department’s proposed trailer bill language seeks to prohibit the use of 340B drugs in Medi-Cal. In the event that CMS does not grant the state permission to entirely exclude 340B drugs from Medi-Cal, the state will seek CMS approval for limiting the use of 340B drugs in Medi-Cal.</p> <p>Although this trailer bill language was not included in the final Budget deal, DHCS is likely to continue efforts to reform the 340B program through the regulatory process.</p>	<p>05/15/2018 Heard in Senate Budget Subcommittee No. 3: Health and Human Services</p> <p>01/16/2018 Trailer bill language published on the Department of Finance website</p>	<p>Watch</p> <p>CalOptima provided feedback as part of the CAHP and LHPC comment letters to DHCS</p>
AB 2331 Weber	<p>Medi-Cal Eligibility Redetermination: Would allow developmentally disabled individuals receiving services at regional centers to remain continuously eligible for Medi-Cal. Rather than the beneficiary being responsible for ensuring that annual redetermination is performed, counties will use information provided by the California Department of Developmental Services (DDS) and DHCS to ensure that they meet Medi-Cal eligibility criteria.</p>	<p>05/25/2018 Held under submission in Assembly Appropriations Committee</p> <p>02/13/2018 Introduced</p>	<p>CalOptima sent letter of support</p> <p>LHPC: Support</p>
AB 1963 Waldron	<p>Opioids – Treatment: Would increase provider reimbursement rates for Medication-Assisted Treatments (MAT). MAT requires that patients receive counseling, behavioral therapies, and recovery support services in combination with prescribed medication, such as buprenorphine/naloxone, methadone, buprenorphine, and naltrexone. These therapies have proven to be very effective in treating opioid addiction. There is a significant shortage of providers certified to administer MAT treatments. Depending on how the reimbursement structure is constructed, a rate increase could potentially help CalOptima expand access to MAT services in Orange County.</p>	<p>05/25/2018 Held under submission in Assembly Appropriations Committee</p> <p>01/30/2018 Introduced</p>	<p>Watch</p> <p>CalOptima provided feedback to the bill author</p>
AB 2741 Burke	<p>Opioids – Supply Limit: Would prohibit providers from prescribing more than a five-day opioid supply to a minor, except in the case of pain associated with cancer, palliative or hospice care, chronic pain, and emergency services and care; and require parental consent for opioid prescriptions.</p>	<p>06/18/2018 Held in the Senate Business, Professions and Economic Development Committee at the request of the author</p> <p>05/07/2018 Passed Assembly Floor and ordered to the Senate</p> <p>02/16/2018 Introduced</p>	<p>Watch</p> <p>CalOptima provided feedback to the bill author</p>

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 1998 Rodriguez	<p>Opioids – Prescription Controls: Would institute more stringent prescription controls related to opioids, including limiting opioid prescriptions to amounts sufficient for not more than three days.</p> <p><i>Bills which are determined to exceed a cost impact of \$150,000 are placed on "suspense file" to be heard by the Appropriations Committees at the suspense file hearing towards the end of the legislative cycle. If the bill moves out of the suspense file, it proceeds to the floor for a vote while bills held on suspense die.</i></p>	<p>08/16/2018 Held in Senate Appropriations Committee Suspense File</p> <p>05/30/2018 Passed Assembly Floor and ordered to the Senate</p> <p>02/01/2018 Introduced</p>	<p>Watch</p>
AB 2430 Arambula	<p>Medi-Cal Eligibility for Seniors: Would adjust the income threshold for seniors eligible for Medi-Cal under the Aged and Disabled Federal Poverty Level Program from 123 percent FPL to 138 percent FPL, bringing it in line with other Medi-Cal programs for adult beneficiaries. Currently, seniors with income levels above 123 percent FPL are only eligible for Medi-Cal if they pay an added out of pocket expense known as "share of cost." Under share of cost, beneficiaries must take full responsibility for health care expenses up to a predetermined amount (share of cost) for the month in which they receive services. Once they meet their share of cost, Medi-Cal pays for any additional covered services for that month. This bill aims to ensure that low-income seniors have access to Medi-Cal at the same income level as most other adult beneficiaries, without incurring extra financial burdens.</p>	<p>08/16/2018 Held in Senate Appropriations Committee Suspense File</p> <p>05/29/2018 Passed Assembly Floor and ordered to the Senate</p> <p>02/14/2018 Introduced</p>	<p>Watch</p> <p>CAHP: Support</p> <p>LHPC: Support</p>
SB 945 Atkins	<p>Breast and Cervical Cancer Treatment Program (BCCTP): Would remove the 18 to 24-month cap on coverage under the state Breast and Cervical Cancer Treatment Program (BCCTP), which would allow members to remain in the program and CalOptima to continue receiving adequate reimbursement for the duration of their treatment. Currently, DHCS administers BCCTP, which provides cancer treatment coverage to individuals diagnosed with breast and/or cervical cancer that meet certain screening and income eligibility criteria. Currently, for individuals enrolled in the state BCCTP program, treatment coverage is limited to 18 months for breast cancer and 24 months for cervical cancer.</p> <p>Provisions from SB 945 were included as trailer bill language in AB 1810 (Committee on Budget, Assembly) which was signed into law eliminating the treatment term limits. The Budget includes \$8.4 million General Fund allocation for this purpose.</p>	<p>06/26/2018 Held in the Assembly Health Committee at the request of the author</p> <p>05/29/2018 Passed Senate Floor and ordered to the Assembly</p> <p>01/29/2018 Introduced</p>	<p>Watch</p> <p>LHPC: Support</p>

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2275 Arambula	Medi-Cal Quality Requirements: Would create new quality requirements for Medi-Cal managed care plans, which would be a significant departure from the state’s current quality assurance and performance improvement program. Amended language allows National Committee for Quality Assurance (NCQA) accredited plans, like CalOptima, to submit survey data collected annually as part of the NCQA accreditation.	08/22/2018 Passed Senate Floor and ordered back to the Assembly for concurrence in Senate amendments 05/30/2018 Passed Assembly Floor and ordered to the Senate 02/13/2018 Introduced	Watch CAHP: Oppose LHPC: Oppose CalOptima provided feedback to the bill author
AB 2299 Chu	Materials for Medi-Cal Members: Requires all Medi-Cal managed care plans’ (MCPs) written health education and informational materials to meet a readability and suitability checklist established by DHCS. Informational materials would also be required to go through a “community review” process prior to submission to DHCS. Under current state policy, MCPs are already required to meet readability and suitability standards for all written materials. Currently, CalOptima’s Health Education and Cultural Linguistic Services departments already review all informational materials released to members in all threshold languages. This bill would add an additional step – the community review – to the current process. This additional step could delay the release of member materials for an additional 45 days. According to analysis conducted by staff, while the intent of the bill appears to benefit members, these added requirements would create unnecessary delays in releasing information to members.	08/22/2018 Passed Senate Floor and ordered back to the Assembly for concurrence in Senate amendments 05/29/2018 Passed Assembly Floor and ordered to the Senate 02/13/2018 Introduced	Watch CAHP: Oppose LHPC: Oppose CalOptima provided feedback to the bill author
AB 2579 Burke	WIC to Medi-Cal Express Lane: Would establish an “express lane” eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to Medi-Cal. WIC is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program.	08/16/2018 Held in Senate Appropriations Committee Suspense File 05/30/2018 Passed Assembly Floor and ordered to the Senate 02/15/2018 Introduced	Watch CAHP: Support LHPC: Support
AB 2193 Maienschein	Maternal Mental Health Clinical Case Management Program: Would require health plans to develop a maternal mental health clinical case management program to address mental health conditions that occur during pregnancy or postpartum period. Upon analysis by staff, CalOptima’s Comprehensive Perinatal Services Program (CPSP) appears to comply with the requirements of the bill, as currently written, as these overlap with existing standards and requirements in Medi-Cal managed care contracts.	08/16/2018 Passed Senate Appropriations Committee and ordered to the Senate Floor	Watch CalOptima provided feedback to LHPC

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 1125 Atkins	Access to Mental Health at FQHCs: Would allow a Federally Qualified Health Center (FQHC) to be reimbursed by the state for a mental health visit that occurs on the same day as a medical face-to-face visit. Currently, a patient must seek mental health treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would give members access to both primary care and on-site mental health care on the same day, while ensuring that clinics are appropriately reimbursed for both services. Currently, approximately 138,000 CalOptima members receive care at FQHCs.	<p>08/16/2018 Passed Assembly Appropriations Committee and ordered to the Assembly Floor</p> <p>05/30/2018 Passed Senate Floor and ordered to the Assembly</p> <p>02/13/2018 Introduced</p>	<p>CalOptima sent letter of support</p> <p>LHPC: Support</p>
AB 2029 Garcia	Billable Visits for Service Outside the FQHC's Four Walls: Among other provisions, this bill would align state and federal regulations to allow FQHCs to bill for services provided to CalOptima members outside the FQHC's four walls. Current federal law allows FQHCs to provide services to patients at temporary shelters, a beneficiary's residence, a location of another provider, or any location approved by the U.S. Health Resources and Services Administration (HRSA). Allowing FQHCs to bill for services outside their four walls would expand access to care for CalOptima members who are homebound, require specialized transportation or reside in temporary shelters.	<p>08/16/2018 Held in Senate Appropriations Committee Suspend File</p> <p>02/05/2018 Introduced</p>	<p>Watch</p> <p>CalOptima provided feedback as part of LHPC comment letter to the bill author</p>
AB 2965 Arambula	Medi-Cal Eligibility: Extends full scope Medi-Cal coverage to eligible individuals who are under 26 years of age, regardless of immigration status.	<p>08/16/2018 Held in Senate Appropriations Committee Suspend File</p> <p>05/30/2018 Passed Assembly Floor and ordered to the Senate</p> <p>02/16/2018 Introduced</p>	<p>Watch</p> <p>CAHP: Support</p> <p>LHPC: Support</p>
SB 974 Lara	Medi-Cal Eligibility: Extends full scope Medi-Cal coverage to eligible individuals who are 65 years of age or older, regardless of immigration status.	<p>08/16/2018 Held in Assembly Appropriations Committee Suspend File</p> <p>05/30/2018 Passed Senate Floor and ordered to the Assembly</p> <p>02/01/2018 Introduced</p>	<p>Watch</p> <p>LHPC: Support</p>

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2718 Friedman	Transitional Medi-Cal Eligibility for CalWORKs Recipients: Extends Medi-Cal eligibility from six months to twelve months for families transitioning off the California Work Opportunity and Responsibility to Kids program (CalWORKs). Current state policy allows for a six-month extension of coverage after a family exits the program, and an additional six months if their income remains at or below 185 percent FPL. This bill would allow families to retain access to Medi-Cal coverage for twelve months, regardless of income, by requiring the state to implement the federally allowable twelve-month period option.	08/16/2018 Held in Senate Appropriations Committee Suspend File 05/30/2018 Passed Assembly Floor and ordered to the Senate 02/15/2018 Introduced	Watch
AB 2203 Gray	Medi-Cal Provider Rates: Beginning July 1, 2019, would require DHCS to increase Medi-Cal primary care provider rates to the rate paid for those services under the federal Medicare program.	05/25/2018 Held under submission in Assembly Appropriations Committee 02/12/2018 Introduced	Watch
AB 2122 Reyes	Pediatric Blood Lead Testing: Would require DHCS to notify parents of children enrolled in Medi-Cal of lead testing requirements and inform them when their children have missed the test. Under current law, children are to be tested at 12 months of age and again at 24 months. This bill would require DHCS to report its progress in meeting the lead testing requirements on an annual basis. Medi-Cal managed care plans would be required to notify and educate health care providers that fail to blood test at least eighty percent of enrolled children. According to the bill language, a disproportionate number of children who test positive for lead-poisoning are enrolled in Medi-Cal.	08/23/2018 Passed Senate Floor and ordered back to the Assembly for concurrence in Senate amendments 06/14/2018 Amended to include provider notification and education and re-referred to Senate Health Committee 05/31/2018 Passed Assembly Floor and ordered to the Senate 02/08/2018 Introduced	Watch CalOptima provided feedback to the bill author

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2472 Wood	<p>Medi-Cal Public Option Feasibility Study: Would require Covered California to prepare a feasibility study to assess the possibility of establishing a public health insurance plan. The plan would permit individuals whose income is greater than 138 percent of the federal poverty level to purchase Medi-Cal coverage. Among other requirements, the study would explore the feasibility of allowing Medi-Cal managed care plans to negotiate with Covered California regarding offering products on the California Health Benefit Exchange in counties where only two or fewer plans are available for purchase through the Exchange.</p>	<p>08/22/2018 Passed Senate Floor and ordered back to the Assembly for concurrence in Senate amendments</p> <p>06/07/18 Amended to merge AB 2416 language regarding requirement for Medi-Cal managed care plans to negotiate with the Exchange</p> <p>Re-referred to Senate Health Committee</p> <p>02/14/2018 Introduced</p>	Watch
AB 3175 Rubio	<p>Child Life Specialist: Would require that services provided by certified child life specialists be covered under the California Children's Services (CCS) program. CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with specialized health care conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, among others. CCS-eligible children living in select counties, including Orange County, will transition from fee-for-service to Medi-Cal managed care as part of the Whole Child Model (WCM), established as part of SB 586 (Chapter 625, Statutes of 2016). In Orange County, the CCS WCM transition is scheduled to take place in January 2019. Certified child life specialists are allied health care professionals that support children and families coping with the stress and uncertainty of life altering healthcare crises.</p>	<p>05/25/2018 Held under submission in Assembly Appropriations Committee</p> <p>02/16/2018 Introduced</p>	Watch
SB 906 Beall	<p>Medi-Cal Mental Health Services Peer Certification: Would require DHCS to establish a statewide certification program for peer and family support specialists and to include as a service to be reimbursed under the Medi-Cal program. Among other responsibilities, a peer and family support specialist would provide individualized support services to members with mental health care needs and substance use disorders.</p>	<p>08/16/2018 Passed Assembly Appropriations Committee and ordered to the Assembly Floor</p> <p>05/30/2018 Passed Assembly Floor and ordered to the Assembly</p> <p>01/17/2018 Introduced</p>	Watch

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 399 Portantino	Autism Spectrum Disorder Treatment: Would make changes to current law related to the treatment of Autism Spectrum Disorder, such that managed care plans would be required to cover certain treatment protocols that are not currently covered, such as the Developmental Individual-difference Relationship (DIR) model and “Floortime.” These therapies are intended to be spontaneous play sessions between a child with autism and an adult. Also, this bill would reduce the required educational levels of autism service paraprofessionals.	08/16/2018 Passed Assembly Appropriations Committee and ordered to the Assembly Floor 01/29/2018 Passed Senate Floor and ordered to the Assembly 02/15/2017 Introduced	Watch CAHP: Oppose LHPC: Oppose
AB 2565 Chiu	Covered California Premium Assistance: Would require Covered California to offer enhanced premium assistance to individuals between 200 percent and 400 percent FPL who enroll in health care coverage through the Exchange. The enhanced premium assistance would be in addition to the current federal subsidies. According to the bill author, the cost to the state would be \$300 million, and would increase financial assistance to approximately 550,000 people enrolled in Covered California. While this bill does not impact Medi-Cal directly, it is of interest to CalOptima because individuals often “churn” between Medi-Cal and the individual market.	08/16/2018 Held in Senate Appropriations Committee Suspend File 05/30/2018 Passed Assembly Floor and ordered to the Senate 02/15/2018 Introduced	Watch
SB 171 Hernandez	Medicaid Managed Care Final Rule (“Mega Reg”): Implements certain provisions of the Mega Reg by making changes at the state level regarding Medi-Cal managed care plans. Specifically, this bill changes the way public hospitals receive supplemental payments and creates a new, across-the-board Medical Loss Ratio (MLR) standard for Medi-Cal managed care plans. DHCS received federal approval for the new public hospitals directed payment structure, comprised of the Enhanced Payment Program (EPP) and the Quality Incentive Program (QIP), in April 2018.	10/13/2017 Signed into law	Watch
SB 608 Hernandez	Hospital Quality Assurance Fee (QAF): Would modify the QAF to bring it into compliance with CMS Medicaid Managed Care Final Rule requirements. The current language of the bill only reflects a portion of the California Hospital Association’s proposal to reform the QAF. DHCS received federal approval for the new Private Hospital Directed Payment (PHDP) structure in March 2018. The new structure begins a 10-year phase out of the current QAF structure and phase in of the PHDP.	09/01/2017 Held under submission	Watch

CAHP: California Association of Health Plans
LHPC: Local Health Plans of California

Last Updated: August 23, 2018

2017–18 Legislative Tracking Matrix (continued)

2018 Federal Legislative Dates

January 3	116 th Congress convenes 1st session
March 26–April 9	Spring recess
July 27–September 3	Summer recess
November 6	General Election

2018 State Legislative Dates

January 3	Legislature reconvenes
February 16	Last day for legislation to be introduced
April 27	Last day for policy committees to hear and report bills to fiscal committees
May 11	Last day for policy committees to hear and report non-fiscal bills to the floor
May 25	Last day for fiscal committees to report fiscal bills to the floor
May 29–June 1	Floor session only
June 1	Last day to pass bills out of their house of origin
June 5	Statewide Primary Election
June 15	Budget bill must be passed by midnight
June 28	Last day for a legislative measure to qualify for the Nov. 6 General Election ballot
July 6–August 5	Summer recess
August 7	Special Election for CA Senate District 32
August 17	Last day for fiscal committees to report bills to the floor
August 20 – 31	Floor session only
August 31	Last day for bills to be passed. Final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature
November 6	General Election
November 30	Adjournment <i>Sine Die</i> at midnight
December 3	Convening of the 2019-20 session

Sources: 2018 State Legislative Deadlines, California State Assembly: <http://assembly.ca.gov/legislativedeadlines>

Board of Directors Meeting September 6, 2018

CalOptima Community Outreach Summary – August 2018

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

In FY 2017–2018, the Community Relations department received 167 requests for CalOptima to participate in public activities. Approximately 93 percent (154 of 167) of the requests met at least one of the criteria required for CalOptima’s participation. CalOptima participated in approximately 86 percent (133 of the 154) of the approved public activity requests. CalOptima did not participate in approximately 21 approved public activity requests due to limited staff availability, short notice or cancellation of events.

Public activities attended range from health, literacy, housing and community resource fairs, to back-to-school events, conferences and community celebrations throughout Orange County. During these events, CalOptima interacted with current and potential members of all ages and ethnic backgrounds. Approximately 33 percent of these events provided outreach to the general public, combined populations of children and families, adults, and seniors. Approximately 32 percent of these events provided outreach to children and families, 30 percent outreached to seniors and people with disabilities, 2 percent outreached to veterans and their families, and 3 percent outreached to foster children and

homeless individuals/families. The remainder of the events were educational seminars and conferences for staff development.

CalOptima also provided financial support to nearly 60 community events. A total of \$67,397 was contributed to community events that provided opportunity for CalOptima staff to engage with members/potential members. Financial support for these events included registration fees and sponsorships. Financially supporting these community events provided CalOptima opportunities to outreach to members and potential members, and to promote awareness of CalOptima in the community, CalOptima's programs and services, and long-term collaborative partnerships with requesting entities.

For additional information or questions, please contact Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities

During August 2018, CalOptima participated in 34 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
8/01/18	<ul style="list-style-type: none">• Orange County Aging Services Collaborative General Meeting• Anaheim Human Services Network Meeting• Orange County Healthy Aging Initiative Meeting
8/03/18	<ul style="list-style-type: none">• Covered Orange County General Meeting• Help Me Grow Advisory Meeting
8/06/18	<ul style="list-style-type: none">• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting
8/07/18	<ul style="list-style-type: none">• Collaborative to Assist Motel Families Meeting
8/08/18	<ul style="list-style-type: none">• Buena Park Collaborative Meeting• Anaheim Homeless Collaborative Meeting
8/09/18	<ul style="list-style-type: none">• FOCUS Collaborative Meeting
8/13/18	<ul style="list-style-type: none">• Orange County Veterans and Military Families Collaborative Meeting• Fullerton Collaborative Meeting
8/14/18	<ul style="list-style-type: none">• Orange County Strategic Plan for Aging — Social Engagement Committee Meeting
8/15/18	<ul style="list-style-type: none">• 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
8/16/18	<ul style="list-style-type: none">• Orange County Children's Partnership Committee

[Back to Agenda](#)

- Surf City Senior Providers Network Meeting
- Orange County Women’s Health Project Advisory Board Meeting

- 8/21/18
 - Placentia Community Collaborative Meeting
 - Orange County Cancer Coalition Meeting

- 8/23/18
 - Disability Coalition of Orange County
 - Orange County Care Coordination for Kids

- 8/27/18
 - Community Health Research and Exchange

- 8/28/18
 - Orange County Senior Roundtable
 - Santa Ana Building Healthy Communities

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff to Attend	Events/Meetings
8/04/18	2	<ul style="list-style-type: none"> • 130th Anniversary Back to School Celebration (Sponsorship Fee: \$1,000 included a table for outreach at event.)
8/10/18	2	<ul style="list-style-type: none"> • Annual Senior Resource Fair hosted by the Office of Congresswoman Linda Sanchez
8/11/18	2 2	<ul style="list-style-type: none"> • Back to School Health Fair hosted by the Institute for Healthcare Advancement (Registration Fee: \$25 included a table for outreach at event) • Orange County Asian and Pacific Islander Mental Health Summit hosted by St. Joseph Health
8/18/18	2	<ul style="list-style-type: none"> • Super Senior Saturday hosted by the City of Buena Park Senior Center (Registration Fee: \$150 included a table for outreach at event.)
8/25/18	2	<ul style="list-style-type: none"> • Ridiculous Goodness Event hosted by Depression and Bipolar Support Alliance
8/26/18	2	<ul style="list-style-type: none"> • Back to School Health and Resource Fair hosted by the Boys and Girls Club of Garden Grove

CalOptima organized or convened the following seven community stakeholder events, meetings and presentations:

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

- | Date | Events/Meetings/Presentations |
|-------------|--|
| 8/01/18 | <ul style="list-style-type: none"> • CalOptima Health Education Workshop — Topic: Shape Your Life |

- 8/08/18
 - CalOptima Health Education Workshop — Topic: Shape Your Life
 - CalOptima New Member Orientation for Medi-Cal and Medicare eligible members (Farsi and Korean)
- 8/15/18
 - CalOptima Health Education Workshop — Topic: Shape Your Life
- 8/22/18
 - CalOptima Health Education Workshop — Topic: Shape Your Life
- 8/23/18
 - CalOptima New Member Orientation for Medi-Cal eligible members (Chinese, Arabic and Vietnamese)
 - CalOptima Health Education Workshop — Topic: APS AES Workshop

CalOptima provided zero endorsements for events during this reporting period (e.g., letters of support, program/public activity event with support, or use of name/logo).

CalOptima Board of Directors Community Activities

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

<h1>September</h1>				
Date and Time	Event Title	Event Type/Audience	Staff/Financial Participation	Location
Thursday, 9/6 9-11am	++Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 9/6 9-10:30am	++Refugee Forum of Orange County	Steering Committee Meeting: Open to Collaborative Members	N/A	Access California Services 631 S. Brookhurst St. Anaheim
Saturday, 9/8 10am-1pm	+Huntington Beach Council on Aging Senior Saturday Community Festival	Health/Resource Fair Open to the Public	Sponsorship \$850 2 Staff	Huntington Beach Pier Huntington Beach
Monday, 9/10 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, 9/10 2:30-3:30pm	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 9/11 9-10:30am	++Orange County Strategic Plan for Aging-Social Engagement Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine

* CalOptima Hosted

1 – Updated 2018-08-1

+ Exhibitor/Attendee
++ Meeting Attendee

[Back to Agenda](#)

Tuesday, 9/11 10-11am	*CalOptima New Member Orientation <i>Presentation in English and Spanish</i>	Community Presentation Open to the public	1 Staff	CalOptima
Tuesday, 9/11 2-4pm	++Susan G. Komen OC Unidos Contra el Cancer del Seno Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	Susan G. Komen OC 2817 McGaw Ave. Irvine
Wednesday, 9/12 12-1pm	++Buena Clinton Neighborhood Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Clinton Youth and Family Center 12661 Sunswept Ave. Garden Grove
Wednesday, 9/12 12-1:30pm	++Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Thursday, 9/13 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, 9/13 3:30-5:30pm	++State Council on Developmental Disabilities Regional Advisory Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	State Council on Developmental Disabilities
Thursday, 9/13 5-6:30pm	*Health Education Workshops Shape Your Life	Open to the Public Registration required.	N/A	Ponderosa Family Resource Center 320 E. Orangewood Ave. Anaheim
Friday, 9/14 3:30-5:30pm	++Senior Citizens Advisory Council Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies.
Saturday, 9/15 10am-1pm	+City of Anaheim Active Older Adult Program Health and Resource Expo	Health/Resource Fair Open to the Public	2 Staff	Downtown Anaheim Community Center 250 E. Center St. Anaheim
Sunday, 9/16 11am-3pm	+OC Social Services Agency Foster Family Picnic	Health/Resource Fair Open to the Public	2 Staff	Kiwanis Land 9840 Larson Ave. Garden Grove

* CalOptima Hosted

2 – Updated 2018-08-1

+ Exhibitor/Attendee

++ Meeting Attendee

[Back to Agenda](#)

Tuesday, 9/18 8:30-10am	++North Orange County Senior Collaborative All Members Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	St. Jude Community Services 130 W. Bastanchury Rd. Fullerton
Tuesday, 9/18 10-11:30am	++Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Trinity Center Placentia Presbyterian Church 849 Bradford Ave. Placentia
Wednesday, 9/19 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, 9/19 1-4pm	++Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies
Wednesday, 9/19 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, 9/20 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
Thursday, 9/20 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. 17 th St. Santa Ana
Thursday, 9/20 5-6:30pm	*Health Education Workshops Shape Your Life	Open to the Public Registration required.	N/A	Ponderosa Family Resource Center 320 E. Orangewood Ave. Anaheim
Thursday, 9/20 2-4:30pm	*CME Workshop Pain Management and Opioids	Open to Physicians and Licensed Health Care Professionals Registration required.	N/A	DoubleTree Hotel 100 The City Drive Orange

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3 – Updated 2018-08-1

+ Exhibitor/Attendee
++ Meeting Attendee

[Back to Agenda](#)

Friday, 9/20 7:30am-4pm	++Annual SoCal Alzheimer's Disease Research Conference	Conference Open to the Public Registration required.	Registration fee \$250	Irvine Marriott Hotel 18000 Von Karman Ave. Irvine
Monday, 9/24 12:30-1:30pm	++Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton
Tuesday, 9/25 9-11:30am	*Community Alliances Forum	Community Presentation Open to the Public Registration recommended	N/A	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 9/25 7:30-9am	++Santa Ana Building Healthy Communities	Steering Committee Meeting: Open to Collaborative Members	N/A	KidWorks 1902 W. Chestnut Ave. Santa Ana
Thursday, 9/27 8:30-10am	++Disability Coalition of Orange County	Steering Committee Meeting: Open to Collaborative Members	N/A	Dayle McIntosh Center 501 N. Brookhurst St. Anaheim
Thursday, 9/27 10-11am	*CalOptima New Member Orientation <i>Presentation in Farsi and Korean</i>	Community Presentation Open to the public	1 Staff	CalOptima
Thursday, 9/27 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
Thursday, 9/27 5-6:30pm	*Health Education Workshops Shape Your Life	Open to the Public Registration required.	N/A	Ponderosa Family Resource Center 320 E. Orangewood Ave. Anaheim

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4 – Updated 2018-08-1

+ Exhibitor/Attendee

++ Meeting Attendee

[Back to Agenda](#)